AIMS

JOURNAL

Dare we say it?
Physiological birth

Volume 35, Number 1
2023

AIMS

The Association for Improvements in the Maternity Services

Registered Charity No: 1157845 2018

Contact Details

Join AIMS – www.aims.org.uk/join-us

Contact – www.aims.org.uk/contact

Donations – www.aims.org.uk/donate

Getting involved – www.aims.org.uk/volunteering

Events – www.aims.org.uk/events

Shop – www.aims.org.uk/shop

About AIMS – www.aims.org.uk/about-aims

Vol:35 No1
AIMS Journal (Online)
ISSN 2516-5852

~~~

If you would like to submit articles to the AIMS Journal, we would be delighted to receive them. Please email journal@aims.org.uk

~~~

Contents

Editorial

Why does physiological birth matter?

Alex Smith

The theme for the March 2023 issue of the AIMS journal is, dare we say it, physiological birth. Carolyn Warrington opens this editorial by explaining why physiology-informed care enhances every birth and protects the well-being of the whole family.

Carolyn Warrington

AIMS has recently published a position paper calling for physiology-informed maternity services that are designed and act with an understanding of physiology. As we state in that paper we believe that this approach is key to underpinning a holistic approach to maternity safety. This means having a focus on avoiding causing harm to the long-term well-being of the whole family, including their mental health, as well as on reducing the risk of mortality and short-term physical harm.

There has been much discussion about 'misguided pursuit of normal birth at any cost' which AIMS is concerned has undermined the focus on understanding physiology and how that understanding can optimise birth in all settings, however the baby is born.

In one setting, this might be maintaining a quiet "oxytocin bubble" to support a physiological placental birth. In another, it might mean leaving the cord intact while initiating the resuscitation of a baby born at the threshold of survival.

We believe this fresh approach is key to developing safe, respectful services that focus scarce resources where they are needed. This is about understanding the science that underlies birth physiology, enabling births to be supported to happen without unnecessary intervention, or, where it is appropriate, with the support of obstetric interventions and advances in a way that works with, not against physiology.

Our position paper[1] outlines our aspirations. The campaigns team are looking for help to develop a vision of what a fully physiology-informed maternity service would look like, a checklist of actions needed to achieve our vision, and case studies of how an understanding of physiology has improved maternity services. Want to get on board? Please email campaigns@aims.org.uk

Author bio: *Carolyn is a birth enthusiast and an advocate of parental choice and human rights in birth. She had a beautiful home birth with her first baby, followed by a medicalised twin birth. She is a home-edding parent of three, and just happens to be an obstetric senior registrar!*

Image by Sophie Jenna

The issue opens with my (Alex Smith) every-day description of the physiological process of labour and birth, linking biological facts to the labouring person's lived experience. Doula Natalie Meddings, follows by setting her knowledge of physiological birth into its current political context and asking the controversial question, 'is physiological birth a dangerous cult or a scientific fact?' Birth artist Sophie Jenna reflects on her personal birth journey and shares some of her beautiful artwork with AIMS readers, while author Sallyann Beresford brings art into the title of her piece holding that there is an art to giving birth and setting

out her five key principles for supporting physiological birth. Midwife, aromatherapist and yogi, Nicole Schlögel, considers the socio-cultural birth environment and its impact on the birth experience, which is followed by a report on the 'Biomechanics for Birth' courses run by Molly O'Brien, who is also a midwife.

Moving away from the theme of physiological birth, but all interlinked in their different ways, we have a number of other important contributions to this quarter's issue. Dr James Munro introduces Care Opinion, an online feedback platform for health services across the UK, and AIMS volunteer Leslie Altic tells us about Continuity of Midwifery Carer schemes in Northern Ireland. The AIMS Campaigns team review the latest MBRRACE report, which covers the confidential enquiries into maternal deaths and morbidity in the UK and Ireland over the three-year period 2018-2020, and Nadia Higson reports on a recent conference that was looking at various aspects of the impact of Covid-19 on maternity and child services and how these can inform services as they rebuild. Next we have a fond farewell to, and from, Julia Cumberlege and Cyril Chantler, champions for changing childbirth for the better, written up for us by Jo Dagustun, and this is followed by the very sad news of the death of Beverley Lawrence Beech. Beverley was Chair of AIMS for forty years and it was her strong and fearless voice that brought me to AIMS and that echoes still. In this issue she is remembered by Debbie Chippington-Derrick. Last but not least, there is the AIMS Campaigns team's list of everything they have been doing since December.

We are very grateful to all the volunteers who help in the production of our Journal: our authors, peer reviewers, proofreaders, website uploaders and, of course, our readers and supporters. This edition especially benefited from the help of Anne Glover, Carolyn Warrington, Jo Dagustun, Danielle Gilmour, Joanna Rana, and Josey Smith.

The theme for the June issue of the AIMS journal is birthplace. We will be looking at the social and political forces that shape people's feelings and decisions about place of birth, as well as what current research shows about holistic safety and the place of birth. With this theme in mind, we warmly invite reflections on personal birthplace decisions, and any accounts of births in unusual places! If you have a story to share, please email editor@aims.org.uk for further information.

Alex Smith (Editor)

1 AIMS position paper on Physiology-Informed Maternity Services. www.aims.org.uk/assets/media/730/aims-position-paper-physiology-informed-maternity-care.pdf

Article

Physiological birth: how it works

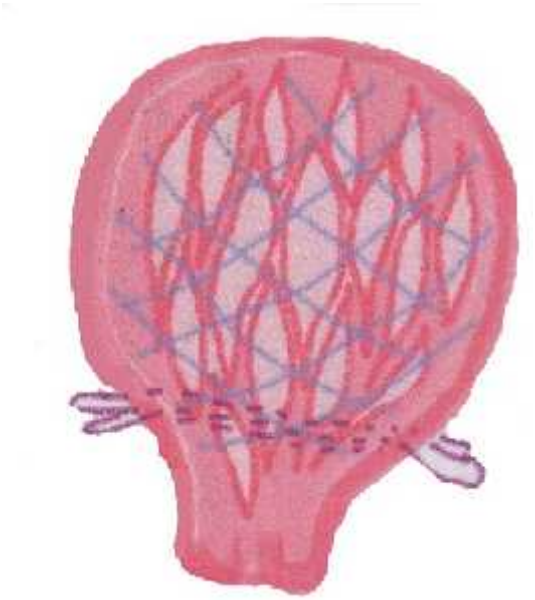
by Alex Smith

By Alex Smith

These days, it is easy to believe that birth is a medical procedure rather than simply being the final day or two of a physiological process that has been unfolding since conception. As a culture, we have become a little hoodwinked by the medical model of care and literally lost sight of birth as a physiological process - a process that, not always, but more often than not, could safely unfold within the course of the woman's normal daily round without any need for clinical supervision, latex gloves, protocols and partograms. In this article I hope to lift the 'hood' to take a look at just a few ways in which the pregnant body adapts in readiness to give birth safely and smoothly *when trusted to do so in the time that it takes.*

> *Childbirth is a physiological process that can be accomplished without complications for the majority of women and babies.*[1]

Starting with the womb: The womb or uterus is a bag of muscle that sits in the pelvis supported by the pelvic floor muscles and anchored to the pelvis, like a hot air balloon to the ground, by the uterine ligaments. When no baby is in residence, the womb is about the size of a small pear, but in pregnancy it can stretch and grow to the size of a large watermelon. The womb contracts every 15 to 20 minutes throughout life (otherwise it would atrophy) and, in labour, these contractions become so powerful that they make the womb the strongest muscle in the human body.



The womb is made of layers of muscle fibres. Longitudinal fibres are represented in the image above by the pale pink shapes, diagonal fibres are represented by the blue lines, and circular fibres, present in the lower part of the womb, are represented by the purple 'drawstring'.

The opening of the womb, the area below the drawstring, is called the cervix. This can be felt at the top of the vagina like a circular doughnut. The passage through the cervix, the os, tends to face towards the back wall of the vagina, while the body of the womb lies forward over the bladder. In the non-pregnant state, the cervix feels firm like the tip of the nose, but very early in pregnancy the hormones progesterone and relaxin prepare the womb and soften maternal tissues making them stretchier. As a result, the cervix starts to feel softer like the lips, the uterine ligaments relax, and the womb becomes less contractile or more quiescent, allowing

both the womb and the baby to grow. At the same time, the circular 'drawstring' fibres remain contracted keeping the opening of the womb closed and the baby safe and warm inside.

The softening effect of relaxin also allows the mother's rib cage to expand in pregnancy, requiring bras to be loosened long before there is any pregnancy bump. This facilitates the increase in lung capacity that is required to supply oxygen to the 45% (on average) increase in maternal blood volume. These vital changes happen within the privacy of the mother's body, without question or doubt. We may worry about losing the baby of course, but because no one is measuring or monitoring ribcage expansion, blood volume increase or relaxin levels, we give those aspects little if any thought and generally trust our bodies to know what to do.

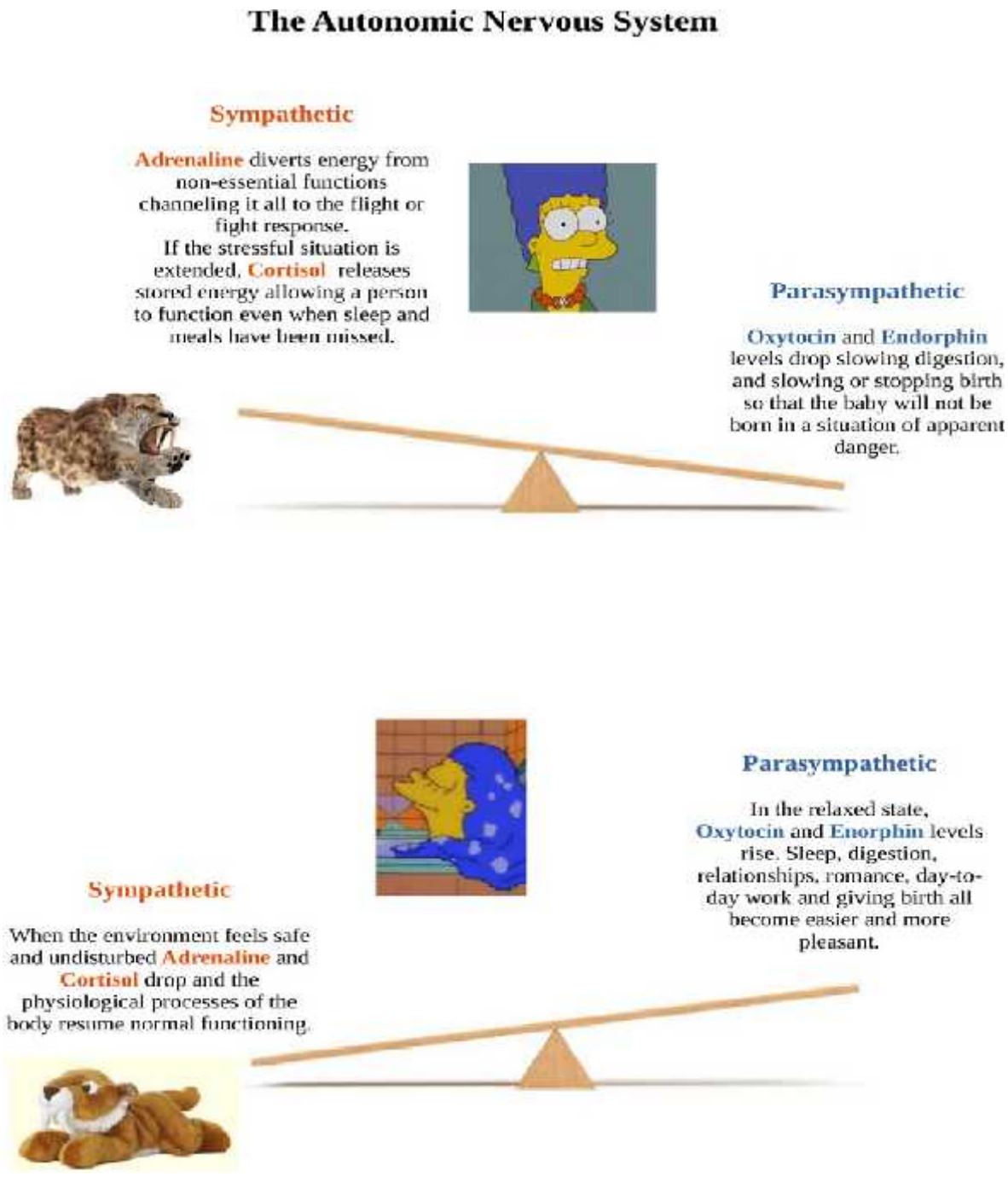
If we imagine the womb as a knitted grow-bag for the baby, the cervix is its polo-necked opening. Originally made of a firm aran yarn, the cervix changes in pregnancy to cashmere with shirring elastic or lycra. The vast majority of labour, from the first twinges to the final hour or two before the baby emerges, is concerned with the further softening, shortening and opening up of the polo-neck cervix wide enough for the baby to ease through into the vagina. There is no injury happening during this time; it is simply a series of muscular contractions driven by the hormone oxytocin. As oxytocin increases, the contractions become stronger, longer and closer together - and still no injury. This pattern of increasingly powerful waves of tightening is a welcome sign that the body knows just what to do. As the waves get stronger, levels of maternal endorphins increase. Endorphins are hormones that are chemically very similar to morphine but without the side effects. They act as a natural analgesia and help the mother to feel calm and relaxed and even quite sleepy as labour reaches its strongest phase. [2]

Contractions and retractions: When a muscle contracts, the muscle fibres shorten and fatten, and as the muscle relaxes the fibres become long and thin again. The womb contracts in this way throughout every day of a woman's life, but as pregnancy advances, the mother may feel these every-day contractions as an intermittent tightening sensation. During each wave of tightening her belly will feel firmer to touch, similar to the feel of the contracted biceps of a champion weightlifter through a jacket sleeve. In labour, however, the nature of the contractions change and when each contraction fades away the fibres get long and thin again - but not quite as long as before the contraction. This means that there is a gradual shortening of the longitudinal fibres with every labour contraction. This phenomenon is called retraction. Retraction has the effect of pulling the cervix up and then open. The longer and stronger the contraction, the greater the retraction. Retraction also reduces the space inside the womb. This has the effect of pushing the baby lower and lower with the firm pressure of the baby's head on the internal os assisting in the opening of the cervix.

As the yellow net 'womb' is pulled upwards, its long 'cervix' neck shortens and then opens until the avocado 'baby' can pass through.

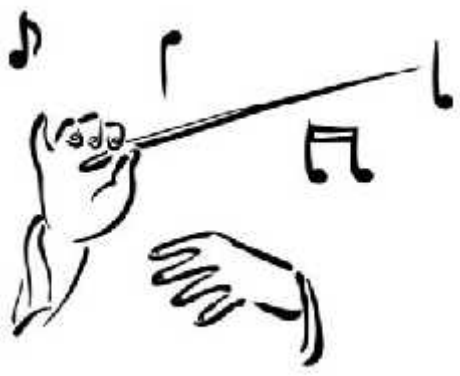
Contractions and the autonomic nervous system[3] : In order for the cervix to open smoothly, the 'drawstring' circular fibres need to relax. If the environment feels strange or if the mother feels watched, the sympathetic branch of her autonomic nervous system automatically produces stress hormones that will come to her aid. Adrenaline provides her with the power to confront a situation or to flee, tightening the 'drawstring' in order to give her time to find a place of

safety and privacy before the baby arrives. The sympathetic branch works with the parasympathetic branch as a see-saw. When adrenaline goes up, oxytocin goes down, thus slowing or stalling labour. It is never a case of the mother being too stressed; adrenaline is her super-power in a stressful environment. Human beings are mammals and physiological birth requires the same quiet and undisturbed environment that we prepare for our animal friends, if it is to proceed in the smoothest and safest way.



Gap junctions and the active stage of late pregnancy: There is a transitional phase of activity in late pregnancy when the body is changing from working to keep the baby in, to working to help the baby out. This phase can happily stop and start (or continuously trickle) for many hours or days while all the final behind-the-scenes preparations are made. When this activity is noticeable (it isn't always) it is referred to as prodromal labour or as the latent stage of labour, but it may be better to think of it as the active stage of late pregnancy and to carry on with normal life accordingly.

It may also be helpful to think of labour as a concert, and this late pregnancy activity as the orchestra in place and tuning-up as the audience arrives. The lights are on, people are taking their seats and chatting excitedly, there is a lot going on, but, even if you have never been to a concert before, you know this isn't it. Then, at a certain point, when all is ready, the lights dim, a hush descends, and the conductor comes onto the stage. Now, the discoordinate sounds of instruments being tuned are replaced by stronger, rhythmic and coordinated waves of sound that eventually swell up and fill the entire hall leaving you feeling completely absorbed and focused - now you know for sure that this is it. The conductor in my analogy represents a physiological change that takes place in the womb just before and throughout a labour that starts spontaneously. At this point of readiness, gap junctions or connexins appear between the muscle cells of the womb, increasing in size and number as labour progresses. Gap junctions allow messages to be passed between the cells so that their activity (their contracting) becomes more coordinated, and thus, more effective. This of course has implications for labours induced before the body is ready.



Physiology and the length of pregnancy: when does the concert start? No one really knows for sure why labour starts when it does but there is growing evidence that babies play a significant part by sending chemical messages to their mothers' bodies that they are ready to be born, and that labour starts spontaneously when both mother and baby are prepared, physically and neuro-hormonally, for optimal labour, birth, and early postnatal wellbeing.[4] The length of a normal healthy pregnancy varies widely and 'term' (when the baby is considered to be mature) is given in the text books as being between 37 and 42 weeks of pregnancy, a range of 35 days. A study in 2013 looking at the natural length of human pregnancies agreed with this figure.[5] It is important to note though that they excluded babies born before 37 weeks (when many babies born shortly before this time are ripe and ready to go), and they excluded babies born by caesarean section or induction before the natural onset of labour, with twenty-four percent of respondents later reporting medical interventions that had artificially shortened their pregnancy. Therefore we have no idea how long those pregnancies would have been and so the study, while confirming that the usual 40 week mark is only one day within a wide range, does nothing to show us the true limits of that range.

Birth environment and the mind-body connection: Thinking of the 'tuning-up' phase as a normal phase of late pregnancy (rather than early labour) means that the labour 'clock' has not started ticking in our minds, and that carrying on with normal life feels little different from carrying on through any of the other 'minor discomforts' of pregnancy. Amish women in America, who tend to have shorter (and apparently easier) labours, carry on with the housework, only calling the midwife when the birth seems close.[6] Unless we are living in danger, the normalcy of the home environment and home routines has a positive effect on the physiological process because this is generally where we are at our most relaxed - and at our least inhibited. The thinking brain has little to do with it. The older part of the brain listens to our sensory input and when things look, sound, feel, smell and taste like home, stress hormones are at their lowest and the autonomic nervous system is balanced in favour of supporting the birth process. However, the older brain also listens to our beliefs so that, even at home,

if each wave of tightening is greeted by the belief that labour is inherently impossible or dangerous, or that the sensations of normal labour are insufferable, the balance may tip the other way until the mother is helped to feel confident and safe again. Thus, not only is it the physical environment that affects the physiological process, but also the cultural environment from which the mother has shaped her belief system. Furthermore, the beliefs of her birth attendants will also have an affect on labour progress. Other people's doubt and fear is very infectious and once 'breathed in', it becomes our own.

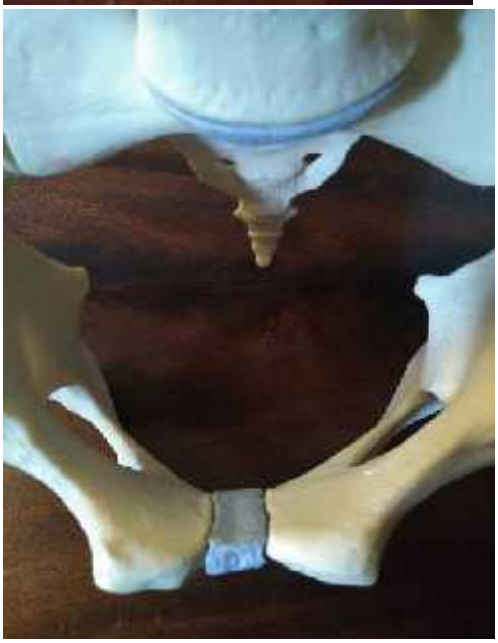
A first time mother and her seconds-old baby. This young mother grew up within a family culture that trusted the birth process. She planned her homebirth environment according to her deeply held beliefs.

Continuing the journey from the womb and out into the mother's arms: Eventually, the tissues of the cervix and lower segment of the womb have been gathered up leaving the cervix fully open, the lower wall of the womb quite thin, but the roof of the womb, the fundus, thick with muscle fibre. With the polo-neck cervix effectively pulled over the baby's head, further contractions utilise the fundus as a piston gently but powerfully guiding the baby downwards, through the vagina and into the mother's waiting arms. The powerful womb could easily do all the work, especially when the mother is in her most comfortable position, kneeling or on all fours perhaps, and especially when she feels unrushed and undisturbed. She may well have an urge to bear down but, unwatched and in complete privacy, would only follow her instincts. In this way, both the work of the womb and the instinctive pushing of the mother can be regarded as part of the physiological process. On the other hand, forced, extended pushing, directed by the midwife or doctor, is not part of the physiological process. It is a technique or intervention called Valsalva pushing (after an 18th century doctor) and carries risks without improving outcomes.[7] It is not part of evidence-based practice and, although still widely employed, it is not routinely recommended.

Making room for the baby: Many women worry about how their baby will be able to travel through and emerge from what feels like such a narrow passage. This is how it happens - the widest part of a baby is the head and, with chin on chest (the position of our head when pulling on a tight jumper), the head is about 10 cm or 4" across, roughly the size of a grapefruit. The baby's head is able to mould, with the skull bones (that are not fused at birth) slightly overlapping as required to fit through the mother's pelvis.

The pelvis, thanks to the stretchy effect of the pregnancy hormones, is able to expand, increasing its capacity by 30%

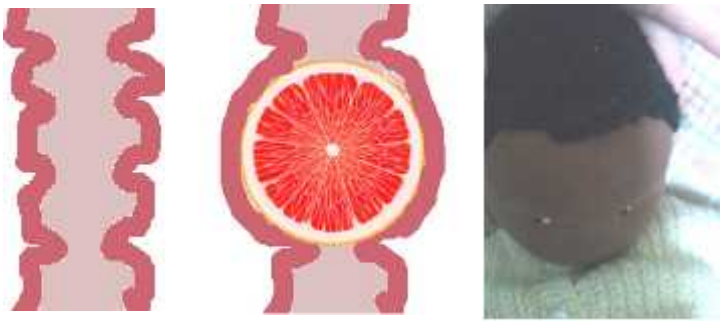
when the mother is upright. When she is unwatched and unrushed, the mother instinctively moves in a way that makes further space available. For example, she may lean forwards, or raise one knee, or stand and raise alternate feet. In a strange and clinical environment, and with other people watching and directing her, she is unlikely to tune into these instinctive behaviours. Thus, privacy is required to fully support the physiological process.



In the first picture, the pelvis is positioned as if the mother is standing; in the second it is as if she is standing and leaning forwards. This movement is seriously hampered when the mother is sitting or lying down.

The squidgy slippery baby (widest bit about 10 cm - the distance between your thumb and middle finger when they form a C shape) is travelling through the mother's expandable pelvis cushioned by the walls of the vagina. The vagina is not a smooth tube of tissue; it is made of horizontal folds of tissue called rugae. Rugae can unfold like an accordian and then, thanks to relaxin, stretch further still to make room for even the plumpest baby. The sensations during this last phase of the birth are felt in the back passage at first, and then, as the baby turns around the curve in the pelvis and presses onto the pelvic floor, the sensations move too and the mother feels them as stinging or burning around the entrance to her vagina. These feelings naturally prompt the unwatched and undisturbed mother to move closer to the floor to be ready to receive her baby.

The physiological process plans for every baby to be born on a natural life-support machine: The baby is born and gathered into the mother's arms. Meanwhile, the placenta is still attached to the inside of the womb and functioning as before. As long as the cord is not clamped, and while it is still pulsating, the baby will be receiving oxygen via the placenta providing a back-up supply while breathing becomes established. At birth the cord and placenta hold about one third of the baby's blood volume. As the blood continues to circulate from the baby to the placenta and back, over the next few minutes, more and more is left in the baby - very much like the tide coming in. Deferring cord clamping benefits even the tiniest babies.[8] Stem cells in the cord are also drawn into the baby during this time and these are believed to be beneficial.[9] After some time, the cord stops pulsating and gradually becomes whiter and flatter. The blood vessels close on their own and there would



be no actual need to clamp or tie the cord once they have. The physiological process has that covered.

During this time the mother's natural instinct is to hold her baby close to her body. This skin to skin contact has huge benefits for the baby during the transition from womb to world. The temperature of the skin on the mother's chest is thermo-responsive to the baby, ensuring that the baby is warmed or cooled as needed to maintain an optimal temperature, and doing this more effectively than a radiant heater. We have known this since at least 1980[10] and it is true even for very premature babies.[11] Skin to skin contact also regulates the baby's breathing, heart rate and glucose levels helping to maintain physiologic stability. This is true for all babies, even very tiny babies and those requiring special care.[12] These benefits are probably the result of lowering stress levels in the baby.[13]

The birth of the placenta: During a physiological birth the womb remains contracted after the baby is born and the waves of contractions cease for a while. This gives the mother and baby time to recover themselves and for the baby to find the breast for the first time. As long as there is no bleeding, and as long as the mother remains well, it does not matter whether this phase lasts a few minutes or a few hours.[14] Eventually, rhythmic contractions resume and, because the baby is no longer inside, the womb can contract down much more, thus reducing its internal surface area causing the placenta to peel away. The mother often responds to this fresh activity by wanting to become more upright again. The placenta drops down through the vagina and is expelled easily followed by an amount of blood from where the placenta had been attached. Further bleeding is then controlled by the diagonal muscle fibres of the womb contracting tightly around the bleeding vessels acting as 'living ligatures'. New mothers have a naturally higher level of clotting factors in their blood and this also helps to lower their risk of bleeding heavily after a birth. As with the earlier phases of labour, the physiological process works best when the mother feels unobserved and unrushed. Interacting with her baby in warmth and privacy will leave her awash with oxytocin helping the womb to contract, the placenta to separate and the physiological process to be completed in the safest possible way.

Author Bio: *Alex is an editor for the AIMS journal, a grandmother and great grandmother, and witness to some truly wonderful physiological births. She has close to half a century's experience as a childbirth educator.*

ENDNOTES

1 WHO (2018) WHO recommendations - Intrapartum care for a positive childbirth experience. Transforming care of women and babies for improved health and well-being. https://apps.who.int/iris/bitstream/handle/10665/272447/WHO-RHR-18.12-eng.pdf

2 Buckley SJ. Executive Summary of Hormonal Physiology of Childbearing: Evidence and Implications for Women, Babies, and Maternity Care. J Perinat Educ. 2015;24(3):145-53. doi: 10.1891/1058-1243.24.3.145. PMID: 26834435; PMCID: PMC4720867.

3 "The autonomic nervous system is a component of the peripheral nervous system that regulates involuntary physiologic processes including heart rate, blood pressure, respiration, digestion, and sexual arousal. It contains three anatomically distinct divisions: sympathetic, parasympathetic, and enteric." - Waxenbaum JA, Reddy V, Varacallo M. Anatomy, Autonomic Nervous System. [Updated 2022 Jul 25]. In: StatPearls [Internet]. Treasure Island (FL): StatPearls Publishing; 2022 Jan-. Available from: https://www.ncbi.nlm.nih.gov/books/NBK539845/

4 Hundleya V, Downe S, and Buckley S J (2020) The initiation of labour at term gestation: physiology and practice implications. Best Practice & Research Clinical Obstetrics & Gynaecology, Volume 67, Pages 4-18. http://eprints.bournemouth.ac.uk/33482/1/Hundley%20Downe%20Buckley%20Book%20chapter_accepted.pdf

5 Jukic AM, Baird DD, Weinberg CR, McConnaughey DR, Wilcox AJ. Length of human pregnancy and contributors to its natural variation. Hum Reprod. 2013 Oct;28(10):2848-55. doi: 10.1093/humrep/det297. Epub 2013 Aug 6. PMID: 23922246; PMCID: PMC3777570.

6 "Amish women spend the early stages of labor working in the home; cooking, cleaning, and completing other daily chores." Jolly, Natalie. 2017. "Birthing New Kinships: The Cross-Pollinating Potential of Amish Health Research." Journal of Amish and Plain Anabaptist Studies 5(2):147-61.

7 Hamilton C. (2016) Using the Valsalva technique during the second stage of labour. BJM Volume 24 · Issue 2 https://www.britishjournalofmidwifery.com/content/clinical-practice/using-the-valsalva-technique-during-the-second-stage-of-labour/

8 Rabe H, Mercer J, Erickson-Owens D. What does the evidence tell us? Revisiting optimal cord management at the time of birth.

Eur J Pediatr. 2022 May;181(5):1797-1807. doi: 10.1007/s00431-022-04395-x. Epub 2022 Feb 2. Erratum in: Eur J Pediatr. 2022 Feb 14;: PMID: 35112135; PMCID: PMC9056455.

9 Lawton C, Acosta S, Watson N, Gonzales-Portillo C, Diamandis T, Tajiri N, Kaneko Y, Sanberg PR, Borlongan CV. Enhancing endogenous stem cells in the newborn via delayed umbilical cord clamping. Neural Regen Res. 2015 Sep;10(9):1359-62. doi: 10.4103/1673-5374.165218. PMID: 26604879; PMCID: PMC4625484.

10 Färdig J A. (1980) A comparison of skin-to-skin contact and radiant heaters in promoting neonatal thermoregulation. Journal of Nurse-Midwifery, Volume 25, Issue 1, pages 19-28.

11 Lode-Kolz, K, Hermansson, C, Linnér, A, Klemming, S, Hetland, HB, Bergman, N, et al. Immediate skin-to-skin contact after birth ensures stable thermoregulation

12 World Health Organisation (2022) WHO advises immediate skin to skin care for survival of small and preterm babies. https://www.who.int/news/item/15-11-2022-who-advises-immediate-skin-to-skin-care-for-survival-of-small-and-preterm-babies

13 Pados B F. (2019) Physiology of Stress and Use of Skin-to-Skin Care as a Stress-Reducing Intervention in the NICU. Nurs. Womens. Health., 23 (1) pp. 59-70 https://www.sciencedirect.com/science/article/abs/pii/S1751485118302356

14 Editor's note: The current UK medical definition of retained placenta is when it hasn't been born within 30 minutes following medical management, and within 60 minutes during a physiological birth. https://patient.info/doctor/retained-placenta. However, there are many anecdotal reports of delays of many hours without any problems. Patience and lack of disturbance is usually followed by the safe arrival of the placenta when the body is ready.

~~~
~~~

Article

Physiological birth: a dangerous cult or a scientific fact?

by Natalie Meddings

The notion of 'normal birth' has been a point of contention for a while. There was Jeremy Hunt's denunciation of normal childbirth as an ideology'[1]; the RCM's 'RE:birth' project[2] recognises the "difficult conversations" around the term 'normal birth' and is seeking to identify alternative language[3]; the NCT is increasingly focused on supporting parents postnatally; and a sceptical media unanimously present natural birth as dangerous and misguided.

This critical consensus, that the reproductive process is just a risky old lottery could be civilizational, the hyper-cautious conclusion of an advanced technocratic age. But all the angsting around how we as a society should refer to and understand natural childbirth feels more orchestrated than that. It feels like a deliberate decision to frame birth biology as unscientific. As if nature itself was out of date and in need of a rebrand.

Articles, reports and phone-ins abound on the subject, pointing up over-zealous midwives, misled manipulated mothers, and all of them in agreement - that the pursuit of natural birth is the idealistic preoccupation of a backward few. Physiology as folklore if you like. Like here for example, in the Guardian[4]:

> *With 'normal' increasingly redefined thanks to Ockenden, as a potentially dangerous goal, and the catchy but fatuous 'natural' finally recognised - though by no means everywhere - as insensitive to women compelled by nature to accept technological assistance, a range of replacement synonyms testifies to the continued market for minimal intervention.*

Or again in the BMJ[5]:

> *The language around birth and persistent use of the words 'natural' and 'normal' in the UK belittles the experience of many women and is both socially harmful and offensive.*

And more generalised alarm, this time in the Telegraph, 'This Cult of the Normal Birth is Dangerous'[6]:

> *As I type this, somewhere in our country there is a woman trying to have a baby and they are not safe.*

But this public debate on birth is for the most part disingenuous. The focus appears to be natural physiological birth. But nowhere, in any of the coverage, is physiological birth explained or basic evidence referred to, for example NICE's bedrock guideline[7] 'For women who are at low risk of complications, giving birth is generally very safe for both the woman and her baby.' Or the 2012 Birthplace study[8] which found that women enjoying a healthy pregnancy were safe to give birth in any setting. Or that most important and widely confirmed reason to aim for a physiological birth – because it gives mother and baby the best chance of a healthy start.[9]

What gets dissected and questioned is maternity care's management of birth; or parents' experience of the hospital process – its competence and capacity for facilitating labour. Actual factual detail of birth physiology – the inherent risk of which is under scrutiny after all - is conspicuously missing.

It feels like a reminder is required, of what bioethicist and author Alice Dreger points out: 'the most scientific birth is often the least technological birth.'[10]

We need to pull away from the powerful current pushing everyone to the same point – a place where truth is what the majority says it is - and to lay out the actual truth. The plain facts of birth physiology as they exist.

Birth begins with the cervix – the neck of the womb – softening and ripening in response to the weight of the baby's pressing down as well as prostaglandins that release as a result of that pressure. Together with these mechanical cues, a chemical conversation starts up and the baby sends a signal to the mother's pituitary gland that they're ready to be born.

Oxytocin fires and contractions begin – muscular waves that cause the womb to thicken and bunch at the top, shrinking the available space and driving the baby downward, to where there is more give and room.

And so the opening starts. The cervix that was thick, firm and well out of the way, becomes so stretchy, soft, and in the way that the baby starts to funnel through, drawn by gravity, driven by contractions, without any conscious action being required.

As contractions strengthen and intensify, the momentum of active labour establishes and the body shifts into a deeper automatic gear. Providing the woman has what she needs - freedom to move her body and adequate privacy, peace and quiet to enable release of requisite hormones - the body's inbuilt biological urge to get the baby safely born is activated.

It is a part of the brain called the hypothalamus, the deep coordinating centre responsible for basic functions like hunger, thirst, blood pressure and temperature, that organises this powerful physiological urge, taking control by releasing influencing hormones that drive labour.

When the mother is safe, relaxed, and undisturbed, a cocktail of hormones flow fully and freely and guide her. Self-awareness and conscious management of her body reduces, her actions and behaviours become involuntary and spontaneous, instructing her on what to do to help her uterus work without resistance and let the baby through; like leaning forward, sighing and moaning, swaying her hips, instinctive positions and behaviours that allow her to breathe deeply and bring ease and relief.

Gravity, maternal movement and the shaping action of the mother's pliant pelvis takes the process on, helping the baby to tuck-dive, to move down, back and through the pelvis, setting in train a beautiful biochemical quickstep; the deeper the baby drives, the faster oxytocin flows, the more regular and powerful contractions become; the more regular and powerful contractions become, the deeper the baby drives – an exponential feedback loop that propels the baby through the neck of the womb on into the birth canal where expulsive contractions bring the birth to its conclusion.

How can this everyday miracle fail to impress? How can we not be awed by the primal coherence of the human body in birth – and give it its due? In my book, How to Have a Baby, I recommend people to do just this, and make physiology their foundation. I recommend that they get a crystal-clear understanding of:

- How the body works in birth
- The level of protection needed in order for it to be fully powered
- Even though physiological birth would unfold safely for the majority,[11] there will always be a small minority where medical support feels welcome and appropriate

'It's not an opinion I'm teaching, it's physiology,' I'd reply when people would ask by teaching 'natural birth' if I wasn't setting parents up for disappointment when their birth didn't go to plan.

When parents can prepare from a completely clean page like this, free from the reflexive fear and inherited opinions that so easily colour feelings and shape experience negatively, they trust the inherent capability of the body and do what they need to support it – maximising their odds of having a straightforward, predictable birth.

Better still, when labour doesn't unfold predictably, because of the baby's position or some other block, it is that deep grasp of physiology that makes that evident. When things don't go to plan despite giving the body what it needs, it becomes clear. Judith Lothian writes in her article, 'Why Natural Childbirth?'[12]:

> *Women are inherently capable of giving birth, have a deep, intuitive instinct about birth, and, when supported and free to find comfort, are able to give birth without interventions and without suffering.*

But such faith is unfounded, and will feel less true in a situation where a mother is being managed in labour – her dilation evaluated in the transitory setting of triage; or her body confined to a bed with monitoring belts; or where contractions are

controlled via a variable speed infusion pump. In conveyor belt situations like these, the high resolution information flowing through a woman's body, biochemical and mechanical cues that would naturally guide her, are hard to hear. And then labour is more unreliable. As obstetrician Michel Odent has said[13]:

> *Women cannot release the hormone they are supposed to be releasing for giving birth.We have completely forgotten what the basic needs of a labour woman are - the things that help that hormone to release - privacy, feeling safe and not feeling observed.*

Listening to women's personal accounts, birth outcomes have become so commonly complicated as a consequence, it isn't surprising that the conclusion drawn is that natural birth is to blame and birth educators seem to be creating unrealistic expectations, as the BBC's recent article 'The Pressure on Women to have a Natural Birth,' implies.[14]

> *Many women who follow positive birth courses say they feel an undercurrent of idealising 'natural' births in particular. For some instructors, a big part in emphasising how birth can be 'positive' comes with talking about how a woman's body is 'designed' to give birth - and the subtext can be that medical interventions impede, rather than assist, this process.*

But the facts of female biology aren't wishful thinking. Nor are they a set of mysterious unknowns only experts can decipher and impart. Physiology is knowledge – a sustainable ecosystem parents have every reason to trust and prepare from as a starting point. Nottingham University's Associate Professor of Midwifery Denis Walsh writes in his book 'Evidence-based care for Labour and birth'[15]:

> *The really exciting dimension of a broader understanding of evidence is its potential to rehabilitate physiological birth as not only possible but as desirable for the vast majority of women...*
>
> *Evidence that springs from intuitive, embodied experiential and anthropological origins as well as research has the power to reconnect us to the transformative nature of this ancient rite of passage event. And then not only individual women but families, communities and even nations will benefit.*

Author Bio: *Natalie Meddings is a doula, active birth yoga teacher and mother to three children. She is the author of How to have a Baby and Why Homebirth Matters and presents a podcast with doula colleague Jenna Rutherford called 'Mothers Talking.' She lives in SW London with her husband Danny, two cats and her last sixteen year old baby.*

END NOTES

1 Ockenden Review Volume 685: debated on Thursday 10 December 2020 https://hansard.parliament.uk/commons/2020-12-10/debates/D1AA9BD9-DC78-47D0-BCEE-84E3A3A94199/OckendenReview

2 RCM RE:birth project. https://www.rcm.org.uk/rebirth-hub/what-is-the-rebirth-project/

3 Editor's note: Statistics for the number of births that are entirely physiological (start, continue and conclude without any medical support whatsoever) are very difficult to find. Data often shows numbers for caesareans, assisted births and inductions but do not say how many of these overlap (e.g. inductions leading to caesareans or assisted births) - while the number given for spontaneous vaginal deliveries may include labours that have been induced or augmented, epidurals, and episiotomies.

4 Bennet C. (2022) Relentlessly pushing the idea of 'natural' childbirth is an affront to pregnant women. The Guardian. https://www.theguardian.com/commentisfree/2022/apr/16/relentlessly-pushing-natural-childbirth-abuse-pregant-women

5 Downey L. (2019) Childbirth in the UK—it's time to be honest about what the NHS can deliver. The BMJ OPinion https://blogs.bmj.com/bmj/2019/07/24/laura-downey-childbirth-in-the-uk-its-time-to-be-honest-about-what-the-nhs-can-deliver/

6 Pearson A. (2022) This Cult of the Normal Birth is Dangerous. The Telegraph https://www.telegraph.co.uk/columnists/2022/04/13/cult-normal-birth-exists-lives-mothers-babies-danger/

7 NICE (2014-2022) Intrapartum care for healthy women and babies https://www.nice.org.uk/guidance/cg190

8 NPEU (2012) Birthplace in England Research Programme. https://www.npeu.ox.ac.uk/birthplace#the-birthplace-cohort-study

9 Supporting Healthy and Normal Physiologic Childbirth: A Consensus Statement by ACNM, MANA, and NACPM. J Perinat Educ. 2013 Winter;22(1):14-8. doi: 10.1891/1058-1243.22.1.14. PMID: 24381472; PMCID: PMC3647729.

10 Dreger A. (2012) The Most Scientific Birth Is Often the Least Technological Birth. The Atlantic https://www.theatlantic.com/health/archive/2012/03/the-most-scientific-birth-is-often-the-least-technological-birth/254420/

11 WHO (2018) WHO recommendations - Intrapartum care for a positive childbirth experience. Transforming care of women and babies for improved health and well-being. https://apps.who.int/iris/bitstream/handle/10665/272447/WHO-RHR-18.12-eng.pdf

12 Lothian JA. Why natural childbirth? J Perinat Educ. 2000 Fall;9(4):44-6. doi: 10.1624/105812400X87905. PMID: 17273230; PMCID: PMC1595040.

13 Odent M. (No date) Interview with Owl Productions https://www.youtube.com/watch?v=8x8ip4VVGAI

14 Ruggeri A. (2023) The pressure on women to have the 'perfect' birth. BBC Family Tree https://www.bbc.com/worklife/article/20230122-positive-birth-and-hypnobirthing-movements

15 Walsh D. (2007) Evidence-based Care for Normal Labour and Birth: A guide for midwives. Routledge

Article

Why Birth Art?

by Sophie Jenna

I love to paint and create, and have since childhood. When I was pregnant, I felt like growing a baby was the ultimate act of creativity! Like many mothers, I set to work educating myself about physiological birth and doing everything I could to prepare myself. I listened to audiobooks and read through multiple books on the stages of birth and how best to support oneself without drugs or medical interventions. I learned about how I could use my voice to say no, I could assess my own risk in any given situation. I realised that I didn't need to "know" anything to give birth, my body would just do it, but I think due to the culture of fear we live in, I wanted to reassure myself with understanding.

One of the best things I did for myself during the pregnancy was to join a weekly "village prenatal" circle with deregistered midwife Joy Horner and doula Jady Mountjoy (from whom I received wonderful doula support). Not only was I gifted a wealth of information through the educational aspect of the group, which left me feeling empowered with knowledge, I also found a space to express my fears, thoughts, emotions. I met other women having babies around the same time as me, and together we created birth artworks. Being an artist, I loved this aspect of the group!

No matter how much I prepared for my birth, I still couldn't completely believe I would do it. I myself was a caesarean baby after my mum was exposed in labour to the hospital environment that does not in any way support physiological birth. The unsurprising outcome was presented as a failing of her body rather than a failing of the system. I am so sad to think this is how more and more mums are giving birth. Knowing what I know now, I think it is surprising that any woman gives birth normally within that brightly lit, unfamiliar, uncomfortable environment surrounded by strangers. Having this story as my blueprint for birth left me with a niggling feeling that I should prepare for my worst case scenario 'just in case', so I researched my options for emergency caesarean sections and created a plan with all my preferences and choices such as waiting for the cord to turn white before cutting. I am so pleased that this plan was never needed in the end because I have since learned that these choices are usually not adhered to with just one minute being considered as 'delayed' cord clamping! At the time however, having this plan allowed me to set those fears aside and focus on what I truly wanted: a normal, physiological birthing experience for me and baby.

When it came to the birth, I eventually settled on going to the midwife led unit (MLU) which was what felt right at the time. This was more in relation to not feeling that the house was the right place rather than any concerns or worries about the birth. In relation to the birth itself, I felt excited and surrendered. I watched many home birth videos on youtube to try and prepare myself. I found a birth podcast and devoured the stories, gleaning nuggets of wisdom from the women's different experiences. When labour began at 41 weeks, we stayed at home for the first 30 hours of the early stages, slowly transitioning to a more active labour. We went to the birth centre and ended up having another 30 hours of stop-start contractions with lots of back pain as the baby was posterior (back to back). I declined all checks at the beginning as I knew my baby and I were well but, as things were taking so long and because I also had PROM (premature rupture of the membranes), they wanted to transfer me to the labour ward, so eventually I agreed to some intermittent monitoring as a compromise to stay on the MLU.

The thirty hours were filled with many emotions from laughter and joy to disappointment and frustration. I had many moments of feeling I couldn't cope and other moments, especially later towards the end, when I felt very able to cope and flow with the sensations. My doula had to advocate a lot for me and my choices and it would have been impossible to maintain that advocacy without her and her skills.

Eventually the baby was ready and I settled on a supported squatting position to birth him. I had a physiological placenta birth too and also breastfeed immediately. I was beyond ecstatic that not only did I have a healthy baby but I had also experienced a positive, empowering birth. I was prouder of myself in that moment than I have ever been at any time in my life. Even now I pinch myself that I did it! I did it even though it took two and a half days, even though I was outside of hospital guidelines, even though I sometimes doubted myself, even though it was hard work. I wish that same joy and jubilation for all mothers, and I truly believe that if our culture and maternity system was supportive of physiological birth, more would experience it.

All three images by Sophie Jenna, instagram @artistsophiejenna

My takeaway from my choice of birth place was that I would not choose a MLU again: even though everything went well, and the midwives were lovely, nothing happened there that couldn't happen in a domestic or home environment, and the sheer level of advocation and compromise that had to happen from my doula in order to clear the path for my birth to occur feels so wrong and unnecessary. It was exhausting for her and me to keep holding those boundaries. Giving birth in an institutional space feels counterintuitive. Having strangers in the room, even very friendly and kind ones, feels bizarre looking back. In those postpartum days, none of this mattered. I was on such a high and feeling such triumph that I got to give birth in such an awesome way.

A few days later however, everything settled and reality hit me. I loved my baby more than I knew it was possible to love, but I was also past exhausted, breastfeeding round the clock. I felt the weight of the responsibility hit me like a ton of bricks. I was completely floored by the change in identity and the loss of energy, freedom, and purpose outside of the home; and also by the lack of differentiation between day and night, and the sudden change in what felt important such as life values. I remember thinking and feeling incredulously that it cannot be normal for it to feel this huge. Yet, as the weeks and months passed, I spoke to other mothers and realised that to some extent, yes, it is normal to feel this way. Everyone is experiencing some level of immense change and essentially grief too, for the life left behind. It is normal for it to be a huge change emotionally and physically.

I think this is the beginning spark for my birth artwork. In recognising and acknowledging that birth and life after birth is a noteworthy, important, potent, life changing experience and rite of passage for a woman, I began to deeply value my birth story and other women's stories. Although no more babies were coming for me, I stayed in a home birth support group on Facebook and read with great interest hundreds of birth stories over the next two years, learning more about physiological birth, solidifying what I already knew and growing my knowledge through hearing other stories. I was a full time, stay at home mum for two years, so I didn't have time to channel my passion into any physical form. When my son started a village preschool at the age of 2, I leapt on the opportunity to create my first painting, inspired by my own birth. I didn't plan for it to have any purpose beyond being a nice way to spend my newfound free time and a therapeutic expression of my experience as a mother. However, two more followed, and then I exhibited them in a group show. I was surprised and glad to receive positive feedback, and I made the offer online to create paintings for other mothers to honour their birth journeys.

For over a year now I have created a steady stream of paintings for mothers. Each story that comes to me feels like such a gift, I have to pinch myself that I am trusted and that I have the opportunity to create art about these births. I feel very grateful and happy when a mother plans a painting with me and I begin work: it is a truly joyous act of women supporting women. Some of the stories that have come to me are ecstatic and joyful and just want to be celebrated, while others are hard stories that need lots of love and tenderness. Sometimes the hardest ones are the ones that most need a painting. It's a small gesture in the face of birth trauma, but it's a way of saying this story matters, this story deserves to be told, and shared, and given a voice. Even though I am a huge advocate for optimising physiological birth, stories that don't follow this path aren't less important to me; they are all deeply, uniquely valuable. I LOVE

creating my birth paintings and when I am at work I feel this amazing, purposeful creative flow.

For the paintings I use a lot of warm, womb or blood like colours as well as watery colours. Night skies and moons feature heavily as I associate night time with those early days and birthing days. Many women birth in pools, so the curved edges of the pools and water surface protecting their bodies is a common feature too. My paintings can take me many weeks to complete, fitting them around my own motherhood and other work duties and never hurrying or rushing, letting the journey take place in its own time. Sometimes I reflect on just how similar the creative process is to the birthing one: moments of wanting to give up, of not knowing, of knowing, of feeling inspired and motivated, of feeling stuck; the many ups and downs of the journey but eventually getting to the end one way or another. The paintings are less about creating a portrait but more about trying to capture the energy and the essence of the experience. I want to work on my ability and skill as an artist and just keep going with them. I have discovered a real sense of purpose in these paintings.

I have just grown more passionate and excited about birth as time goes on. I feel deeply within my bones that birth matters, that birth is meaningful. Birth is an 'everyday' miracle every time it happens. It is a life changing rite of passage, a spiritual event for mother and baby and everyone else involved. Each individual birth story is inherently worthy of acknowledgment and value. It should not have to be endured as an unhappy medical event but sometimes it turns out that way within the system we are in, or even, occasionally, just due to mother nature, and I will listen to those stories just the same as I will listen to a home birth story. My artwork is personal, political, spiritual. Putting paint to paper and giving birth the time, love, attention and care that it takes to make art, is a statement. I am saying that birth is important, and beautiful. Birth is not something that happens on the sidelines of real life, it's not something that we should hand over to strangers. Birth is a core moment in our lives as women and mothers. Birth is ours, it is powerful.

Author Bio: *Sophie Jenna, mother to a three year old son, is an artist who creates paintings celebrating birth. She began with inspiration from her own birthing journey, and went on to make art for other mums and births. sophie.danby@hotmail.co.uk*

Article

The Art of Giving Birth – Five Key Physiological Principles

by Sallyann Beresford

Sallyann Beresford

Physiological birth is a hot topic these days, as more and more pregnant women are recognising the benefits of giving birth with little or no intervention. The term physiological means that the body is left to function on its own without interference from modern medicine. By using the word 'physiological' and moving away from the word 'normal' or 'natural', it helps to emphasise and remind us that the process should be untouched, unhurried and undisturbed. If this sounds like something that is resonating with you and your plans of avoiding medical management, then it's essential to become well informed about how even the most basic of interventions can affect physiology and change the path that your birth takes. The following five key principles are filled with practical tips and information that are aimed at assisting you to avoid many of the simple mistakes that can sabotage your plan. These principles are interwoven, and each one benefits the other.

1 Understand Your Hormones - 'If you don't get hormones, you won't get birth'

The first principle is to deeply understand the role that hormones play within the birth process and identify how your personality can affect optimal production of oxytocin – the hormone required to produce contractions and dilate your cervix. Are you impatient? Are you an overthinker? Do you like control? It is important to be honest with yourself because on the day, excitement, consistent analysing, and any attempts to accelerate labour, will introduce adrenaline and trigger the sympathetic nervous system. Once in fight or flight mode, your blood will be directed away from your uterus and towards your limbs. Being primed and ready to run from danger at a moment's notice is not an ideal state for labour. In addition, the fears, words, and actions of anyone supporting you will squash your production of oxytocin further. Without an abundance of oxytocin progress will be slow and leave you feeling tired and depleted of energy. Once you know what interference might arise and affect your hormone production, you can consider strategies to overcome these issues. I recommend you build a nest in early labour and get settled into comfortable positions that help you relax. Ideally you should avoid telling family and friends, so switch off your phone and rest without conversation. You can prepare an oxytocin kit in pregnancy by gathering pillows, soft blankets, positive affirmations, playlists of your favourite music and pleasant scents or fragrances that can encourage further relaxation. Identify a place in your home where you will feel most comfortable, safe, loved and warm. If you are having a hospital birth, then try and re-create this nest as soon as you arrive. The more you understand your own needs and how they are affected by hormone production, the easier you will find the process. By being honest and open, your birth partner will also be able to support you more authentically.

Top Tip – To ensure high levels of oxytocin, avoid the use of gadgets and apps that record or time your contractions. These can unwittingly keep you in a state of high alert, where you think you are relaxing but in reality are distracted by analysing both the length of your contractions and the distance between.

2 Trust Your Instincts – 'Your instincts are your greatest superpower'

The second principle is to trust in the knowledge that your instincts are within you, ready and waiting to be accessed at a moment's notice. Just like other mammals, your instincts are crucial to your survival, so you can truly rely on your inner wisdom to keep you safe at all times. Even by exploring the idea of giving birth physiologically, you are tapping into your innate intelligence. Labour is much easier overall when you believe wholeheartedly in your body's ability to give birth, knowing that even if you did nothing at all to prepare, your baby is capable of being born without interference. By understanding hormone production, you will be fully aware that even the slightest hint of danger can put your body into fight or flight mode. Whilst your ancestors might have had to fight off sabre-tooth tigers, your predators might look more like friends and family who don't agree with your decisions and make you feel upset and annoyed. Or more likely, you will encounter a care provider who wants to interfere with your perfectly planned physiological birth by recommending an induction. Sadly, modern day pregnancy is undermined by fear-based practice, and most care providers are desperate to meddle with a well-designed system. In order to protect yourself from others sabotaging your birth, you may need to change care providers and only surround yourself with like-minded people who support your decisions to labour in a way that feels instinctive to you. You will also benefit from exploring any deep-seated thoughts your subconscious mind might have within, and then work on re-framing those thoughts to positive ones.

Top Tip – Use positive affirmations daily to remind yourself of how instinctive giving birth is. This will re-frame the neural pathways in your brain and overwrite the negative doubts and images that might be stored within from watching T.V. or hearing stories since childhood.

3 Prepare Your Birth Partner – 'Your birth partner can literally make or break your birth experience'

The third principle is to ensure that you have prepared your birth partner to support you in a way that facilitates your ideal birth. It is important that whoever you choose fully understands and respects the decisions you are making – even if they don't agree with you. They need to know 'why' you want to give birth physiologically, how hormones can affect this process, and what you want them to do in order to best support you. Arrange some birth planning sessions with your partner to ensure you have covered every element of the journey, so that they are comfortable with their role. Explore what will bring you joy and pleasure and increase oxytocin. Explore what will annoy you and increase adrenaline. Tell your birth partner how you might want them to advocate for you if the need arises – and what that would involve. It is essential that you are honest and acknowledge how your personality style will affect you during this time. Your birth partner needs to respect physiology and recognise the important role that hormones play. Most importantly they do not need to 'fix' anything for you during your labour, they need to sit and be present and protect your oxytocin - offering comfort and love, snacks and drinks. If you identify that your partner may struggle with this role, then consider hiring a doula to attend the birth as part of your team. It is essential to make this the best possible experience for you all as you enter parenthood. Now is not a time to wing it.

Top Tip – Think about using a 'safety word' in case you decide you no longer want a physiological birth. This gives you the power to vocalise and tell your partner how you feel without them worrying. They can then encourage you to keep going, knowing that you will use your safety word if you change your mind.

4 Know Your Rights – 'Hospital policy is not law'

The fourth principle to planning and achieving a physiological birth, is to understand your rights. For you and your partner to know that you can choose what elements of care you are willing to accept - and decline those you are not. You should never be made to believe that hospital policies and guidelines overrule your rights, and

that you must agree to what you are told. You always have options, and all decisions made about your birth experience are yours to make. Once you recognise that nothing can be done to your body without consent, then you will find it a lot easier to own your birth. Any mention of 'risk' should be discussed in a personalised manner. If, for example, your care provider is attempting to convince you to agree to a medical procedure by saying: 'your risk is double' or 'you are at an increased risk of…', then they are not giving you helpful information. In this instance, you should ask the doctor or midwife for the 'absolute risk[1]' – which offers statistics. Care providers do not have the right to force you to accept an intervention that you do not want. If you are subjected to coercive language, remember that you do not have to justify your reasons for choosing to decline interventions. This is important, because it is common for care providers when making recommendations, to leave you feeling that they somehow have a greater investment in the health and well-being of both you and your baby. By stepping into your power and learning more about these five key principles, you will begin to develop an inner confidence that will ensure you never make decisions that put you or your baby's life in danger.

Top Tip – Question everything! You will only have this birth once, and the memories will last you a lifetime. This is not true of your care provider. They are not the one going home with your baby and will never see the repercussions of their recommendations. You do not have to explain why you want more information, or why you might choose to decline interventions. If your care provider is not supportive – ask for one that is.

5 Trust Your Body – 'When the body is in charge, very little will go wrong'

The final principle is to learn how to deeply trust your body. When you know that your baby can be born without anyone touching you, it can help you to lean into the process and go with the flow. You can let go of dates and time pressures. You can follow your body by adopting instinctive positions. You can breathe and relax and let the sensations of labour wash over you, knowing that they are never going to be more than you can handle. Your uterus will change and adapt with each contraction by drawing the cervix upwards in preparation to expel your baby. In fact, the more you can release your thoughts and let oxytocin flow, the easier the journey will be for you both. Anyone who is overthinking, over-analysing, and trying to control this process may struggle – particularly if the baby needs time to align and labour is long. Once dilation is complete and your baby is ready, you will experience a physiological surge of adrenaline. This will wake you up and give you all the energy you need to push despite possibly feeling sleepy only moments before. In a physiological birth, your baby will cleverly adapt to the size and shape of your birth canal intuitively. As they are born, the lungs will transition in their own time as blood is pumped from the placenta, through the umbilical cord and into their body, giving them all the iron rich blood and stem cells they need for early life. The bacteria they are exposed to in the vagina supports their immune system as it builds, and colostrum is there, ready and waiting to give them nourishment in those early hours whilst they learn to develop your milk supply. These incredible events that take place before our eyes assure us that our bodies are miraculous. When you leave your body alone to give birth, very little will go wrong.

Top Tip - The secret to achieving your dream physiological birth is to try and not rush the process. Even simple things like sitting or bouncing on a birth ball is not restful enough for early labour and can exhaust you. If you are trying to speed up labour in any way you are not working with your body, you are engaging with your thinking brain and this will slow labour down.

Author Bio: *Sallyann Beresford is an experienced doula and antenatal educator. She is the award-winning author of 3 books and hosts a weekly podcast. Her recent book The Art of Giving Birth - Five Key Physiological Principles is aimed at helping the reader not only plan but succeed at achieving a physiological birth.*

END NOTES

1 Editor's note: 'Absolute risk' is the actual number of times the 'risk' in question is likely to happen out of the number in a given population. For example, 1 in 100 or 1 in 1000. It is helpful to also have the figure for that outcome in a population not to be considered at extra risk. For example, the overall risk for people with this condition is 2 in 1000, compared with 1 in 1000 for people without this condition.

Article

Considering the invisible parts of the birth environment

by Nicole Schlöge

Nicole Schlögel

Last Sunday morning, when witnessing the birth of a little boy, I was reminded once again that the environment we create around the birthing mother matters…a LOT!

This mum had chosen a home birth despite her previous caesarean section. Her waters had released some 22 hours previously by the time her little man tumbled into the world. Anyone who has practised midwifery in the NHS will know that those details, the caesarean birth a few years ago and the length of time since the waters had released, could easily ruffle some feathers.

Luckily not last Sunday. My colleague and I were entirely on the same page when it came to supporting this mum after the first trickle of clear fluid revealed a spontaneous rupture of the membranes. The history of the previous caesarean birth had been addressed long ago. The team I have been so fortunate to become a part of has figured out a solid structure to navigate out of guideline care. The parents had been counselled well about why a history of an abdominal birth prompts the suggestion of labouring in hospital. They were facilitated in thinking about their options. They considered the 1 in 200 chance of having a scar rupture[1] and what having this happen at home could mean. Waiting for an ambulance, transfer time to the nearest hospital, the possibility that by fluke no ambulance would be available; they considered all of that. When it came down to it, they felt that true birth physiology was most likely to unfold at home and that birth physiology in itself was most probably a protective factor on the large scale of things. Their little boy was born straight into the heart of this family in his parents' bedroom. The older siblings were admiring his cute little face within minutes of the placenta landing on a pad on the floor whilst I helped the mum into a supported squat. It came physiologically, no synto[2], no prodding, no pulling, no fuss and no major blood loss. All was well.

According to a major systematic review published in the leading medical journal The Lancet in April 2020 homebirth is just as safe as hospital birth for both mother and baby.

Altogether, around 500,000 births were included in the meta analyses which makes this a very reliable finding. All the women in the studies were having their first babies. They were all considered to be at a low risk of birth complications.

The interesting part is that women who gave birth at home were more likely to breastfeed their babies, less likely to have major tearing of their birth passage, less likely to bleed so heavily that a blood transfusion was required, less likely to have an emergency caesarean or instrumental birth and more likely to find their birth a positive experience[3], [4].

Whilst none of the women in the systematic review had had a caesarean birth before, those benefits were important to the parents I met last Sunday. Birth physiology can unfold best at home and that's what made the decision for them.

Over the years of practising as a midwife I have come to recognise that a birth environment that allows birth to unfold is created not solely by addressing the physical space but also the mental environment of the parents and all those

present at a birth. It is also created by the environment we have created collectively as a society nationally and globally.

What I bring to a birth matters. My mental landscape matters. The birth of my own daughter, what I read in the paper, and the birth I attended yesterday; no matter how much time I spend on gaining perspective on my own individual experiences, I can't help but bring them to the birth. They have shaped me, my own way of looking at it continues to shape me and that goes for every one of us.

No matter how dim the lighting or how serene the soundscape, fear and apprehension hinder the process as much as fluorescent lighting does. Fearful thoughts release adrenaline in the birthing parent, we know that. But what about the doubts and fears that are brought to the birth space by birth partners, other family members and care providers? Our collective consciousness as a society even? Do they disrupt the fascia of a birth space?

Take for instance a 'big' baby. What does the suggestion 'your baby is big' do to parents? Even if we disregard the fact that the maternity system is likely going to suggest an induction of labour (despite a lack of evidence to support this practice), the mother will have associations with the notion that the baby 'is big'. Her care providers, too, will be on high alert because of the associated increase in the risk of shoulder dystocia. What does that do, this fear of shoulder dystocia? And what about the often poorly researched reports in the media about individual tragedies? Could all of this prompt practitioners to act when no action is required? Could we continuously disrupt a process[5] and in doing so nurture our distrust of physiology?

The vast majority of 'big' babies arrive perfectly fine when we let birth unfold. In fact the biggest baby I have ever seen being born was born in the birthing pool. The baby was 11lb 3oz (5.1kg). None of us expected the baby to be this big, and so the baby 'wasn't' big - until he was born. So, to an extent, your baby is as big as you think - until your baby is born[6].

Our internal environments matter as much as our external environments do and this is why it is important to get clear on what our fears and doubts are before giving birth or attending a birth. Asking yourself how you really feel about birth physiology, how much you trust it or how deeply you are conditioned not to trust it, is a worthwhile exercise and learning how to let go of niggling thoughts and fears quickly as they arise, can be very helpful for everyone in the birth room, not just the parents.

The families I have cared for over the years have guided me to the R.O.A.D. acronym. In the R.O.A.D. acronym, I talk about overcoming internal and external obstacles to your dream birth scenario. The external ones are almost exclusively posed by guidelines and policies and by the apprehensions and fears present in society today. R.O.A.D. stands for Recognise and release fears, Overcome the obstacles, Accept what you can't control and Do the work. I use it to help families understand their own internal landscape as well as the external backdrop of modern maternity care. Birth has gotten pretty complicated. Physiology is generally only allowed to unfold if it does so within a set of policies and guidelines - unless parents assert their intentions. Learning how a baby emerges from a body is no longer enough, parents must also know how birth is observed in modern obstetric care. They must learn what the guidelines for routine care are in order to be able to put them into perspective and then interpret them within the context of their own values and beliefs.

No matter how we prepare for giving birth, getting to know our minds and exploring our internal environments with curiosity, love and compassion, will help us on our journeys. In doing so we can maybe create a collective birth space that allows for birth physiology to be celebrated rather than feared.

Author Bio: *Nicole is a midwife, aromatherapist and yogi and has recently published her first book. '7 Secrets Every Pregnant Woman Needs To Hear Before Giving Birth: The New Midwife's R.O.A.D. To Birth Hypnobirth System' is available on Amazon.*

ENDNOTES

1 Royal College of Obstetricians and Gynaecologists (2015). Birth after Previous Caesarean Birth (Green-top Guideline No. 45). Accessed via: https://www.rcog.org.uk/guidance/browse-all-guidance/green-top-guidelines/birth-after-previous-caesarean-birth-green-top-guideline-no-45/

2 Hutton, et al. (2019). Perinatal or neonatal mortality among women who intend at the onset of labour to give birth at home compared to women of low obstetrical risk who intend to give birth in hospital: A systematic review and meta-analyses. EClinicalMedicine. 2019;14:59-70. Published 2019 Jul 25. doi:10.1016/j.eclinm.2019.07.005 Accessed via: https://pubmed.ncbi.nlm.nih.gov/31709403/

3 Reitsma, et al. (2019). Perinatal or neonatal mortality among women who intend at the onset of labour to give birth at home compared to women of low obstetrical risk who intend to give birth in hospital: A systematic review and meta-analyses. EClinicalMedicine, 2019. Accessed via: https://www.thelancet.com/journals/eclinm/article/PIIS2589-5370(20)30063-8/fulltext

4 Reed R. (2019) Big Babies: the risk of care provider fear. https://midwifethinking.com/2019/09/02/big-babies-the-risk-of-care-provider-fear/

5 Editor's note: Synto is short for syntocinon, which is artificial oxytocin given via a drip.

6 Editor's note: In the words 'disrupt a process' the author is recognising how medical intervention is known to alter the physiological process resulting in one intervention then requiring another. This has been referred to as 'the cascade of intervention'. Thus, if it is fear (rather than actual need) that triggers the first intervention, it is fear that may be the root cause of us distrusting the physiological process.

~~~~

Previous issues of the AIMS Journal online

AIMS Journal articles from 1998 to the present day are available on this page of the AIMS website - www.aims.org.uk/journal.
Choose what you would like to read by date or title from the drop down menu on the left side of the page.

Many journals are also available to read in magazine format at https://issuu.com/search?q=AIMS%20Journal.
You can read and download the magazine, free of charge.
~~~~

Article

Teaching midwives about physiology-based care: going beyond the core curriculum

Molly O'Brien

Molly O'Brien

A discussion with Molly: what I learned - By Alex Smith

A few weeks ago I enjoyed the privilege of a long phone call with Molly O'Brien. Molly is a childbirth preparation teacher, midwife educator and a registered midwife. Her career of over twenty years has been based on her passion for enabling normal physiological birth, and she is currently very much in demand running workshops for midwives to help them do just that. I called her to ask about these workshops.

Molly explained that the course is called 'Biomechanics for Birth'. It focuses on ways that midwives can recognise when the birth process goes awry due to a mechanical issue. Any kind of prolonged labour (as defined in the medical model) is known as labour dystocia, and is often given as a leading reason behind high intervention rates, traumatic birth experiences, including forceps and caesarean birth for first time mothers. It can cause great distress, increased pain and exhaustion, yet it is poorly understood and under researched. The baby's position is cited as one of the causes of prolonged labour.

However, Molly has discovered from her own experience, from listening to women, and from her observation and study over the years that a baby who is in a suboptimal position is a consequence, not a cause of labour dystocia (Ed: if we understand that labour can be delayed in the very early preparatory phases even before the onset of noticeable contractions). A mechanical imbalance in the pelvis can create a reduction in space meaning the baby may have to position itself in angles that don't fit best for that mothers' pelvic shape. When recognised early, and with a better understanding of the anatomy (mechanics) of the living (bio) pregnant body, the mother can be helped to move in ways that make more space for her baby. In this way, a longer, more painful labour can be averted.

Her belief is that women can generally give birth unaided and that the power balance should lie with the mother who can utilise these techniques to help herself and her baby have a birth that is safe, positive and joyful.

While the course teaches techniques to midwives, Molly stressed that these are not yet more things that are done to helpless women by 'expert' others. Her belief is that women can generally give birth unaided and that the power balance should lie with the mother who can utilise these techniques to help herself and her baby have a birth that is safe, positive and joyful. Indeed, when completely unobserved, women probably use these movements instinctively, but, in the presence of even a friendly supportive midwife, cultural conditioning overrides instinctive behaviour and the woman defers to the midwife. The midwife, however, can return agency to the mother by creating the right conditions and by inviting the use of these techniques when the mother seems to need them. Molly says that everyone working in the birth world should know this information and that resolving a difficult or obstructed labour using the gentle and harmless approaches of biomechanical understanding, should be part of midwifery and obstetric training[1].

I asked Molly why she felt that midwives were not already taught about the knowledge that underpins biomechanics. She then spoke about birth as a feminist issue with the medical model of birth being one that has arisen from the subjugation of women over previous generations. Not only are women in labour under the control of 'the system', but so too are midwives and therefore their training will naturally support this status quo.

Not only are women in labour under the control of 'the system', but so too are midwives and therefore their training will naturally support this status quo.

Molly said that an understanding of biomechanics alone is not enough to improve women's birth experiences. Her course encourages midwives to re-evaluate their perceptions of birth and to challenge the status quo. Listening to the woman, valuing her knowledge about how the baby is passing through her pelvis and validating her experience is essential. She says that, "The essence of the course is "Biomechanics for Birth", but its context is the political agenda of the maternity and childbirth arena."[2]

Finally, I asked about what actually happens on one of her courses for midwives. Molly explained that the course lasts for seven hours. There is also some important pre-course reading required about the relevant anatomy and physiology. In the morning, Molly leads the group through the story of a woman with a longer and painful prodromal labour[3], exploring her labour and birth journey through maternity services within the medical model where the majority of women give birth. At each turn of the story participants discuss and critically analyse common practices, solutions, evidence and effectiveness. Participants discuss a different way of observing, using watchful attendance, without depending on some of the more intrusive and intimate examinations like vaginal examination. Later, discussions are developed on how best to support and optimise the physiological process using biomechanical techniques and freedom of movement in the birth room, placing the woman at the centre of care.

The afternoon session focuses on teaching specific biomechanical techniques and positions.

On her website, Molly lists the course content:

- Definition of labour dystocia, suboptimal positions, statistics and birth outcomes
- Applying Biomechanics to birth including anatomy and physiology, causes of dystocia, who has a higher chance and why, and how to recognise it in a timely manner to increase the chance of a positive birth experience.
- Practical techniques including instinctive and flexible sacrum birth positions[4], the use of rebozo[5] and positions to help labour progress such as forward leaning inversion, side lying release, abdominal lift, modified exaggerated lateral position, birth balls and peanut balls
- Techniques to improve diagnosis of a mechanical issue complicating the birth process
- Other helpful strategies that support physiological birth
- Empowering midwifery and challenging the status quo
- Research and evidence
- Communication, consent and documentation

I wondered whether course participants were putting their learning into practice and if so, whether they were seeing real differences. Molly told me that midwives and obstetricians around the country are excited at the results they are seeing when using the techniques. Audits are being carried out in several NHS Trusts and preliminary results show a reduction in instrumental births and severe perineal trauma, and an increase in better birth experiences.

While there has not yet been a formal evaluation of the training Molly offers to midwives and healthcare professionals, she is encouraging each participant to record at least three case studies of births that have included use of the techniques taught in the course. She uses these in an advanced course to help build a useful anecdotal picture of how biomechanical techniques can influence the course of labour. More immediately, and very importantly, midwife feedback about the course is excellent. The reviews include comments about how practical and interactive the day is and one respondee wrote about the course:

> *"I feel it has brought me back to being a midwife rather than an obstetric nurse"*

Listening to Molly's passion and enthusiasm for "supporting and preserving normal birth"[6] I was left feeling very heartened. Molly shares the same goal as AIMS[7] in wanting to see more women have a positive experience of maternity care, and her work is a vital contribution to change the conversation in childbirth.

Molly O'Brien: *Molly worked as a clinical midwife in the NHS for 20 years. She is now an associate lecturer, birth preparation teacher and freelance trainer. In the course of her career she developed techniques to diagnose and rectify labour dystocia. She teaches online and travels all over the world teaching her Biomechanics for Birth course.*

ENDNOTES

1 Editor's note: Prodromal labour is the term given to the fairly intense period of non-progressive pre-labour contractions that many women experience.

2 Molly's website - https://www.optimalbirth.co.uk/index.php/blogs/biomechanics-for-birth-a-labour-of-love

3 Editor's note: This refers to positions of the mother that allow for the optimal flexibility and opening of her pelvic bones. This flexibility is impeded when her sacrum (the back of the pelvis) is pressed against the bed.

4 Editor's note: Rebozo is a practice that refers to a long scarf of the same name worn by women in some South American countries. Amongst many other uses, it has traditionally served as an aid in labour. https://www.aims.org.uk/journal/item/rebozo-in-an-nhs-setting

5 Molly's website - https://www.optimalbirth.co.uk/index.php

6 AIMS position paper on Physiology-Informed Maternity Services. https://www.aims.org.uk/assets/media/730/aims-position-paper-physiology-informed-maternity-care.pdf and AIMS Physiology-Informed Maternity Services campaign. https://www.aims.org.uk/assets/media/818/campaigning-for-physiology-informed-maternity-services.pdf

7 Editor's note: Molly has identified an important gap in midwifery training. It should not be down to chance or choice whether or not a midwife develops this knowledge. As service users, we expect any midwife attending us to have this knowledge and skill set. The AIMS position paper says, "Both initial training and continuing professional development for all maternity services staff should focus on promoting an understanding of physiology and a holistic view of safety". We ask how this perceived gap matches up with the (pre registration) NMC standards and the (post registration) Core Competency Framework.

Article

Introducing Care Opinion

by Dr James Munro

Perhaps more than in any kind of healthcare, memories of maternity care last a long time – maybe a whole lifetime. Whether pregnancy and labour are complex or straightforward, safe or unsafe, happy or sad, every aspect of care will be remembered and reflected on.

And whatever the experience, many women, or their partners or families, have something to say to the staff who cared for them. They may simply want to say "thank you", or explain who made them feel safe, and how. Or they may want to raise a concern, suggest an improvement, or explain what they found lacking.

But how easy is it for women – or indeed anyone – to give honest feedback to health services in a way which feels meaningful and effective? Given the standard NHS routes for feedback such as surveys, the "friends and family test" (in England), and the complaints system, you might think that this is a solved problem. Unfortunately, that's not the case.

In practice, despite these formal systems, many people say that they were never asked for any feedback about their care. And, perhaps unsurprisingly, even when people do have concerns about their care a large majority are reluctant to raise them, for fear of being seen as 'a problem patient' and perhaps even making matters worse.[1] Others, who have raised concerns before, may have seen no impact from their feedback (was it even heard?) and given up.

Meanwhile, from a staff perspective, the traditional systems may appear unhelpful: feedback data is inaccessible, or outdated, or too brief to be informative or actionable. The systems are one-way so issues can't be clarified. Complaints don't connect to quality improvement. The focus is on measuring performance rather than learning and growth. Surely we can do better?

At Care Opinion we've been thinking about these issues, and building a service to address them, for nearly two decades. Care Opinion is a non-profit business (a community interest company), established in Sheffield in 2005. Over the past 18 years we have slowly but steadily built an online feedback platform for health services across the UK (www.careopinion.org.uk), allowing anyone to quickly and easily post feedback about the service they used, which we publish after moderation. Care Opinion is now used by around 500 organisations, and has become the system-wide feedback platform for the NHS in Scotland and Northern Ireland.

Of the 540,000 stories currently on Care Opinion (which includes stories from nhs.uk too), over 15,000 are about maternity care. Because the feedback author remains anonymous, it is safe to raise difficult issues – but despite this, about 70% of stories are completely positive:

> *"She knew my background and why I was so anxious with this pregnancy. I had a gorgeous baby girl at 35 weeks and Toni even took the time to come and see me after my operation."*[2]

Even when stories raise concerns they are often constructive and specific, providing rich and actionable information. For example, one long and detailed story noted:

> *"My appointment letters always stated the appointment would be with a specific doctor in obstetrics, but I never met this person once. It was always someone else (different) every time."*[3]

Encouragingly, this feedback was taken seriously and a subsequent response from the lead midwife for community and outpatients reported: "Together the staff and SCM have revised the organisation of the OPD clinic to ensure that… every woman attending will see the same midwife or buddy midwife at each visit to maintain continuity and provide consistent care in pregnancy."[3]

This kind of public response matters, and not just for the person who shared that story. It sends a powerful

message to others using the service, and indeed to staff too: that this is a place where feedback is taken seriously and used to help make care better. Research to date suggests that this helps build trust and understanding among patients[4], while lifting the morale, confidence and pride of staff.[5] In short, this kind of open, online, near real-time feedback is a win-win for those using the service as well as those providing it.

You might wonder what we can learn from these 15,000 stories of maternity care. The answer is both banal and profound: that what matters most is to feel respected and cared about; to be listened to and taken seriously; and to be provided with information and explanation on what will happen or has happened.

That we cannot assume that this quality of care will be consistently present is a sad reflection on modern healthcare (and not at all, I believe, unique to the UK). But there is also encouraging news: our experience suggests that over time, teams actively engaging with online patient feedback seem to become less defensive, more open to hearing concerns, and more willing to take action to address issues. Further, the stream of gratitude which flows through Care Opinion may be powerful in supporting staff wellbeing, fostering better relationships and even raising performance[6].

The research evidence on Care Opinion is growing, but still limited, and we have much to learn[7]. But already it is clear that the benefits of this approach are more than simply informational – they are also relational. I am very hopeful that, over time, we will come to see that this kind of feedback can be healing and restorative for patients and staff alike.

Author Bio: *James Munro has worked at Care Opinion since it was founded in 2005, and has been CEO since 2014. His background is in clinical medicine, public health and health services research.*

ENDNOTES

1 National Audit Office. Feeding back? Learning from complaints handling in health and social care. NAO, London 2008. Available at https://www.nao.org.uk/wp-content/uploads/2008/10/0708853.pdf

2 Care Opinion post 2: https://www.careopinion.org.uk/911825

3 Mazanderani F, et al. Caring for care: Online feedback in the context of public healthcare services. Social Science & Medicine, 2021. https://doi.org/10.1016/j.socscimed.2021.114280

4 Care Opinion post 1: https://www.careopinion.org.uk/1011891

5 Baines R, et al. Implementing online patient feedback in a 'special measures' acute hospital: A case study using Normalisation Process Theory. Digital Health, 2021. https://doi.org/10.1177/20552076211005962

6 Lloyd, Rebecca & Munro, James & Evans, Kerry & Gaskin-Williams, Amy & Hui, Ada & Pearson, Mark & Slade, Mike & Kotera, Yasuhiro & Day, Giskin & Loughlin-Ridley, Joanne & Enston, Clare & Egglestone, Stefan. (2022). Health service improvement using positive patient feedback: systematic review and change model. 10.1101/2022.09.10.22279800.

7 Munro J. We are missing the potential of patient feedback. NIHR blog, 2020. https://www.nihr.ac.uk/blog/we-are-missing-the-potential-of-patient-feedback/24336

Article

Transforming to Continuity of Midwifery Carer - Exciting Times for Northern Ireland Maternity Services

By Leslie Altic

Leslie Altic

Since the publication of Changing Childbirth[1] and Better Births[2], UK maternity services have slowly been moving towards implementing Continuity of Midwifery Carer (CoMC). This model can be described as one where women receive consistent care from the same midwife or a small team of midwives throughout their pregnancy, birth and the early postnatal period, enabling the development of respectful and trusting relationships between midwives and the families that they care for. AIMS continues to campaign for this transformation to maternity services across the UK[3].

The current maternity service model means that women receive care from different midwives depending on the stage of pregnancy, risk factors, where they live and what local services are available. With over-stretched staffing and resource issues continually challenging the system, the women who speak to me often report an experience of maternity care that is disjointed, rushed and impersonal. This frequently leaves women feeling as if they are just another number, unprepared for birth or not knowing who to turn to with questions or concerns. As someone who feels lucky to have received continuous care through each pregnancy, it was extremely reassuring and very personal to have built a relationship with my caregiver; I felt safe and supported by someone who knew me and my family.

By facilitating truly individualised care, the CoMC model of care leads to better clinical outcomes for women and their babies as well as a more positive experience [4,5] Research has shown that women are less likely to experience stillbirth and pre-term birth, less likely to experience induction or interventions and more likely to have a spontaneous vaginal birth. Evidence also indicates that midwives may benefit from working within this model, experiencing greater professional satisfaction and more autonomy, with less anxiety and burn-out [6,7].

CoMC has been embedded in the Nursing and Midwifery Council standards and all midwifery students must now learn and work in this model during their studies. In Northern Ireland, caseload midwifery had been an option for women but was not the standard model of care and was phased out about a decade ago. With the caseload model, women received continuity before and after the birth, but were still unlikely to be supported by a midwife they knew in labour. Of the five Trusts in Northern Ireland, the Northern Trust piloted a continuity of carer scheme called the Lotus Team,[8] and the Southern Trust launched the Birth at Home team[9], which follows the principle of the continuity model for women that are planning home births. Both teams have received extremely positive feedback from women who have used the service[8,10] .

In 2022, Emma received care from the Birth at Home team in the Southern Trust:

> *"I first heard from the team by phone call shortly after my 12 week booking appointment. From this call onwards all of my appointments were with the small team of midwives in my own home. As they are a small team, communication was excellent. I didn't feel like I had to explain or repeat myself every visit. I was able to contact the team if I had any concerns and speak to someone I already knew, and who knew me. It was very reassuring. Coming up to the birth, I knew that it would be a familiar face walking*

through the door when I was in labour. Having the same midwife for labour who had met me at 16 weeks and multiple other visits gave me a sense of instant comfort, which I fully believe helped the labour process. Overall, it was an incredibly positive experience."[11]

To date, though, the CoMC model has not been fully implemented across Northern Ireland, and so in 2021, a regional group ranging from midwives and doctors to service users was set-up to begin the move towards transforming maternity care here. As it will involve significant reform and a fundamental cultural shift from the current model, it is being rolled-out in a phased approach. One of the issues at the centre of the planning is an awareness that some previous attempts at CoMC and caseload models in the UK have led to higher levels of burnout in the midwives working within the model [12]. Doing it in this slow and steady way means that as well as learning from previous experience in Northern Ireland and successful schemes across the UK, we can manage and adapt to any issues encountered by the first local teams. This should mean that when the model has been fully implemented it will run smoothly and sustainably. Taking a regional approach also means that CoMC will be available and work in the same way across the country; there will be no postcode lottery.

Teams will be made up of a small number of midwives, a maternity support worker and a linked obstetrician, thus it is an integrated approach to maternity services. As the roll-out continues, student midwives will also have the opportunity to work in this model during their training. Teams will run on a mixed-risk caseload, covering both women having straightforward and complex pregnancies, and be geographically based (as large portions of Northern Ireland are quite rural) and midwives will support their choice of birth place. At the booking appointment, the woman will meet her named midwife who will be responsible for coordinating her care and aim to see her for all appointments; these can be flexible and arranged to suit both the midwife and the woman. Should there be a need for clinical referral to additional support services, the woman's named midwife will attend these appointments with her to ensure continuity. This can be especially beneficial for women who have more complex pregnancies or support needs as they often will not see a midwife while under consultant-led care.

Phase 1, the organisational structure and development of the regional model for Northern Ireland has been completed and we are now entering Phase 2, the initial small-scale program of the first two teams in each Trust. Each Trust has a local implementation group headed up by the Trust's CoMC lead midwife which looks at how the teams can be rolled out to meet the needs of the local population. The first CoMC teams will prioritise those who are at increased risk of poorer outcomes, such as those living in areas of greatest social deprivation, smokers, Black, Asian and mixed ethnicity groups, and women aged 20 years and younger, then the scope will widen as new teams are added. The aim is that at full implementation, CoMC will become the standard model of maternity care in Northern Ireland and the majority of women will be able to benefit.

At each level and phase of the program, a number of key stakeholder groups are involved, from midwives and student midwives, to maternity support workers and obstetricians and especially service user representatives. This ensures that the model is co-designed and co-produced from the outset so that it meets the needs of all those working within the model as well as the women and families they support. As a service user representative with many years of involvement in the improvement of maternity services, I have been part of the implementation plan right from the start and am a member of the regional group as well as my local Trust group. It is vital to bring the service user voice at every level in the development of this model so that it can be designed with their experience at the forefront.

The first teams will launch in April 2023, with the second teams to follow shortly after that. There will be challenges along the way, but with initial feedback from service users who are very excited about the change, the commitment of amazing midwives who are keen to work within this model, and the widespread involvement of other groups in this transformation, there are exciting times ahead for expectant parents in Northern Ireland.

Author Bio: *Leslie Altic is a birth and postnatal doula and hypnobirthing teacher based in Belfast. For more than 8 years she has been involved with shaping maternity services in Northern Ireland through local Maternity Service Liaison Committees, regional policy working groups and campaigning charities. Leslie is also a member of the AIMS Birth Information Team.*

[1] Changing Childbirth (1993) Changing Childbirth - Report of the Expert Maternity Group, Survey of good communications practice in maternity services. London: HMSO

[2] NHS England (2016) National Maternity Review: Better Births – Improving outcomes of maternity services in England – A Five Year Forward View for maternity care. Available online at: www.england.nhs.uk/wp-content/uploads/2016/02/national-maternity-review-report.pdf

[3] Implementing Continuity of Carer September 2022

www.aims.org.uk/campaigning/item/implementing-coc

[4] Sandall, J., Soltani, H., Gates, S., Shennan, A. and Devane, D. (2016) Midwife-led continuity models versus other models of care for childbearing women. Cochrane Database of Systematic Reviews, available online at: www.cochranelibrary.com/cdsr/doi/10.1002/14651858.CD004667.pub5/full

[5] Perriman, N., Lee-Davis, D. and Ferguson, S. (2018) What women value in the midwifery continuity of care model: A systematic review with meta-synthesis. Midwifery 62: 220-229.

[6] Fenwick, J. Sidebotham, M., Gamble, J. and Creedy D.K. (2018) The emotional and professional wellbeing of Australian midwives: a comparison between those providing continuity of midwifery care and those not providing continuity. Women Birth 31(1): 38-43.

[7] Pace, C.A., Crowther, S. and Lau, A. (2022) Midwife experiences of providing continuity of carer: A qualitative systematic review. Women Birth 35(3): e221-e232.

[8] Glover, A. (2020) Campaign update: Continuity of Carer, Northern Ireland - trying to do it properly! AIMS Journal 32(4), available online at: www.aims.org.uk/journal/item/campaign-update-continuity-carer

[9] Southern Health and Social Care trust (2022) Birth at Home. southerntrust.hscni.net/birth-at-home/#:~:text=Since%20they%20started%20in%20November,by%20the%20Trust%20this%20week

[10] Care Opinion (2022) Supported for our Homebirth. www.careopinion.org.uk/898417

[11] Fraser, E. (2023) Email to Leslie Altic, 19 January.

[12] Taylor B, Cross-Sudworth F, Goodwin L, Kenyon S, MacArthur C. (2019) Midwives' perspectives of continuity based working in the UK: A cross-sectional survey. Midwifery, Volume 75, Pages 127-137.

Article

Mental Health-related maternal deaths: reflections on the MBRRACE report

by the AIMS Campaigns Team

In this article, the AIMS Campaigns Team provides a short summary of the latest MBRRACE report 'Saving Lives, Improving Mothers Care'[1], and offers some reflections on the recommendations proposed to reduce mental health related deaths.

The report, published in November 2022, covers the confidential enquiries into maternal deaths and morbidity in the UK and Ireland over the three-year period 2018-2020. During this time, 229 women (10.9 women out of every 100,000 giving birth) died during pregnancy or the first six weeks after giving birth, including nine who died from Covid. Excluding the Covid deaths the rate was 10.5 out of every 100,000 giving birth, compared to 8.8 out of every 100,000 in the three years 2017-19.

A further 289 women (13.8 women out of 100,000 births) died between six weeks and a year after the end of their pregnancy. This rate has not changed significantly since the first MBRRACE report in 2010.

It is worrying that despite the Government's ambition to reduce maternal mortality by 50% between 2010 and 2025, this latest report shows that the downward trend has stalled. In fact, between the periods 2010-12 and 2018-20 the proportion of mothers dying increased by 3%, excluding deaths from Covid. This has been driven by an increase in the direct death rate (those directly due to pregnancy and birth) and in particular by increases in deaths from suicide, pre-eclampsia and haemorrhage.

It is also worth noting that of those who died, "detailed assessment showed that for… 38% improvements in care may have made a difference to their outcome."

In the report the authors comment that, in addition to the deaths directly due to Covid, "There is little doubt that changes to and pressures on maternity services as a result of the Covid-19 pandemic also contributed to some of the other maternal deaths during this same period." It seems likely that reductions in face-to-face contact both antenatally and postnatally will have led to serious problems being missed.

Overall, the majority of maternal deaths in the period covered by the report (86%) occurred postnatally. This included 32% in the first six weeks, and 54% between six weeks and a year after giving birth. In particular, the majority of both suicides and deaths from substance abuse occurred postnatally, with a peak at 6-9 months. This is particularly worrying given the ongoing limitations on in-person postnatal support, which has in many areas declined further as a result of pandemic measures, making it less likely that women who develop postnatal mental health problems will be identified.

It is cause for great concern that issues identified in previous reports persist or have even deteriorated. Black women are still almost four times more likely, and Asian women almost twice as likely to die compared to white women. Despite the increased focus over recent years, there has been no significant narrowing of these gaps. Women from the most deprived areas are two-and-a-half times more likely to die than those from the least deprived areas, and this gap continues to increase. At least eleven percent of the women who died were at 'severe and multiple disadvantage' as a result of having more than one risk factor, which might include a mental health diagnosis, substance abuse or domestic abuse. The authors comment that this figure is likely to be an underestimate.

Just over a quarter of the women who died were born outside the UK. Although overall the death rate was not significantly different between those born in and those born outside the UK, it was significantly higher for women born in Bangladesh.

The full report contains detailed analysis and recommendations for the leading causes of maternal deaths, with chapters on caring for women with multiple morbidities, cardiovascular problems, hypertensive disorders, early pregnancy disorders and critical care. In this article we will focus on the issue of mental-health related deaths, which are addressed in Chapter 3.

Mental-health related deaths

The report reveals that suicide is taking an increasing toll of new mothers, and especially teenage mothers, with many of these having previously been in care. In 2020, women were three times more likely to die by suicide during pregnancy or up to six weeks after the end of pregnancy compared to 2017-19. This is 1.5 women out of every 100,000 giving birth.

Suicide also remains the main cause of direct deaths in the period between six weeks and a year after birth, and overall, deaths from all mental health-related causes account for nearly 40% of deaths occurring within a year after the end of pregnancy.

Quite aside from the horror of these individual deaths must be the realisation that for every mother who dies by suicide or from other mental-health related reasons, there will be many more who are suffering severe mental and emotional problems. The report makes a number of important new recommendations for detecting and supporting those at risk, in addition to reminders of "Existing recommendations requiring improved implementation" but do these go far enough? A lot of the recommendations have the effect of reducing the woman to a problem to be solved by the professionals, which may not be the most helpful approach for someone who is already feeling disempowered and vulnerable. **Should the focus not be on working with a woman to identify the care and support that will benefit her?**

For example, one recommendation is for professionals to **"Be alert to factors, such as cultural stigma or fear of child removal, which may influence the willingness of a woman or her family to disclose symptoms of mental illness, thoughts of self-harm or substance misuse."** The difficulty here is that disclosing mental health issues may indeed lead to a baby being removed from parents. We are still seeing the same issue that we have seen for decades of women being reluctant to reach out for support from fear that support will not be forthcoming, but rather that any issues they disclose will be used against them. Perhaps what is needed is a more empathic approach by both healthcare and social services professionals towards supporting and reassuring mothers/families in this situation, so that a referral to Children's services becomes a real offer of help rather than a threat.

Another recommendation is **"Recognise the importance of a trauma history in the assessment of risk. Involve specialist Perinatal Mental Health Teams where there is a history of significant involvement with secondary mental health services or significant risk, particularly if it is a first pregnancy."** Trauma history is an important consideration, but any exploration needs to be done sensitively and with awareness of the potential impact of requiring people to revisit previous trauma. We are concerned about how well-equipped staff working directly with parents are to carry out the initial conversation in an appropriate manner, before deciding whether to involve the specialist Perinatal Mental Health Team – especially given the pressures and time constraints under which midwives have to work. (And by the way, shouldn't that be 'offer of referral to' rather than 'involve'? Again, women need to be confident that they will be offered actual help and not just have this flagged as a risk factor.).

A third new recommendation is **"Allow sufficient opportunity in electronic records systems for free text written comment rather than relying solely on 'tick boxes'. Where a woman has a history of mental health difficulties, make a brief (as a minimum) comment on mental health."** Again, we feel that this needs to be done sensitively and ideally in partnership with the woman. If it is seen as a health professional passing judgement on her, it could easily lead to a breakdown in trust and do more harm than good. Perhaps in addition to noting any issues there should be clear documentation of what support has been offered, and then if the women accepted the support whether it was found to be helpful. Sadly, AIMS often hears that support is either not forthcoming or is not helpful.

There is a comment in the report that "Many of the women who died through either suicide or substance misuse struggled to engage with services." The recommendation is about multiple services working together when planning contacts. While this may be helpful, surely it is also important to explore the factors which might be preventing women from engaging – such as lack of trust, fear of stigma, lack of awareness of how to access support or practical difficulties with childcare or transport etc - and developing strategies to address these?

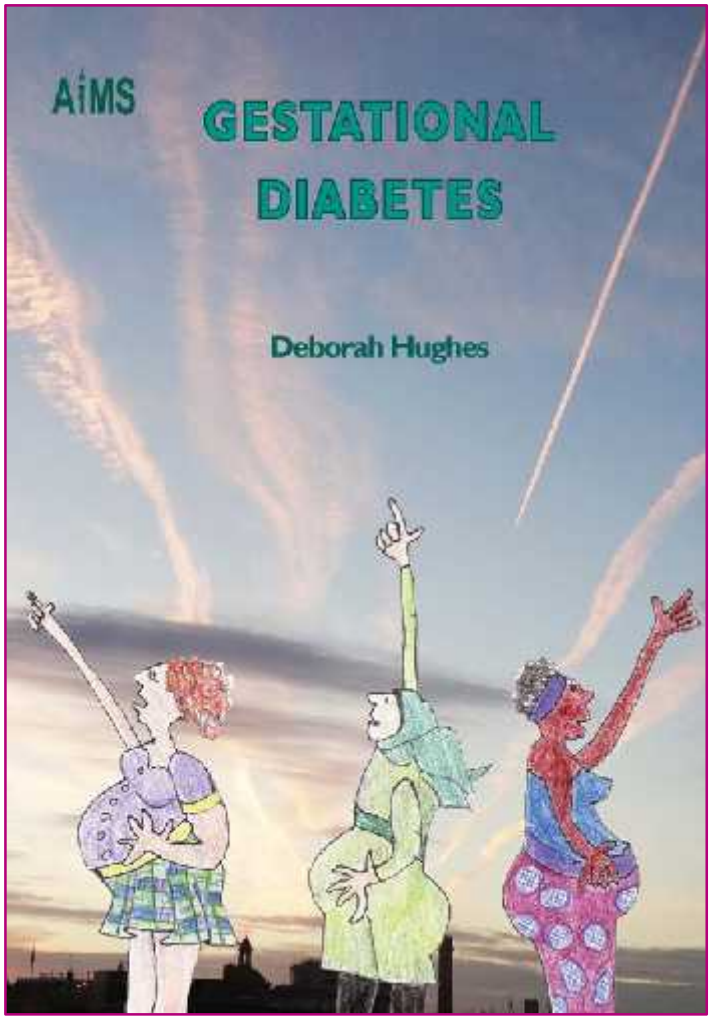
One of the existing recommendations is “continuity of mental health care.” We wonder why there is no mention anywhere of the benefit of Continuity of Carer throughout the maternity period, especially for women who have or are at risk of developing mental health problems. The opportunity to form a trusting relationship with a midwife must surely facilitate disclosure of “symptoms of mental illness, thoughts of self-harm or substance misuse” as well as domestic violence. This could help to improve the identification of women at risk, as well as making it more likely that they will engage with support that is offered.

A major problem is that all these recommendations require staff working directly with parents to have the time and skills to engage effectively with what are often extremely vulnerable women, and specialist Perinatal Mental Health Teams to be adequately resourced to deal with what is likely to be an expanding caseload as the cost-of-living crisis begins to bite. In the current state of the NHS, how likely is this?

ENDNOTES

[1] MBRRACE (2022) Saving Lives, Improving Mothers Care. Reports | https://www.npeu.ox.ac.uk/mbrrace-uk/reports

~~~



Deborah Hughes (BA (Hons), RM, MA, PGDEd) gives her expertise on the subject of Gestational Diabetes.

AIMS knows that many women are being diagnosed with Gestational Diabetes or are faced with the decision to be tested for it, without having all the information they want. Midwives, student midwives, doulas, hynobirthing practitioners and all others who work with women now have a significant resource. Jennifer Williams insightful illustrations and infographics, adding humour and making this complex subject more accessible.

Available in paperback (£8)
and kindle format
from
the AIMS shop

www.aims.org.uk/shop
~~~

Article

Conference Report: Pandemic recovery of maternity & child services September 2022

By Nadia Higson

Nadia Higson

This conference, organised by the Royal Society of Medicine's Maternity and the Newborn forum, provided a platform for research findings from PIVOT-AL (Parent-Infant coVid OrganisaTional Academic Learning collaborative[1]) looking at various aspects of the impact of Covid-19 on maternity and child services and how this can inform services as they rebuild. The PIVOT-AL collaboration is a network of researchers who came together during the pandemic to carry out a wide range of rapid-funded projects, with an emphasis on sharing and open access.

Professor Soo Downe opened the day by reminding us that the challenge is to identify "How are we going to stop doing what we've always done" which will require radical change at the system level. If changes are only made on the basis of 'what goes wrong' they can have unintended consequences for what usually goes right. What is needed is a move towards the concept of 'Safety II' (drawn from resilience engineering[2, 3]) which includes a focus on maintaining safety.

There were too many individual presentations to cover in detail in this short article, but a number of important themes emerged.

Many presentations provided evidence for what AIMS Helpline volunteers observed about the damaging impact of service restrictions on women and their partners, and the unhelpful nature of blanket policies[4]. As Dr Pat O'Brien from the Royal College of Obstetricians and Gynaecologists (RCOG) said in a panel discussion, in many cases "common sense went out of the window."

Research showed that service users were angered by the changes in maternity services, by lack of information about the changes, and lack of birth options, and felt unable to plan due to constant changes in policy. Often, they tried to regain a measure of control by making decisions that would give them some degree of certainty. That might be to plan for a homebirth or freebirth, for induction or for a planned caesarean. Many had a sense that hospital was unsafe due to Covid.

Several speakers reflected on the clash between infection control demands and relational, human caring, which led to holistic well-being being deprioritised. As one speaker commented "True safety is not just 'not dying.'" This impacted on staff as well as service users, with the conflict between public health ethics and clinical ethics making them unable to offer person-centred care, resulting in "burn-out, demoralisation and 'moral injury.'"

A number of presentations focused on the impact of the pandemic and the resulting maternity services restrictions on the mental and emotional wellbeing of mothers and families. Despite evidence that the pandemic increased the incidence of domestic violence, the rate of reporting was low and referrals to secondary mental health[5] decreased by 78%. The

rate of people scoring positive for depression increased by 40% but there was no change in referrals. It is likely that the lack of in-person appointments meant that problems were not identified.

Based on a national online study, during the first lockdown there was a 43% prevalence of PND and 61% prevalence of anxiety - substantially higher than the rates normally reported. A qualitative study identified the high level of distress caused by being left to navigate pregnancy and birth alone. Another study found that younger women and LGBTQ+ parents scored higher on postpartum anxiety than other groups.

There were also concerns about the impact on babies. Although lockdowns meant that babies had more interactions with their parents, the effect of seeing fewer people seems to have led to lower ability to attend to sensory input and sensitivity to social stimuli, which may lead to future problems with socialisation.

The day finished with a summary of:

- What novel care practices developed during the pandemic should be retained
- What pre-pandemic practices need to be reinstated
- What pandemic practices should be stopped
- The guiding themes for this were recognising:
- the importance of partner support ("If this ever happens again, we can't take partners away")
- the importance of relationships between service users and carers, in the community as well as in hospital
- the equal importance of physical, mental and moral health[6]
- the need for clear, concise and consistent communication across all services
- the need to allow creativity and the search for innovative ways to offer care to continue

Work is underway to support 'build back better[7]' by synthesising the findings of the PIVOT-AL studies to draw robust conclusions on which to base policy. Roadshows are planned to discuss the findings and plan the way forward, including listening events in all four nations. We can only hope that despite the current crisis in the NHS, Trust Boards and maternity services management will make the time to listen and act on these findings with the urgency they deserve. However, it's been concerning to see that the knee-jerk response to the recent ambulance strikes has, in many Trusts, been to place blanket bans on support for homebirths and birth centre births regardless of individual needs.

If you are an MVP user representative or other birth activist, why not challenge your local maternity service to explain how they are 'building back better' in the light of this research - or are they simply "doing what {they've} always done?"

Author Bio: *Nadia Higson is an AIMS Trustee, volunteer AIMS Coordinator, and a member of the Campaigns Team, in which capacity she led AIMS campaigning on pandemic-related maternity service restrictions. She is also a local MVP user rep and an NCT antenatal practitioner. She was the principal author of the AIMS Guide to Induction of Labour and has written several of the Birth Information pages on the AIMS website, including "Coronavirus and your maternity care".*

ENDNOTES

[1] PIVOT-AL - twitter.com/PIVOTAL_Collab

[2] "Safety management through centralized control, labelled by Hollnagel as 'Safety-I', aims to align and control the organization and its people through the central determination of what is safe. Safety management through guided adaptability, or 'Safety-II', aims to enable the organization and its people to safely adapt to emergent situations and conditions." www.sciencedirect.com/science/article/pii/S0951832018309864

[3] "Safety management should therefore move from ensuring that 'as few things as possible go wrong' to ensuring that 'as many things as possible go right'. We call this perspective Safety-II." www.england.nhs.uk/signuptosafety/wp-content/uploads/sites/16/2015/10/safety-1-safety-2-whte-papr.pdf

Editor's note: Safety 1 equates with pathogenesis, Safety 2, with salutogenesis. www.aims.org.uk/journal/item/editorial-salutogenesis

[4] AIMS comment: Applying blanket policies without taking account of individual needs may have contravened the Equality Act 2010. www.gov.uk/guidance/equality-act-2010-guidance

[5] Editor's note: 'Secondary mental health' is the term used for referrals from the first or primary health practitioner consulted (for example, a midwife or GP) to more specialist mental health care.

[6] Editor's note: I take the term 'moral health' to mean the state where one's behaviours are congruent with one's personal values of what is right or wrong. Moral injury is when one feels forced to do something believed to be wrong - or forced not to do something believed to be right. (Examples might include: leaving your partner when she is in labour and wants you there; or, as a midwife, not inviting the partner to stay, even though you knew separation would add to the mother's distress and affect the course of her labour.)

[7] Department of Health & Social Care (2022) 'Build Back Better: Our Plan for Health and Social Care'

https://www.gov.uk/government/publications/build-back-better-our-plan-for-health-and-social-care/build-back-better-our-plan-for-health-and-social-care#our-plan-for-healthcare

Article

A fond farewell to, and from, Julia Cumberlege and Cyril Chantler, champions for changing childbirth for the better

By Jo Dagustun, AIMS volunteer and Maternity Transformation Programme (England) Stakeholder

Julia Cumberlege and Cyril Chantler

It was a truly poignant moment at our Council meeting in January as Julia Cumberlege announced that she and Cyril (chair and vice chair of the Stakeholder Council respectively) would be relinquishing their maternity roles at the end of March 2023. Seven years on from the publication of Better Births, they have stayed on to oversee the implementation of the report's recommendations, but they have surely now done their time, and on behalf of AIMS I would like to thank them for their commitment to this task. What we have now is Better Births firmly established as a key part of England's maternity transformation strategy, and it is time for others to step up to provide leadership for this important work.

What I have found remarkable in the domain of UK maternity service improvement work is how so many people devote decades of their life to this cause, well beyond the normal retirement age. Julia Cumberlege is perhaps a prime example of this, working in and around the edges of UK government for decades, to offer leadership and support for the implementation of a maternity policy that is fit for purpose. Many will also know Julia's excellent work to investigate the mesh scandal.

In maintaining a positive outlook, she inspires the best in others. I have been fortunate to come to know Julia through my volunteering for AIMS, and have very much appreciated her ongoing work to support the implementation of Better Births (2016). Seven years on, there is much that has been achieved but much still to be done. In many areas, it could perhaps best be said that we are nearing the starting line for launching the transformation demanded in that report. But we also have new strength to draw on, in the form of the growing, dynamic and diversifying maternity service improvement community. As an AIMS volunteer, I know that my work will continue to be inspired by Julia and Cyril's leadership, and I thank them for their incredible service. Here is their statement:

A message to the women of England and their families from Baroness Cumberlege

Today, Sir Cyril Chantler and I are announcing that we are stepping down from our positions on NHS England's Maternity Transformation Board and the Maternity Stakeholder Council at the end of March 2023. It has been an absolute honour to be involved in these initiatives for the past seven years and to have led the National Maternity Review before that. We have chosen this moment because we both have growing commitments elsewhere that require more of our time.

We looked back at Better Births, the report of our Review, which we published in 2016. The following words are from the Letter to the Women of England and their Families that formed the foreword to Better Births:

> "The birth of a child should be a wonderful, life-changing time for a mother and her whole family. It is a time of new beginnings, of fresh hopes and

new dreams, of change and opportunity. It is a time when the experiences we have can shape our lives and those of our babies and families forever.

These moments are so precious, and so important. It is the privilege of the NHS and healthcare professionals to care for women, babies and their families at these formative times."

Our message to the women of England, today, seven years later, is the same. Maternity care is all about you, your baby and your family. It needs to be shaped around you. It needs to be a partnership between you and the team that cares for you. It must be safe and it needs to be based on your informed choices. Good maternity care is not done to you, it is done for you and with you. With you and your baby at its centre. It needs to be personalised care.

Good maternity care will always be at the heart of a good health service. And Better Births was all about good maternity care. The past seven years has been a privilege for the two of us; to meet and work with so many wonderful, talented and passionate people both at national level and in hospitals and communities across England. We thank them all.

Maternity care has been on a journey of improvement. The goal is to make services as safe and as personalised as possible. The journey is not over; much has been achieved but more remains to be done. We may be stepping back but we will be watching the next stages of the journey with the keenest of interest and we look forward to being among the first to recognise the progress that is to come. We are confident that NHS England's work will be continuing through the single delivery plan and that Better Births will continue to be their guiding vision.

Finally, to you - the women of England and your families - we say this: maternity services and the teams that provide them are there for you, to make your maternity journey the best it can be for you and your baby. It is your body, your child. Never forget that you are at the centre of maternity care. We hope that, supported by wonderful maternity teams, your maternity experience is among the most special of moments in your life.

Baroness Julia Cumberlege
Sir Cyril Chantler

January 31, 2023

In Memoriam: Beverley Lawrence Beech

A personal reflection by Debbie Chippington Derrick

Beverley Lawrence Beech, 14 Nov 1944 - 25 Feb 2023

Beverley's sudden illness and death has come as a severe shock to all who knew her. With just a few days to go to the publication of the March AIMS Journal we only had time to include this brief personal reflection about someone who was so significant in the history of AIMS and the wider maternity services improvement community. We plan to publish a full obituary in our June issue, and will also be putting together a memory book to share with her family. If you have a memory or tribute that you would like to share, please send it to enquiries@aims.org.uk

It was the births of her sons David and Alan which started Beverley on her journey to her most amazing career as an advocate for women, much of that working within AIMS, an organisation which she chaired for forty years. Her brave and clear voice about what was wrong, and what was unacceptable gave many others the confidence to speak out. The number of families who are grateful to her for this is immense, with many many more benefitting from her work without being aware of what she did for them.

In addition, her influence on those working in the maternity services should not be underestimated. Through in-depth discussions, speeches and writing she helped many health care staff to see things differently and to realise that they personally had a role in making improvements. She also provided support to health care professionals who were standing up for women and families. The two most prominent cases she was involved in were those of Wendy Savage and Becky Reed and the Albany practice.

Many people will have memories of how Beverley supported them personally, by helping them to be able to make informed decisions about their own birth, or to make a complaint about the care that they had received. Her influence was certainly there for me when I decided to have my fourth baby at home after three previous caesareans. For others, she helped them develop the support work they were doing. I have often heard her speak about starfish and rescuing them one at a time - each one rescued was important, even though you couldn't rescue them all.

Many will also be able to look back on shared conversations, drinks, lunches, journeys or even hotel rooms (keeping down AIMS costs), or just the impact of reading her words.

I was lucky enough to be able to work closely with Beverley for over a decade at AIMS, but also to have been a friend. She spent time with my family, and my husband spent many an hour sitting in her basement office in Surbiton sorting various issues with her computer. We were honoured to have been able to attend her 70th Birthday and I have lots of memories of happy times spent with her. I remember fondly a European Network of Childbirth Associations (ENCA) meeting in Paris, where we hired bikes and cycled to the Eiffel tower and lay on the grass in the evening sun.

She had only moved from Surbiton at the beginning of December 2022, to a house right next to her sailing club in Hammersmith. She had so much more to live for, and our thoughts are with the family and friends who have been deprived of this time with her.

Her speech at the AIMS 50th event which was held at her sailing club gives highlights of her work over several decades https://www.aims.org.uk/journal/item/50-years-campaigning

If you haven't read her articles, the following examples from the AIMS Journal should give you a flavour:

Challenging the Medicalisation of Birth

www.aims.org.uk/journal/item/challenging-the-medicalisation-of-birth

Violence in obstetrics

www.aims.org.uk/journal/item/violence-in-obstetrics

Pressing for Change

www.aims.org.uk/journal/item/pressing-for-change

She was an inspiration to a generation of birth activists and never lost her passion for improving the maternity services. Her challenging and compassionate voice will be missed, and those like me who had the privilege of working with her will miss her insightfulness and sharp wit.

Author Bio: *Debbie has been an AIMS Member for 35 years and an AIMS Volunteer for 18 years. She was previously Vice Chair of AIMS and Chair of Trustees, and is now a current AIMS Trustee and member of the AIMS Management Team.*

What has the AIMS Campaigns Team been up to this quarter?

By the AIMS Campaigns Team

Written outputs:

- 'Physiology-informed maternity care' article for the British Journal of Midwifery
- AIMS statement on the Kirkup Report
- Maternity Continuity of Carer article for The Practising Midwife
- Feedback to NHS-England - Saving Babies Lives Care Bundle v3
- Article for Liberator magazine on the state of the maternity services
- Journal article on MBRRACE report 'Saving Lives, Improving Mothers' Care'
- Conference report: Pandemic recovery of maternity & child services

Conferences and meetings attended:

- 7th November: NHS-E Maternity & Neonatal Service User Voices online event
- 10th November: Charities and Service Users Maternity Continuity Network meeting
- 10th November: Virtual launch of MBRRACE-UK Saving Lives, Improving Mothers' Care report 2022
- 12th November: AIMS Volunteers meeting
- 15th November: Maternity Matters - A Focus on Baby Loss
- 22nd November: Challenging Practice in Maternity Care - run by Health Service Executive, Ireland, for the West of Ireland area
- 23rd November: GMC (General Medicine Council) Patient Roundtable
- 24th November: Maternity Transformation Programme (MTP) Stakeholder Council meeting

- 1st December: Charities and Service Users Maternity Continuity Network meeting
- 1st December: NHS England Board meeting
- 3rd December: ARM (Association of Radical Midwives) Conference, Continuity of Carer. Presentation on behalf of AIMS
- 8th December: QMNC (Quality Maternal and Newborn Care) Research 'watch party'
- 13th December: Oxford Brookes seminar. Positive reciprocal partnerships between women, maternity clinicians, educators, and researchers: challenges and opportunities
- 14th December: AIMS mini presentation at Maternity & Midwifery Hour
- 15th December: MTP Stakeholder Council - Delivery Plan Engagement Session
- 18th January: QMNC Research 'watch party'
- 24th and 27th January: MTP Stakeholder Council related meetings
- 31st January: MTP Stakeholder Council
- Throughout the period:
- Midwifery Hour, Wednesday evenings
- Various Continuity of Carer related and other 1-1 meetings

What we've been reading:

- MBRRACE-UK Perinatal Surveillance Report
- MBRRACE-UK Saving Lives, Improving Mothers' Care report
- Article by some of our colleagues in ENCA: Parent organizations' experiences of the pandemic response in maternity care in thirteen European countries
- CQC Maternity Survey 2022

What we've been watching:

- 15th November Maternity Matters: A Focus on Baby Loss
- 'Belfast Midwives' documentary on Channel 4
- 2022 update of a presentation on 'Obstetric violence and human rights' at the RCOG World Congress 2014, Hyderabad, India by Dr Amali Lokugamage
- Two videos demonstrating relationship-based care and the idea of a social model of maternity care being grounded in welcoming and supportive community hubs: What's it like being a LEAP Midwife? and LEAP Midwives - Women's experiences

Thanks to all the AIMS campaigns Volunteers who have made this work possible. We are very keen to expand our campaigns team work, so please do get in touch with campaigns@aims.org.uk if you'd like to help!

There for your mother

Here for you

Help us to be there for your daughters

www.aims.org.uk

Twitter – @AIMS_online

Facebook – *www.facebook.com/AIMSUK*

Helpline

helpline@aims.org.uk

0300 365 0663