

Dignity in Childbirth

PROJECTS & PERSPECTIVES

Birthrights Dignity in Childbirth Forum, 16 October 2013



Dignity in Childbirth: Projects and Perspectives
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Introduction

Elizabeth Prochaska, Founder of Birthrights

When Birthrights put out a call for submissions describing maternity initiatives that promote dignity in childbirth, we did not know what response to expect. We have been overwhelmed and excited by the papers we received. The projects and perspectives described here are undoubtedly just a small sample of the exceptional work that is taking place across the UK, but they reflect the passion and dedication that exists for improving childbirth among health professionals, academics and campaigners.

The Dignity Forum on 16 October 2013 marks the beginning of the Birthrights campaign to promote dignity in maternity care. We hope that the authors and projects featured here will work with us to challenge assumptions and raise standards.

The role and influence of key professionals in the decision-making processes of pregnant girls

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This research study draws on the narratives of fourteen young women, aged 15-18, to explore their experiences of pregnancy and motherhood. The aim of the research is to examine how they believe becoming pregnant in their teenage years has shaped and influenced their lives, with a particular focus on education.

In the United Kingdom teenage motherhood has typically been depicted in the media and government policy as highly problematic for individual young women and as a severe problem for society that must be tackled (Duncan, 2007). However, in recent years there have been attempts to provide a counter analysis of teenage motherhood in order to challenge the traditional view of teenage pregnancy as a devastating event. This has led to a surge in qualitative studies that focus on the views of teenage mothers in order to understand how they conceptualise their experiences of pregnancy and motherhood. This focus on individual experience, rather than statistical data, is based on a commitment to examining how people make sense of their own major life experiences (Smith, Flowers and Larkin, 2009). This has helped expose an alternative discourse of teenage motherhood. The meanings young women give to teenage pregnancy and motherhood are found to be different in key dimensions from traditional cultural narratives. Based on the findings of many qualitative studies it is now argued by a growing number of academics that teenage motherhood can help instigate positive change in young women's lives, rather than engendering a pathway to disadvantage and social exclusion (for example, Barn and Mantovani, 2007; Clemmens, 2003).

This presentation draws on Melissa's story to illustrate how her pregnancy impacted upon her education. This research study problematises the concept of teenage pregnancy as a 'positive turning point' and argues that while the majority of young women may speak the language of individual choice, control and agency, they are still highly susceptible to external factors which impact upon the educational resources and opportunities available to them. A strong theme which emerged from Melissa's story is the role and influence of key professionals in her decision-making regarding education. In this presentation it will be demonstrated how Melissa's apprenticeship employer and midwife shaped and influenced her educational decisions:

'For my midwife to turn around and say to me you are putting your baby under a lot of stress made me realise that I am going to have to get out of here because everything kind of changed when I got pregnant.'

Melissa's experience with her midwife will be discussed in relation to Valerie Levy's (1999) concept of protective steering.

Respectful, evidence-based care for women with a high BMI increases satisfaction and reduces physical and psychological morbidity

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'Health is never simply "health"; instead it can easily become a means of moralising, of normalising and of regulating.' (Parr 2002: 373, cited in Evans 2006: 259). Fatness, unlike smoking or drug use, is highly visible and, in our thinness-obsessed culture, often incurs immediate moralising and judgement. The language of official publications constructs women with a high BMI as a 'problem' to be managed (CMACE/RCOG Joint Guidelines (2010) *Management of pregnant women with obesity*), incurring a strain on the already over-stretched NHS (HOC 2004). As the state retreats from supporting the most vulnerable in society, and cuts funding for health services, it also perpetuates a discourse of individual responsibility for a 'healthy lifestyle', thereby creating feelings of guilt and shame for many who cannot achieve this for whatever reason.

Pregnant women with a high BMI are vulnerable to stigma during pregnancy care (Furness et al 2011, Russell et al 2010). Women with a BMI over 35, interviewed in one qualitative study, described feelings of humiliation in their interactions with health professionals (Furber and McGowan 2011); one woman reported: 'I felt humiliated and unimportant during one of the biggest events of my life' (Russell et al 2010). Experiencing weight bias is known to have a serious negative impact on victims' physical and psychological health (Mulherin et al 2013), and deters women from accessing care (Amy et al 2006). Stress and anxiety are well known to have a deleterious effect on pregnancy, as well as effects on the baby which extend into childhood (Talge et al 2007). Automatic categorisation of the pregnancy as 'high risk' increases the level of medical surveillance/intervention without necessarily improving outcomes – indeed some interventions may in fact end up jeopardising women's health and that of their babies. Labelling a woman 'high risk' can become a self-fulfilling prophecy (Williams 2011).

Evidence: complications of pregnancy and birth associated with obesity

The use of BMI as a measure is problematic; simple to calculate and document, it is an arbitrary number which cannot include other relevant factors relevant to the individual's overall health. Certain pregnancy complications are indeed linked with high BMI; eg a higher likelihood of diabetes, hypertensive and thromboembolic disorders, miscarriage, and stillbirth. A large Scottish study (Denison et al 2013) discussed on Woman's Hour on 18 September 2013 is the latest study to find raised BMI in pregnancy to be associated with an increased likelihood of a range of adverse outcomes. However, (as the authors themselves note) an **association** should not be assumed to be a **causal** relationship (see also Mander 2011). As obesity is far more common in socially deprived populations, poorer outcomes will also be related to other factors such as lack of adequate nutrition, higher exposure to pollution, smoking, increased stress and so on. The extent to which these factors interrelate has not been ascertained. A nourishing diet, fresh air, and moderate physical activity before

and during pregnancy have long been known to maximise the chances of a healthy mother and baby. Despite preconception care being recommended in countless research publications, provision has reduced over the past two decades and antenatal education has also been heavily cut.

High BMI is linked with a greater likelihood of medical interventions such as induction and augmentation of labour, caesarean section, and adverse outcomes such as haemorrhage, infection, and babies needing neonatal care. Many studies report all adverse outcomes together, but the latter group should be analysed carefully to ascertain the extent to which they are related to problems caused by raised BMI itself or are problems caused by the type of maternity/obstetric care provided. Women with a high BMI are often subjected to a 'cascade of interventions' (Inch 1984) due to the labelling of the pregnancy as 'high risk'. One study found that increased BMI was associated with an increase in the use of artificial oxytocin and epidurals, and with earlier decisions to perform caesarean sections (Abenhaim and Benjamin 2011). When the researchers adjusted for these differences in the management of labour, the rate of caesarean section did not increase with increased BMI. So obstetricians manage labour differently and tend to intervene earlier in women with a high BMI, with resulting increased morbidity. Most studies show a reduction in forceps/ventouse deliveries and an increase in caesarean section in women with a high BMI.

The latest evidence from the Birthplace UK national cohort study (Hollowell et al 2013) contained some reassuring findings for women with a high BMI. It found that otherwise healthy multiparous women with a high BMI 'may have lower risks than previously anticipated'. For women with no complications of pregnancy, a 'nulliparous woman of normal weight had a higher risk of an intervention or adverse outcome than a multiparous very obese woman' (53% cf 21%). The way that birth is managed (or that birth is supported to unfold) particularly in nulliparous women, is therefore central to reducing adverse outcomes.

For example, a nulliparous woman with a high BMI is more likely to have her labour induced, to be encouraged to have an epidural 'just in case', to therefore be immobile and to receive continuous fetal heart monitoring, and have a far higher chance of a caesarean section as a result of all these factors. Tracy et al (2007) in a large population-based study of 753,895 'low risk' women demonstrated the effects of certain interventions on normal birth rates. In their study, only 29.6% of women who had both an induced labour and an epidural had a normal birth; 31.8% with epidural/no induction had a normal birth, 78.6% of women who had induction and no epidural had a normal birth while 86.3% of women with no epidural/ no induction had a normal birth. This early recourse to intervention for women with a high BMI may be particularly detrimental: Acosta et al (2011) found induction and operative birth to be associated with a significantly increased rate of maternal sepsis and recommended limiting induction to clearly indicated cases. Sepsis rates were higher in women with a high BMI. In the most recent maternal mortality report, sepsis was found to be the leading cause of maternal mortality (Lewis 2007).

Discussing risk

Communication about risk should be objective and give the actual numerical risk of a complication occurring. It should also use positive framing as well as negative. For example, evidence suggests that the risk for gestational diabetes is around 10-15% or so in 'morbidly

obese' women, compared to a risk of about 2-5% in the non-obese population. So although it is an increased risk, it also means that about 85-90% of these women will not experience this complication (Vireday 2011). NICE guidance (2012) advocates personalising risks and benefits as far as possible and using absolute risk rather than relative risk (for example, the risk of an event increases from 1 in 100 to 2 in 100, rather than the risk of the event doubles). Using language such as 'three to five times more likely to get gestational diabetes' can inflate the perception of risk and induce fear.

What is best evidence-based care for women with a high BMI?

Caregivers being positive and encouraging, and providing unbiased information. All women should be aware of courses of action that will optimise their chance of a normal birth, as a caesarean section carries a higher risk of complications such as sepsis, haemorrhage or thromboembolic disorders. For women with a high BMI, this knowledge may be even more important.

Continuous support in labour is well known to improve outcomes. The evidence is so compelling that as long ago as 1998 the late Professor John Kennell observed: 'If a doula were a drug, it would be unethical not to use it'. A recent systematic review of 22 studies (Hodnett et al 2013) has confirmed the beneficial effects of a supportive companion, finding that that women allocated to continuous support were more likely to have a spontaneous vaginal birth, less likely to have intrapartum analgesia including epidural, less likely to have a caesarean or instrumental vaginal birth or a baby with a low five-minute Apgar score. They were also less likely to report dissatisfaction. All women should be informed of this evidence but it may be especially important for women at higher risk of interventions.

Continuity of midwifery care. Caseload midwifery care has been shown to improve outcomes. A recent systematic review of 13 studies (16242 'all risk' women) found women allocated to this kind of care had an increased chance of having a normal birth, a reduction in the use of epidural, and fewer episiotomies or instrumental births (Sandall et al 2013). Continuity of care would avoid the situation described by midwives in one small study where midwives meeting a woman with a high BMI for the first time on labour ward, experienced what the researchers termed 'heartsink' at the prospect of trying to support the woman to mobilise and have a normal birth in a highly medicalised environment (Singleton and Furber 2011).

Other approaches to minimise the need for interventions and improve the birth experience

Avoidance of induction/augmentation of labour unless clinically indicated. Sytocinon administration is associated with an increased risk of postpartum haemorrhage (Grotegut et al 2011).

Mobility and upright positions shorten labour, reduce epidural use, reduce the risk of caesarean section and of the baby being admitted to neonatal unit (Lawrence et al 2013).

Use of water enhances mobility, reduces epidural use, increases satisfaction (Cluett and Burns 2012).

Avoidance of continuous electronic fetal monitoring which increases the chance of caesarean section without improving neonatal outcomes (Alfirevic et al 2013).

Privacy optimises hormonal balance and oxytocin production (Buckley 2004, 2009; Uvnas-Moberg 2011)

Respectful, positive attitudes as well as continuity have been found in one qualitative study to make a difference to women's use of pain relief, their confidence and satisfaction with care (Leap et al 2010).

Quote: *'Yes obese women are at higher risk for pregnancy complications but not all obese women incur these risks. Last year I, as a "morbidly obese" woman, had a very healthy pregnancy with no complications and had a natural childbirth. My experience was transformative and gave me a whole new appreciation for my body. I was blessed to have such a supportive medical team with my midwife who never considered me 'high risk' and my doula who had more faith in my body than I had.'* (www.scienceandsensibility.org)

Useful websites

wellroundedmama.blogspot.co.uk

www.scienceandsensibility.org

www.lamazeinternational.org/HealthyBirthPractices

The Nest at Chelsea and Westminster Hospital

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At Chelsea and Westminster Hospital we are currently working on a pilot project to improve the dignity of women in the early stages of labour. This project, known as 'The Nest', is approaching the end of its first year this autumn.

Before The Nest started, women in the latent phase of labour had just 2 options. They were either sent home, or if they did not wish to go home, they were admitted to a busy antenatal ward. On the antenatal ward they would be cared for by a midwife who was also responsible for a number of other women, many of whom had a variety of pregnancy complications. This was far from the ideal of 'one-to-one' care that they would receive on the labour ward. Not only was the care received somewhat lacking, but also the environment was not conducive to establishing labour. These women were in a 5-bedded ward, with the privacy of a curtain only and little resources to help their labour establish. This situation was neither suitable for women or professionals.

The Trust had another project running at the time known as the Directors Den, which encouraged staff with innovative ideas to bid for funding to support their idea. So, a successful proposal was presented to the Directors to secure funds to set up The Nest for a period of 1 year. The concept included a space on the Birth Unit that was comfortable and private; and there would be support from a trained doula 24 hours a day/7 days per week. The doulas are all recognized by doula UK, and are employed on the NHS by the Trust. Chelsea and Westminster is the first Trust in the UK to employ doulas.

Women who are in the latent phase of labour now have the option of spending time in The Nest rather than being sent home or to the ward. Here they are supported by one of our 8 doulas, many of who have additional skills to offer the women such as massage, reflexology and hypnobirthing. While the doula provides care during the latent phase, there is also a midwife on hand should the woman or doula require further input or assistance. For example when the woman requests analgesia or when labour becomes established. Initially the plan was that the doulas would only support women within The Nest. However, it became evident that the women benefited when the doula followed them throughout labour and the birth itself. The doulas prioritise women in The Nest and Birth Unit, but will also support women on the antenatal ward and postnatally. The postnatal support has been an unexpected success in itself with the women having a professional who has adequate time to spend with them helping with breastfeeding and general care.

The Nest has been audited throughout and the results are reassuring. In terms of statistics such as vaginal delivery rates and the use of analgesia, for example, there is little to compare as statistics were not kept accurately prior to the project. They do however appear to indicate that labours are faster, women use less analgesia and are more likely to have a vaginal delivery if they come to the Birth Unit and The Nest. Should women also decide to have an epidural or be transferred to the labour ward, the vaginal birth rate seems to be higher when compared those who go directly to the Labour Ward.

One of the priorities for the Trust is 'patient satisfaction'. From questionnaires that are given to all women in The Nest, it is clear that satisfaction is extremely high with 100% rating the doulas and the Birth Unit as 'good' or 'excellent'. And generally the feedback is very positive with regard to care, privacy and dedicated attention women have received. Not only are the women and their partners happy with their care, but the midwives too are positive about the doulas with their opinions improving throughout the course of the project. In particular, midwives who are newly qualified relish the support they receive and satisfaction levels are high when they then are able to support women to a normal birth.

We are about to embark on the building of a brand new Midwifery Led Unit at the hospital this year. The project has been so successful that the doulas are going to be employed in substantive posts, and there will be more doulas employed throughout the maternity unit. The new MLU will have a 'Nest' area incorporated into it, and there will be some research into the impact of doulas on care in labour in the near future.

Some comments from women who have used The Nest and the doulas:

'It was a five star experience, I could not fault it. I thought our first delivery at C&W was good, but this was excellent.'

'We were so happy that the room and the doula were free. We were concerned that the labour wasn't progressing correctly and were so relieved that C&W offered it as an option to going home. Our overall experience at C&W throughout the pregnancy, labour and post birth has been beyond expectation. We feel that C&W should be known as a centre of excellence, not only in the UK but globally. Thank you so much for getting things right.'

'We had a really positive experience with our doula. It exceeded our expectations of the level of support. It transformed our experience. They provided genuine love, care and compassion. It feels like having a member of your own family looking after you, like your own mother!'

'she [the doula] provided invaluable support which was really welcomed. We thought our care, given the circumstances and needing an emergency caesarean section was outstanding.'

Birth stories: A project to help students understand the lived experiences of parenting with a disability

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A series of small project monies has led to the development of an interactive educational tool to support teaching and learning for students on the Nursing and Midwifery programmes at De Montfort University where we are utilising real birth stories to help students better understand the lived experiences of parenting with a disability in the 21st century in the UK.

A number of parents living with a disability who have recent experiences of using local NHS facilities and other organisations and agencies accessed in their role as parents were interviewed and their stories have now been embedded as fictionalised residents within High Street, a virtual community setting called Montfort. Its key aims are to support and enhance traditional teaching and learning strategies such as lectures with more reflective and interactive activities to encourage independent and autonomous learning using web-based technologies as a collaboration between nursing and midwifery lecturers.

It is appreciated that all parents may have concerns over accessing health care services in the UK but the project lead acknowledges that there may be more complex issues when you have a disability including a hearing or sight loss and is an area under researched (Gregory 2011). All health professionals who may be involved with this wider client group need to be informed of their concerns and try to address these to improve the quality of care offered in order to offer the highest standards of care (Walsh-Gallagher, Sinclair & McConkey 2012). It is hoped that by students hearing real stories of how these parents cope with living with a disability and the additional responsibilities of parenting that this will help them reflect on what their service users rate as good and poor practice.

Key themes have emerged:

- communication
- access to information
- access to buildings

To undertake their roles effectively health professionals must be able to communicate with service users and their families in a variety of health care settings. Students are made aware at the beginning of their studies that NHS services must comply with statutory legislation including the Equality Act 2010. Health professionals can be held personally and professionally accountable for ensuring that they offer a non discriminatory service to all clients so that they receive access to the appropriate information to offer informed choice and therefore gain informed consent to care. There are additional challenges and complex legal and professional dilemmas when health professionals are caring for service users in offering informed choice and gaining informed consent (Lawler 2010).

Discussions around the potential for harm of not communicating effectively with these service users could help students recognise other comparable situations such as when there are

language barriers and when meeting other clients with sensory deprivation or learning differences. Whilst pre-registration students have lectures on disability and equality legislation there is less in the curriculum to actually apply this to practical clinical situations (Gallagher, Sinclair & McConkey (2010) and this tool goes some way to filling this void. It is in line with recent government initiatives where service users are being encouraged to voice their concerns and encouraged to rate their experiences.

There are important public health implications of not addressing the needs of these service users. Evidence shows that things will and do go wrong in the NHS; that patients are sometimes harmed no matter how dedicated and professional the staff but communication is an identified risk factor and if addressed can make care as safe as possible, and that when things do go wrong the right action is taken. Improving communication can help healthcare organisations meet clinical governance, risk management and control assurance targets. Uptake of screening programmes may be affected by poor communication. The Eighth Report of the Confidential Enquiries into Maternal Deaths in the United Kingdom highlights communication between midwives and other members of the multi disciplinary team as integral to improving the health of mothers, babies and children (RCOG 2011) therefore listening to parents explain their needs may help influence healthcare professionals and potentially future managers to influence change.

Whilst health care professionals can empathise with clients to a degree, unless we are ourselves face negotiating stairs in a health centre as a wheelchair user or miss appointments because we cannot access online or telephone booking systems we cannot fully appreciate their perspective. We have encouraged service users with a wide range of disabilities to engage with this process and whilst disappointing to still hear of poor practice it is encouraging to hear also of exemplary practice where one midwife or consultant made a huge difference to these parents.

Birth stories have been published by a number of authors (Donna 2010) and surveys and audit of women's experiences of using maternity services are seen as good practice and have been used to great political effect, yet less is written from the perspective of disabled parents (Moffatt-McKay 2007) despite negative reports (Morris & Wates 2006) and a plethora of legislative and professional directives to change their experiences for the better in recent years (HMSO 2010). It is very difficult to ascertain actual figures but it estimated that out of the 14 million parents in the UK as many as 1.7 million have a disability. These figures could well be an underestimate but it is predicted that the numbers have and will continue to rise (Royal College of Nursing 2007).

Networking with local organisations such as Action Deafness and VISTA and other community organisations led to a collaborative bid to help access research participants. Some part of their story may be used by students whilst on a particular course, as part of the High Street e-learning package. This material cannot be accessed by simply searching the internet. Participants were assured that recordings of their voice were not used in its entirety, but parts were voiced over by another. No identifying information was attached to further protect anonymity.

This project is being funded by and has been given ethical approval from De Montfort University, Leicester. Innovation approaches with this project were the inclusion of a Deaf/BSL researcher who was able to offer participants the opportunity to use their preferred first

language and gain richer data as a result. Minicom systems were used as appropriate. Free mails shots and use of a speaking news line meant we were able to access those with a visual impairment. This has meant we were able to be more inclusive and increase the number of participants as a result honing research skills used in previous projects (Gregory 2011: Williams & Gregory 2012). The research includes participants outside of one locality, and focuses on parents of children under 10 years old thereby adding a more current perspective to work collated by authors before current legislation took effect (Thomas 1997:1998).

Midwives realise that they are only involved in the life of a family for a limited time. It is important for them to see the women in a wider social context, with a history before and after their childbirth experiences, and to fully appreciate the range of services available from the wider multi disciplinary team and third sector organisations. This community based teaching tool is proving an important forum to enhance the reflective skills of pre and post registration midwifery students by hearing of real life birth stories.

Whilst we have begun with birth stories of those whose voices have not always been heard, we are also at a stage where we are able to include other parents who want to share their birth stories. This keeps High Street a dynamic tool reflecting the changes occurring in any street in the UK. The inclusion of a birth centre in the neighbouring village and a long term plan of a new hospital build makes for exciting opportunities for future development once funding is secured.

Dignity in childbirth: Sensitive care for all women

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There is a general acceptance that women are vulnerable during pregnancy and childbirth. Those women who have experienced difficult life events and a lack of parental care as children are perhaps more susceptible to the rigours of labour. Midwives are expected to give both emotional and physical support during labour but there is a great deal that can be done in providing the optimum environments for women to maximise their birthing potential.

For many years Kathryn Gutteridge who founded Sanctum Midwives has been working with vulnerable women particularly those who have been sexually abused, raped or held in a violent relationship. Whilst we have systems in place to screen women for domestic abuse we do not ask about women who have been abused within the context of their growing years. The evidence suggests that as many as 1:4 women have been sexually abused as children and that in most cases it is by a trusted family member or friend. This has implications for the women as she faces motherhood and most certainly when she is in pain during labour.

Many women who have experiences such as these do not necessarily have medical or physical problems and will be assessed as able to give birth in a midwife led setting. It is with this in mind that the Serenity and Halcyon Birth Centres were designed. The focus was placed on managing the environmental features so that women would be enabled to maximise their birthing potential. The impact of walking into a clinical setting for women who have been subjected to harm or emotional deprivation is huge. They may even decline to have any care from health providers for fear of being 'found out'. This impacts upon the woman, the fetus and ultimately the provision of maternity services.

Paying attention to detail in the way a birthing environment looks and feels has been a particular success for our birthing centres. As soon as you step inside the door there is a sense of safety and calm. No bright lights glaring or loud noisy equipment to distract the woman from her purpose. The woman is able to labour in the privacy of her own room, with her family around her and a midwife supporting her throughout. Guidelines and policies are woman and family focussed ensuring that the woman is in control at all times. This makes certain that those women we know who have tragically experienced abuse will not be harmed further but applying a 'universal approach' ensures that those women who have not yet found the courage to disclose will also be safe.

Birth can be healing and empowering – that is what Serenity and Halcyon Birth Centres is designed to do. Offer a safe, calm and professional environment for all women strong or struggling with their emotions to be free from the fear and worry of what will happen to them at this vulnerable time.

Fathers included: The Serenity and Halcyon approach

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Sandwell & West Birmingham Hospitals NHS Trust have 3 years of experience in consulting with and shaping services around women, their partners and families. At the start of the change model it was important to understand the needs of our population and to transform the way maternity care was provided but also the environment that it was offering.

When Kathryn Gutteridge came to the Trust in 2007 a series of consultation events were conducted and one of those events was a Birth Story Lunch. This was held with support and attendance from the communications team who dictated all of the conversations with the families but each couple were interviewed separately and these were filmed. From looking back at those events and listening to the stories of women and their partners it seemed that they felt they were not listened to and their families were not included and respected.

Following on from these consultations a report was completed, recommendations were drawn up, which generally supported a wholesale change in the way we looked at the birth process and who was included in the woman's experience. The project included tackling the attitude and belief of some of the staff who had perhaps lost their way in their role and were not valuing the birth experience as they once did. The project was entitled 'Your Birth in Our Home'. This emphasis was important to see birth in a human context and to reconnect with parents in a celebratory way. Lots of small sessions with staff were held where the experience of birth was discussed and ideas were put forward.

Fathers particularly were one of the groups that were poorly provided for; they described feeling as if they were not welcome, were in the way and not sure what their role was in the birthing process. There were evening sessions held where the views of young fathers were sought and facilitated by Kathryn, a young parent support worker and the project manager for the birth centre development. Fathers particularly felt excluded and treated badly, they had no idea how to interact on behalf of their partner and more often than not were displaying angry outbursts in their communication with staff. Fathers also said that they felt they were denied access to their baby shortly after the birth when their partners were taken from the delivery room to the wards. To remedy this for low risk women the project manager and Kathryn felt that family friendly facilities were vital and improved amenities were planned to meet all the family's needs.

Serenity and Halcyon Birth Centres are built around a family centred model, with fathers/partners present throughout the episode of care. They are shown the kitchen facilities and are expected to provide refreshments for their partner and to rest in the room on our double beds until ready to go home. We believe this works in everyone's interest and fathers are enabled to bond early with their baby.

Workshop on dignity and care in pregnancy and childbirth: Two sides of the story

Dr Jenny Hall & Dr Mary Mitchell, Senior Midwifery Lecturers, UWE, Bristol
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In 2012 a team from the Nursing and Midwifery department at UWE set up a conference day for local practitioners and students on Dignity and Care to highlight dignity issues particularly around elder care. As midwives we indicated that the issues are also relevant to midwifery practice and set up a short workshop as part of the event. The event was repeated on Dignity in Care Day in 2013, the day the Francis report was released.

The participants of the day included practitioners and students from all areas of healthcare and they rotated through all aspects of the event including our workshop. It was key therefore to ensure that the content was relevant to everyone as well as for midwifery.

The aim of this workshop was to present a series of creative triggers to highlight the potential for the loss of dignity, as well as to consider the needs to preserve dignity for both parents and the baby. The triggers included images, sounds, recordings and narratives and comprised negative and positive images in order to stimulate thought. A global perspective was also included with reference to campaigns for international promotion of dignity in childbirth.

The participants were then invited to consider their individual responses to the triggers and to debate the issues in relation to their own practice areas. The discussion was wide-reaching and at the end the participants were enabled to identify key areas for practice improvement in order to develop personal organisational action plans. These were collated and evaluation identified that the workshop had successfully triggered consideration of some relevant issues and it was clear that the participants had been able to apply the content to their own areas of practice.

The success of the workshop we feel lies in the use of creative methods to stimulate emotional as well as cognitive response to the issues. By using real stories participants were able to recognise the importance of their contribution to dignity in health care. We aim to provide this workshop in further arenas including our midwifery programme.

The Positive Birth Movement

Milli Hill, Founder of The Positive Birth Movement
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We are a grass roots movement, spreading positivity about childbirth via a global network of free Positive Birth groups, linked up by social media. We aim to challenge the current epidemic of negativity around childbirth by bringing women together to:

Meet Up, Link Up, and Shake Up Birth

Since our 'birth' in October 2012, Positive Birth groups have spread to all corners of the globe. We now have over 90 groups in the UK, nearly 30 in the USA and Canada, and a further 20 in the rest of the world, including Australia, New Zealand, Turkey, Brazil, France, Germany, Malta and Qatar.

Our core beliefs

The Positive Birth Movement believes that every woman deserves a positive birth.



Positive Birth Means:

- Women are where they want to be
- Choices are informed by reality not fear
- Mothers are empowered and enriched
- Memories are warm and proud

www.positivebirthmovement.org

By positive birth we mean a birth in which a woman feels she has freedom of choice, access to accurate information, and that she is in control, powerful and respected. A birth that she approaches, perhaps with some trepidation, but without fear or dread, and that she then goes on to enjoy, and later remember with warmth and pride.

A positive birth does not have to be 'natural' or 'drug free' – it simply has to be informed from a place of positivity as opposed to fear. The Positive Birth Movement is woman-centred and as such respects a woman's human right to choose where and how she has her baby.

You can birth with positivity in hospital or at home, with or without medical intervention. You can have a positive caesarean, or a positive home water birth. Positive Birth is about approaching birth realistically, having genuine choice, and feeling empowered by your experience.

The Positive Birth Movement believes that communication is the key to shaking up birth. By

coming together, in real life and online, and sharing experiences, feelings, knowledge and wisdom, women can take back childbirth.

What we are and what we do

All of our groups are completely free to attend, and most run at least once a month. They are mostly facilitated by doulas, midwives, and birth workers, and some are led by women who are 'just' passionate about positive birth. They are mainly aimed at pregnant women, but are open to anyone who would like to either gain or share some information and wisdom about birth.

Our groups are not 'antenatal classes' – nobody present is an 'expert' or 'teacher'. They are discussion groups, a place where everyone is equal and where all views and approaches are valid. Each month the Positive Birth Movement sets a discussion topic, which the groups are free to use as a starting point for their meetings. Groups can then feed back thoughts or issues that arise to the main Positive Birth Movement facebook page, which also takes that discussion topic as its monthly theme. Past discussion topics have included:

- Planning a Positive Birth (thoughts, feelings and experiences of 'birth planning')
- What is a Positive Birth?
- Choices in Birth (the many and various choices pregnant women face)
- The Language of Birth (the language we use about birth and why this matters)
- Images of Birth (what images we have seen of birth in our lives and how these have affected our expectations and experiences)
- Place of Birth (how can we have a positive birth in the various locations, what our options are etc)
- The Hour after Birth ... and Beyond (what we can choose to do to make this important time positive, too)
- Oxytocin
- Improving Birth (what needs to change about birth and what can we do about it?)
- Positive Birth Groups aim to be a helpful part of pregnancy; a warm and welcoming place for women to hear stories and ideas, to consider what they really want from their childbirth experience, and to challenge any fears or negative expectations they might have.

We believe that if women are empowered to approach birth differently, birth will be different.

How I got to thinking about Positive Birth...

As a creative arts psychotherapist, trainee doula, writer and blogger about birth, and most importantly, mum – a few things slowly collided for me, and led to the setting up of the Positive Birth Movement in October 2012. Not only do I sometimes feel angry when I hear a 'typical' UK birth story, I also feel that the importance of the experience of birth is often

completely underestimated – for the mother, and of course for the baby too, and the family unit which is just beginning.

In western society, there is evidence of disordered and disrupted attachment everywhere – and I saw a lot of this in my working life before motherhood – in drug and alcohol rehabs, with children in foster care, and with people experiencing all kinds of mental health issues.

In the search to heal this, or even prevent it, we often look to parenting, and to the way that the parents were parented. However, birth itself is often completely ignored.

Experiencing a positive birth is not ‘just’ a ‘feminist issue’, or even ‘just’ a ‘human rights issue’ – it is an issue for all humanity. Birth as a gentle experience, in which all concerned are treated with dignity and respect, maximises the chances of a great start to the mother infant bond, and a confident beginning to parenting. The power of this cannot be underestimated!

Gentler and more positive births could lead to stronger attachments, to better mental health, to better relationships – both personal and societal. To gentler and more positive people – and a gentler and more positive world.

So – looking at the current situation for birthing women in the UK, I felt that change was needed, but felt pretty overwhelmed at the prospect of trying to change ‘the system’. I wondered if, instead of focusing on the system and what was ‘wrong’ with it, we could instead change the way that women entered the system.

In psychotherapy, you learn that you can’t change the way other people behave, and that you can only change yourself. However, if you change yourself, other people are usually forced to change to accommodate the ‘new you’. For example, a bully can’t be a bully without a victim.

So my hope is that by becoming more empowered, informed and knowing their rights, women will enter the system differently, and that the system will be forced to change to accommodate them.

The birth of a Movement...!

At first, I was thinking about these ideas on a small scale. I had the idea of setting up my own birth discussion group, in which people could share ideas and information. Once I had begun to set this up, I wondered – if a birth enthusiast like me is willing to do this once a month for free, maybe others out there would be willing to do the same. Very quickly, I had the idea of a ‘Positive Birth Movement’, the plus sign logo popped into my head, and I set up a facebook page and blogged about it, never anticipating the scale of the response! Perhaps if I had known how big it was going to get, I might have thought more carefully about starting it in the first place!

The response was immediate, and I began to be flooded with emails from people who wished to set up a group. The Facebook page was also popular, and in a year has gained over 3000 ‘likes’.

And with nearly 150 groups worldwide, clearly the idea has caught on!

It seems there are many, many people who are equally passionate about changing childbirth for the better, and who are willing to give up their time for free to do so.

How it is run

Quite 'loosely', would be the short answer to that!

Because it was set up on the spur of the moment without much planning, the Positive Birth Movement has developed quite organically as it has gone along, and has evolved in its own way according to the input of all those involved.

I try to hold some cohesion by running a Facilitators group on Facebook and sending out monthly newsletters to all our groups. Everyone involved is 'linked up' by social media and often Facilitators will support and advise each other independently of me.

There is a lot of trust involved. Our 'logo' and 'brand' is out there in the world, and there is no heavy 'vetting' procedure for anyone who wishes to be involved. To some, this might seem risky, but it actually works wonderfully well. Our organisation is all about empowering women and giving them back their autonomy – and this requires trust and respect.

Everyone involved has a great enthusiasm for improving birth, and together we have created what feels like a very non-judgemental and positive space, which I very much hope is reflected in our groups.

As I have said, all of our groups are free, and Facilitators are careful not to use their real life or virtual groups for self promotion or money making activities. So far, the PBM has raised a small amount of money from holding screenings of Face of Birth, but otherwise, no money has changed hands.

Feedback from our Facilitators

Samantha Waldron – Positive Birth Hillingdon, London

When women come together to explore positively new ideas, stories and information, the room becomes fuelled with oxytocin and power. There truly is a feeling of love and connection between us all and we all go away feeling 'high' on the possibilities that can be achieved.

Guinevere Webster – Positive Birth Oxford, UK

We were really excited to add our existing home birth discussion group to the Positive Birth network. Although we felt it was important to keep the focus on home birth because there is no other local forum for this kind of support, being part of the PBM allows us to make it clearer that we are about positive birth wherever it takes place, and people don't have to be considering a home birth to come along or gain from the group.

Ann Charles – Positive Birth Central London

We started in August 2013. I deliberately wanted a venue that wasn't traditionally 'mothy' and would attract people after work. I plumped for the Fifth View bar at the top of Waterstone's Piccadilly. It does nice food and mocktails, you can bring books up from the

pregnancy section of the bookshop for discussion and is the sort of place people can drop in and out without feeling like they've entered a parallel universe of church halls, squash and biscuits. So far we've only had two meetings. The first one – only one person came. Second meeting – a different pregnant lady came. Both were planning a homebirth. The struggle at the moment is getting people to come.

Melissa Thomas – Positive Birth Derby, UK

I think that the Positive Birth Movement Derby was the right place at the right time. In an area lacking any resources for supporting mums and pregnant women it is a refreshing and new outlook. The group really has gone from strength to strength slowly but surely. I truly believe it could become a great network, challenging the fear and outdated attitudes that still pervade most maternity services and practices.

Our biggest success has been gaining the interest of two academics from the University of Derby. Jenny Hallam and Chris Howard approached myself about developing a collaborative research project, investigating the birth experiences of women who use the Positive Birth Movement meetings. I view the study as being a genuine opportunity to open doors with the NHS, taking women's experiences to the fore and getting policy makers and support services to really listen. Time will tell what the outcome may be but I'm thrilled to have been invited on board as a research assistant and thoroughly look forward to growing and nurturing the PBM Derby.

Mathilde Mazau – Positive Birth Glasgow

I co-facilitate Positive Birth Glasgow which my friend and I launched last November. We started our monthly meetings in January this year and our group has since gone from strength to strength. We have over 150 members of our facebook group including mothers, pregnant women, doulas, midwives, an obstetrician, a shiatsu practitioner, trainee midwives and other birth workers. The 'real life' group is a wonderful and safe space for women to share, listen and learn during this amazing time that is pregnancy and birth. The Positive Birth Movement as a whole is an amazing and much needed grass roots movement and we are very proud to be an active part of it.

Feedback from women who have attended our groups

Michelle Levy, Positive Birth Larchmont, New York:

I was thrilled to find a positive birth group near my home during my second pregnancy. Our hostess, Joyce Havinga in Larchmont, chose focus topics such as Postpartum Care, Addressing Fears, or The Role of Oxytocin. This helped steer the group but free conversation and questions were also welcome. Nothing beats a sense of sisterhood when you need it most. Sometimes we received literature. This group is invaluable because more free services need to be available to new mothers. We were all motivated by the good intention to give and receive support.

Sarah Dauncey, Positive Birth Portsmouth, UK

What I love about the Positive Birth Movement meetings is that they are about mums/parents/families empowering themselves and encouraging each other, the 'professionals' who

support the group provide information but the emphasis is on each family taking the information and making their own decisions to have what makes a positive birth for them, no one tells anyone else what they should want or do.

Susan Last, Positive Birth Derby, UK

I became involved with the Positive Birth Movement primarily because, having had three amazing home water births myself, I wanted to spread the word about what might be possible for others. My birth stories are definitely an antidote to the horror stories so many women hear, even if my choices aren't for everyone! I'm also deeply committed to the sharing of accurate information and know that the research I do can be helpful for others, if only to point them down research paths of their own.

Kristina McGuinness, Positive Birth Glasgow

It's amazing to have positive support and encouragement in an area often shrouded not only by negativity but also mystery. It has been an amazing support for me and helped me realise I'm not crazy for wanting a natural home birth.

Veronica Hunter, Positive Birth Larchmont, New York

I recently had a wonderful home birth (VBAC after twin c-section two years ago) of a lovely 9lb 4oz baby girl at exactly 41 weeks. Had I not attended the birth group I would probably have stayed with the Ob I saw up until 30 weeks who would probably not have permitted VBAC of a 9lb 41 week baby. Not having another c-section was very important to me because I truly believe the c-section I had previously got my twins and I off to a difficult start. The ease of breastfeeding this baby girl and her calm nature (perhaps in part due to her smooth entry into the world) have been wonderful and very different from the twins. So many thanks for making me aware of the choices out there and the beautiful way nature designed the process to work.

Nicola Zoumidou, Positive Birth Glasgow

Fantastically supportive group of amazing women. I came away from the Glasgow meeting feeling empowered.

The Positive Birth Movement – Where Next?

Over the next year I would very much like to strengthen and further promote the Positive Birth Movement, whilst maintaining the integrity and spirit which seems to be so appreciated by all involved.

I have taken some advice on gaining charitable status and hope to look into this further in 2014.

Our main aim for the coming year is to increase awareness of our groups among pregnant women – this is a free resource and although some groups are over-subscribed, there are others which are struggling to fill places. I would love any offers of help to connect pregnant women and the midwives who work with them to our groups.

Funding would certainly help us to raise our profile, too, with good quality printed material and a better website at the top of our wish list.

However, even without financial help, I feel sure that the Positive Birth Movement will continue to grow and spread, simply because there are so many women out there who are so passionate about improving birth that they are willing to run our groups at their own expense. What's more, there seems to be a growing sense among 'mothers-to-be' that the current 'average' birth experience, is not really good enough, and a desire amongst them to explore their options and choices. The Positive Birth Movement meets this need perfectly.

Dignity in Childbirth – Respect, Autonomy, Choice

We very much hope to contribute to dignity in childbirth, by encouraging women to become informed decision makers in their birth experience, by spreading more awareness of birth choices, and by encouraging both self-respect and the demand for respectful treatment from all pregnant and birthing women, and all those who work with them.

Choosing a caesarean: The need to understand, respect and support maternal request

Pauline Hull, co-author of *Choosing Cesarean, A Natural Birth Plan* and editor of electivecesarean.com and cesareandebate.blogspot.com
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I am very grateful that the Dignity in Childbirth Forum is dedicated to improving women's experiences across the whole spectrum of birth choices, and for its focus on promoting respect and providing an inclusive platform to hear the voices of all perspectives and choices.

Why? Because as we near the end of 2013, two years after NICE guidance recommended that maternal request caesareans should be supported following discussion and the offer of further support,[1] and still the criticism, vitriol and refusal to schedule prophylactic surgery continues to exist in NHS hospitals around the country. It remains shamefully apparent that whatever the woman's motivation, and even in cases of genuine tokophobia, caesarean choice is all too often dismissed as: 'Too-Posh-To-Push, Ill-informed, Uneducated, Unnatural, Abnormal, Convenient, Selfish, Vain, Unnecessary, Waste of NHS resources...'

Evidently, dignity, respect and support are inherently absent from language and disparaging accusations like these, but there is also a distinct lack of knowledge and understanding.

One of the problems is that many maternity professionals, including those responsible for training the very midwives with whom pregnant women first come into contact, have either not fully understood the NICE guidance, and believe that caesareans should still only be offered where clinically indicated,[2] or they are under pressure to lower their hospital's caesarean rate, and routinely deny maternal requests,[3] despite many doctors choosing surgery for their own children's births. Even NICE's June 2013 Quality Standard for Caesarean Section,[4] which reinforces maternal request support[5] and emphasises the importance of maternal satisfaction, is yet to make a significant impact on practice. NICE recommends offering a 'promptly arranged [discussion] following a request', 'consultant involvement in decision-making' and 'dedicated' lists that provide 'protected surgical and anaesthetic time and appropriate staffing' for planned caesareans, and these standards need to be met.

Supporting Choice

Undoubtedly, there are resource constraints at every level of maternity care, and women who have chosen a planned vaginal birth certainly do not always receive the one-to-one midwifery care that they request, but there is an important *principle* here, which is that *both* birth choices matter, and *both* need to be equally catered and campaigned for.

There is a line in Virginia Woolf's novel, *Orlando*, that has always struck me as very pertinent in the debate about informed choice, and ultimately, respect for each woman's personal birth preferences: 'As long as she thinks of a man, nobody objects to a woman thinking.' This is because in much of the feminist birth literature that exists, it seems: 'As long as she thinks of a natural birth, nobody objects to a woman thinking.' Maternity organisations need to support

all women and all choices; not just those deemed the most natural or 'normal', and fortunately, Birthrights has recognised that medical interventions such as epidurals and caesareans can be very much wanted by some women, and that their human rights matter too.

Improving Understanding

There is a real impact on the lives of women, and their babies, when this legitimate birth choice is not supported, which is not always recognized or fully understood – partly because postnatal care usually ends after six weeks and local GPs or hospital specialists take over. Physical and psychological birth trauma can be devastating when it happens, and when a woman has been refused a caesarean and forced to give birth vaginally, the impact is even worse. My organization hears from women who have lost their babies or seen their babies injured, women whose own bodies are so severely damaged that they have lost their self-esteem, self-worth, hard-earned careers and previously healthy relationships. Literally, some women say their lives have been *destroyed* as a consequence of having a vaginal birth.

Fortunately, there are some very good midwives and obstetricians who completely understand the need for holistic maternity care[6], and who genuinely support caesarean choice, but there is still some way to go. There needs to be better communication with current and trainee midwives, explaining some of the information, statistics and evidence that led NICE to recommending support for caesarean choice, and obstetricians need to be free to make clinical decisions without the arbitrary pressure of increasing 'normal' births at any cost. We need an urgent and unbiased reconfiguration of maternity services, with recognition that midwifery-led care is not the choice of every woman, and that a trial of labour should not be forced on anyone who understands the risks of prophylactic surgery and accepts them.

It's also worth remembering that women are becoming increasingly self-informed, through books and the internet, and can often lose respect for antenatal staff that refuse to acknowledge or are unable to adequately discuss the evidence presented by other medical professionals. Wider access to information has changed things irrevocably, and our maternity care provision needs to change with it.

Wider Implications

The World Health Organization has admitted that an optimum caesarean rate is unknown;[7] and neither the Department for Health nor NICE have recommended caesarean rate reductions. Furthermore, NICE does not use the terms 'normal' or 'normalising' birth in its literature, and yet heavily criticised national policy recommendations[8] stubbornly persist with strategies that focus on these. Aside from the fact that using overall caesarean rates as a measure or indicator of health outcomes is unreliable,[9] and that perinatal mortality, maternal mortality and birth morbidity are much more relevant,[10] the problem with 'encouraging normal birth' is that a trial of labour is often advised in cases where the risk profile of a woman (who may have no personal preference in terms of delivery mode) indicates that she may be very likely to need instrumental or emergency intervention. In cases like these, the woman deserves to be properly informed of her personal birth risks and benefits, including discussion and offer of induction or planned caesarean, instead of being solely advised in a context of vaginal birth as the primary goal. She has the right to unbiased information.

Counting the Cost

Going forward, the downstream NHS costs of different birth plans need to be gathered and evaluated beyond the intrapartum period in order to provide a true and unbiased comparative analysis. Presently, for example, NHS treatments of numerous birth injuries and trauma, not to mention the colossal litigation bills for obstetrics, have largely been ignored. The 2011 NICE guideline update[1] makes an important start, with a Health Economics discussion in which the inclusion of urinary incontinence (i.e. just one downstream adverse outcome of birth) demonstrates a cost model difference of just £84 between PVD and PCD, and says, *'On balance, this model does not provide strong evidence to refuse a woman's request for CS on cost effectiveness grounds.'* Nevertheless, a traditional and persistent focus on intrapartum costs alone has underestimated the true cost of PVD, and obfuscated the potential cost-savings of maternal request support. Adverse birth outcomes are irrefutably costly, and potentially more so when evidence-based guidance is willfully ignored, which is why the work of Birthrights is so important. In the modern medical world, legal rights will often trump moral or ethical responsibilities, and this is what many women – across the whole spectrum of birth choices – are increasingly relying upon.

Dignity in Autonomy

In practical terms, birth rights and birth autonomy will mean different things for different women, depending on their individual birth plan, but one thing I believe all women share is the desire to be treated with dignity, respect and personal care, and above all, for their babies to be healthy. What I would like to offer here, in this context, are a few quotes taken from Mary Wollstonecraft's eighteenth century book, *A Vindication of the Rights of Woman*, which – although not intended for use in a discussion about birth rights – provide interesting food for thought.

Wollstonecraft, a philosopher and feminist who herself died aged 38 following childbirth complications, writes, *'I do not wish them [women] to have power over men; but over themselves.'* To me, this line relates both to women who wish to experience a vaginal birth, and feel empowered if they achieve it, and also to women who want a caesarean or other intervention, which they may feel offers them more control over their birth experience.

In the same book, Wollstonecraft explains, *'But women are very differently situated with respect to each other – for they are all rivals...They are all running the same race, and would rise above the virtue of morals, if they did not view each other with a suspicious and even envious eye.'* For me, this quote is again, relevant here. Firstly, it echoes the way women (and mothers) can disapprovingly communicate with others who do not share their birth perspective or choice, and secondly, it makes me think of the historically uneasy working relationship that has existed between many maternity doctors and midwives.

Both examples demonstrate a real need for greater dignity and respect for each other as women, and as professionals, if we are ever going to achieve true dignity and respect during pregnancy and childbirth. I believe women need information, holistic care, real choices, and for midwives and doctors to offer these in a respectful and unbiased manner.

No Exceptions

The NICE Clinical Audit Tool for implementing its caesarean guidance[11] states that there should be '*no exceptions*' in the criteria below, and I really hope that following the Birthrights Forum, the efforts needed to meet these evidence-based and women-centred goals will take greater precedence over efforts to chase perceived 'ideal' or 'normal' caesarean rates.

- For women requesting a caesarean section, if after discussion and offer of support (including perinatal mental health support for women with anxiety about childbirth), a vaginal birth is still not an acceptable option, a planned caesarean section should be offered.
- An obstetrician unwilling to perform a caesarean section should refer the woman to an obstetrician who will carry out the procedure.

Caseload scheme for vulnerable women: St Mary's Hospital

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Introduction

The many women and children in the UK who face difficult social circumstances struggle to engage with maternity services and experience significantly high morbidity rates (Commission for Healthcare Audit and Inspection 2006, Cantwell et al 2011). This is likely to be partly due to inequality of access to services and education as well as cultural factors placing less priority on maternity care (DOH, 2012). A King's Fund (2008: pg 2) independent inquiry concluded that, 'the overwhelming majority of births in England are safe; however, some births are less safe than they could and should be'.

The complex social circumstances associated with poor pregnancy outcomes include: homelessness, women experiencing domestic violence, women with mental illness and women with substance abuse problems (Boy & Salihu 2004, King-Hele et al 2009). The most recent CEMACE (2011) review into maternal deaths from 2006 - 2008 found maternal mortality rates are highest amongst women seeking asylum or refugee status and those with mental health and learning difficulties. The review found infants born into these circumstances are around twice as likely to be stillborn or die shortly after birth as those who are not, and further evidence shows an association between vulnerable pregnancy, low birthweight and preterm birth (WHO 2008, Goldenberg et al 2008). The CEMACE (2011) report drew attention to the fact that socially excluded women are at higher risk of death during or after pregnancy than other women and those women with socially complex lives who died were far less likely to seek antenatal care early in pregnancy or to stay in regular contact with maternity services. The report also found that 12% of the women who died had features of domestic abuse. 11 of these women were murdered by their husband or a family member. Overall, 38% of these victims of domestic violence were poor attendees or booked late for antenatal care (CEMACE, 2011), and therefore has less than optimal maternity care.

10% of existing children of mothers who died a direct or indirect death in the CEMACE (2011) enquiry were already in the care of social services, the fact that so many of these children were already living in complex circumstances with vulnerable families, highlights the relationship between social exclusion and poor perinatal outcomes. This collective of evidence supports the statement that although maternal and infant mortality in the UK is at an all time low, the gap between social classes continues to widen with detrimental consequences for women and children.

These inequalities directly affect women's birth rights and dignity in childbirth, and should be addressed by maternity services as they are ideally placed to break this cycle with effective interventions in early pregnancy. Marmot's (2010) review of social determinants of health provides guidance on what is possible and what works, proposing policies that are universal but with attention to individual needs at a local level. The review encourages the development of partnerships — with those affected by social inequities working with their health providers. Central to this approach is empowerment — putting in place effective mechanisms that give those affected a real say in decisions that affect their lives and by recognising their

fundamental human rights. These values are echoed in recent maternity service policies and guidelines, encouraging women-centred, individualised care with a focus on choice (DOH, 2007, NICE, 2010, DOH, 2012).

In 1993 a Parliamentary Report on maternity services (Winterton, 1992) highlighted poverty as the major cause of poor birth outcomes and lack of choice. It recognised that maternity care was over-medicalised, and concluded that 'there is a strong desire among women for the provision of continuity of midwife throughout pregnancy'. The National Service Framework (DOH, 2004) marked a fundamental change in thinking about the provision of NHS services for vulnerable women and sought to improve equity of access to services in order to increase survival rates and life chances of children born to disadvantaged backgrounds. Maternity Matters (DOH, 2007) followed by advising commissioners to seek understanding in what barriers exist in current services that may prevent women from seeking and maintaining contact with services, and to overcome these by providing flexible services to meet vulnerable women's needs. In support of these recommendations an NHS guideline (NICE, 2010) called for a reorganisation of services to improve antenatal care for women facing complex social circumstances with the view to prevent complications and potentially save lives. The guideline identified research gaps in known effects of service provision on maternity outcomes and recommended research to compare specialised services with standard maternity care. More recently, the NHS Mandate (DOH, 2012) addressed inequalities associated with vulnerable women and families, setting objectives for commissioners and providers to ensure that over 90% of women receive their first assessment before 12 weeks of pregnancy; maternity services in London currently fall below the national average in their early booking performance (DOH, 2012).

The caseload model of midwifery care

One hypothesised approach to improving maternity care for vulnerable women is the caseload model, defined as 'a named midwife as the lead professional in the planning, organisation and delivery of care given to a woman from initial booking to the postnatal period' (RCOG 2001, Sandall et al, 2013). Enhanced continuity of care for women is a government priority, with the NHS Mandate (DOH, 2012) promising all women a 'named midwife' to ensure personalised, one to one care throughout pregnancy and the postnatal period. This is currently a far cry from reality — a large, national study reported 81% of women had not met any of the midwives caring for them during labour and birth (Redshaw & Heikkila, 2010). The NHS commissioning support for London (2011) states 'most women with complex needs will benefit from continuity of care as it can significantly improve the experience and outcomes for women and their babies, and women are more likely to trust healthcare professionals'.

A growing body of evidence has associated continuity of carer with improved normal birth rates, less intervention and increased satisfaction (Hatem & Sandall, 2008, Hodnett, 2004), but its impact on birth outcomes for vulnerable women remains unclear. More evidence is needed on what interventions work to reach lower socioeconomic groups (Houweling et al, 2007). In response to these recommendations St Mary's Hospital, Imperial College NHS Trust Caseload Team was set up in 2008 to support vulnerable women throughout their pregnancies and childbirth by providing continuity and individualised care. Their philosophy is:

'St Mary's Caseload Midwives believe that by providing continuity of care to women, particularly those in vulnerable situations, they can improve the experiences and outcomes for women and their families.

Their philosophy is underpinned by the known benefits of continuity of carer in creating trusting relationships, and the importance of informed choice. Women are equal partners on the planning and delivery of their maternity care, affirming empowerment and guaranteeing user involvement and choice in place of birth. A woman's named caseload midwife acts as their lead professional to coordinate care and effective communication between health professionals and external services to ensure a supportive network is in place before discharge from maternity services.

The team is expert in normal pregnancy and childbirth, providing integrated care within each area of maternity, including a reliable and well-established homebirth service. They encourage self-efficacy by providing a range of unbiased information that takes account of women's beliefs and values. This includes a non-judgemental approach to understanding that some choices made by women may not fit into institutional guidelines and protocols. The midwives pride themselves on being in touch with the local community and believe that by working in partnership with women and families throughout their pregnancy they can support their individual needs and social integration.'

Following encouraging audit outcomes of childbirth outcomes for the women who had been 'caseloaded' by the team in 2011, one of the caseload midwives conducted a study which aimed to explore the relationship between the caseload and standard models of midwifery care for vulnerable women by comparing women and infant outcomes.

An investigation of the relationship between the caseload model of midwifery for vulnerable women and childbirth outcomes using routine data – a retrospective, observational study

Abstract

Objectives: To compare the effects of caseload midwifery care, with standard maternity care for socially vulnerable women. Comparisons of pregnancy and birth outcomes, interventions and processes were made between the two models of care.

Design: A retrospective, observational study.

Setting: St Mary's Hospital, Imperial NHS Trust, London, UK.

Participants: Data was collected from 216 women's computerised pregnancy and birth details. 21 sets of birth outcomes were missing due to women moving out of area and giving birth at a different trust. Of the 194 vulnerable women who booked for maternity care and gave birth between June 2011 and May 2013, 96 women received standard care and 98 received caseload care.

Methods: Data was analysed using the computer analysis software SPSS to calculate descriptive and inferential statistics, including standard deviation and tests of correlation to control for confounding factors. Differences in outcomes between standard maternity and

caseload care were compared statistically using odds ratios and P-values of less than 0.05 to indicate statistical significance. Odds ratios were adjusted for potential confounding factors in women's demographics using logistic regression analysis. The relationship between type of care and birth outcome was not changed by the inclusion of confounding factors in the model.

Key Findings

The findings for birth processes showed that women who were caseloaded were more likely to have a spontaneous vaginal delivery (40% vs. 27% OR 0.31 95%CI 0.16-0.69, $P < 0.0001$), fewer caesarean sections (11% vs. 35% OR 4 95%CI 1.41-11.33, $P = 0.006$) and more normal births, although the latter was not statistically significant (62% vs. 38%, $p = 0.423$). Women in the caseload group had a significantly higher intact perineum rate (35% vs. 19% OR 4.90 95%CI 2.15-11.17, $p < 0.001$), were more likely to use water for pain relief in labour (32% vs. 10%, OR 4.10 95%CI 1.95-8.64, $p < 0.001$), less likely to use pharmaceutical analgesia (18% vs. 28%, OR 2.42 95%CI 1.35-4.32, $p = 0.003$), and more likely give birth in the midwife led birth centre (13% vs. 6% OR 0.39 95%CI 0.18-0.84, $p = 0.014$) The only statistically significant neonatal outcome was the number of newborns admitted to the neonatal unit was far less in the caseload group (2% vs. 9% OR 0.05 95%CI 0.01-0.27, $p = 0.002$). Processes data showed women who were caseloaded were more likely to be booked for maternity care by 10 weeks gestation (24% vs. 8% OR 0.30 95%CI 0.13-0.70, $p = 0.004$), had a shorter mean postnatal stay (3 days vs. 1 day SD 1.2 vs. 2.2, $p < 0.001$) and less antenatal admissions (0.9(SD 1.1) vs. 1.3(SD 1.5), $p = 0.036$). Women in the caseload group also had a higher mean number of antenatal appointments, and were much more likely to know the midwife caring for them at time of birth (90% vs. 8% OR 0.01 95%CI 0.00-0.27, $p < 0.001$). More women in the caseload group were referred to psychiatry services (26% vs. 8% OR 0.81 95%CI 0.10-0.35, $p < 0.001$), domestic violence advocacy (19% vs. 8% OR 0.31 CI 0.15-0.57, $p < 0.001$) and other support services (51% vs. 28% OR 0.36 95%CI 0.21-0.64, $p < 0.001$).

Conclusions and implications for practice

Overall the caseload model of midwifery care appeared to convey benefit and no harmful outcomes were found. Women who received caseload care achieved higher levels of 'known carer at delivery', increased spontaneous vaginal delivery and intact perineum, and experienced less caesarean section, pharmaceutical analgesia, antenatal admission, NNU admission, and shorter length of postnatal stay. It was not however associated with a significant increase in normal birth. Findings differed from previous literature depending on each outcome, suggesting the model of care may affect different populations of women in different ways depending on their individual needs. Although no harm was identified in the findings, it should be acknowledged that vulnerable women receiving standard maternity care at the Imperial College NHS Trust experienced more adverse outcomes than those receiving caseload care. The trust should therefore be encouraged to offer caseload care to the vulnerable women who are living out of area.

Although the generalisability of these findings is restricted by the non-randomized design and potential confounding, they are encouraging and highlight the need for other maternity units to set up and evaluate services for vulnerable women with a focus on continuity. Future research could investigate the longer-term follow up of women and their families within a full-scale trial, and an insight into vulnerable women's views. The long term impact of these policy and research recommendations has the potential to transform maternity services for

vulnerable women by ensuring equal access and equity in birth rights, improved outcomes for women and infants in subsequent pregnancies and health, an enhanced sense of dignity and respect in childbirth, and better social cohesion and communication with health services.

Birth Companions: Supporting vulnerable women

Annabel Kennedy, Director, Birth Companions

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Birth Companions supports vulnerable pregnant women and new mothers in HMP Holloway and those in the community who have experienced detention or who are at risk of it. Our services are delivered by a small staff team and a larger group of dedicated and skilled volunteers.

Our Activities

In HMP Holloway

Antenatal support: We support women in prison through pregnancy with weekly groups and additional one-to-one support. All pregnant women can attend whether they are birthing while in prison or the community, or are going to keep their baby or not. We ensure they all have the information and support they need to make choices about their pregnancy and birth, and help them to write a birth plan documenting those wishes. It is also an opportunity for women to discuss their pregnancies and how they are feeling. Women tell us that their time with us is the only time they feel like a pregnant woman rather than a prisoner.

Birth Support: We provide birth support to those who would otherwise give birth alone apart from medical staff and/or prison officers. We are able to help a woman through her labour, offering emotional support and companionship and being her advocate if needed. Many women who have experienced sexual abuse find birth especially traumatic and our well trained volunteers help them to feel safe and supported. We are also able to provide a card and small gift for the baby, often the only one they get. We continue to provide postnatal support during their stay in hospital, often providing support with breastfeeding and/or helping a woman prepare for the separation from her baby if she does not have a place on the Mother and Baby Unit (MBU).

Postnatal support: We run weekly Early Parenting groups on the MBU in Holloway prison. The unit can accommodate a maximum of 12 women and their babies who can stay up to the age of 9 months. The group covers a wide range of topics including breastfeeding, weaning, sleeping and crying as well as baby massage. We also provide one-to-one support, especially with breastfeeding. There is a very high rate of initiation of breastfeeding on the MBU compared to similar socioeconomic groups in the community. This has health benefits for both mother and baby. We also support women who have been separated from their babies in hospital when they return to prison. We can also help women who have been separated from their babies to express milk which can then be given to the baby. This has health benefits, and is very empowering for the mother that she is able to do this for her baby despite the separation. Mothers separated from their babies are a particularly isolated group and there is no prison service guidance as to what services should be provided to meet their needs.

In the community

Our service targets the most vulnerable pregnant women and new mothers in the community who have experienced detention or who are at risk of it, who are isolated and have no one else to turn to. We provide emotional and practical support through their pregnancies, birth and early parenthood on a one-to-one basis. This can be in conjunction with family members if this is appropriate. Our post-release support for those who have left Holloway provides continuity and on-going support through what can be a challenging and isolating time, even for those going back to supportive families. In order to ensure they are engaged with services that can support them in the longer term we assist women to link in with the services available in their local communities. This may just be finding them relevant information, but often involves attending services with them initially so as to increase their confidence and ability to engage. By supporting women to attend parenting groups we help them to meet other mothers, and create new networks with local families. This is particularly important for the refugee and asylum seeking women we work with who have suffered violence and abuse, as they are often completely alone with no family around them.

Policy and Practice

In addition to the direct services we provide, we also work to influence policy and practice so as to improve the experience of pregnancy and motherhood throughout the female prison estate. We have worked with the NOMS training team to ensure all officers receiving MBU training will receive information, which we have provided, regarding the specific needs of pregnant women and separated mothers.

We are also planning to examine the new health and commissioning structures to assess if there is potential for influencing maternal health provision for vulnerable women both in prison and the community.

The need for our work

The needs of pregnant women and new mothers in prison reflect the multiple and complex needs of female offenders. Women prisoners tend to come from disadvantaged backgrounds and are therefore particularly vulnerable during their pregnancies due to the effects of poor health, poverty and lack of support from family and friends. Many women in Holloway are dependent on drugs or alcohol and a significant number have mental health problems. Many also have histories of abuse and violence.

A University of Oxford report on the health of 500 women prisoners, showed women in custody are five times more likely to have a mental health concern than women in the general population. The study also found that women entering prison had very poor physical, psychological and social health, worse than that of women in social class V, the group within the general population who have the poorest health (E. Plugge, N. Douglas and R. Fitzpatrick (2006) *The Health of Women in Prison*(Department of Public Health: University of Oxford)).

In many instances the women we support in the community face the same disadvantages. Many of the women have been in prison on short sentences and so continue to live chaotic lives in the community when not in detention. We receive referrals from a range of difference organisations, all of whom specialise in supporting vulnerable women. For example some work with women who have experienced domestic violence, prostitution, homelessness and uncertain immigration status. Facing all of these issues increases their vulnerability to

offending behaviour and thus contact with the criminal justice system and ultimately detention. Others work with women who have fled domestic or political violence or have been trafficked so are very isolated, often with no family support. They have faced extreme trauma in their past, along with detention, either formally through a prison sentence, or informally through trafficking. They often struggle to access the support they require through pregnancy and birth, so our services help them through what could otherwise be a very difficult time. The Community Link project also supports pregnant women and new mums on their release from prison. For many, they may be more isolated and face an increased risk of destitution than when they were in prison. We are able to provide support through this difficult transition period and are able to help them establish links with agencies who can provide long term support.

Aims and Outcomes

Birth Companions' overall aim is to improve the well-being of pregnant women and new mothers who are, have been or are at risk of being detained. We achieve a range of outcomes but the key ones are:

- **Improved mental health and well-being:** women report being more able to cope emotionally with their situation, feeling better supported and cared for, and feel more able to maintain dignity and self-respect.
- **Reduced isolation:** we achieve this through enabling women to support each other, keep in touch with their family, and to access other services.
- **Enabling women to give their babies the best possible start in life:** we help women to make informed choices during pregnancy, birth and motherhood, and feel more able to breastfeed, and improve their parenting skills.

Kat's Story

In order to bring to life the work that we do, here is Kat's story:

'The support Birth Companions gave me to this day is overwhelming. When I arrived in Holloway I was the lowest anyone can be, my biggest fear being my failure as a mother. I'd left two small children and although they were being looked after by my family, I couldn't help but feel heartbroken. The surroundings and environment wasn't my worry it was the fact that I was 23, pregnant with my third child, and facing a lengthy prison sentence. Every day I woke up telling myself I'd failed and when I was moved up to the pregnancy landing, I just wanted to shut myself off, keep out of the way and sleep the days away. Whilst seeing the midwife she mentioned there was a pregnancy group run by the Birth Companions and at first I wasn't keen but talking to one of the officers she assured me that it would at least break up the day. When I arrived at the group I felt so welcome, reassured and even more importantly, accepted. I was encouraged to speak, never asked about why I was in prison and felt comfortable enough to open up about my hopes, fears and expectations as a mother to be. For two hours it felt like we were a normal group of mums and I can honestly say you forget where you are. I felt camaraderie with the group and to this day, I've been home nearly a year, I still keep in touch with the girls. When I gave birth to my son the support I had from Birth Companions was amazing. They really were

my voice when I was in the hospital when it came to the officers and nurses. I even felt confident enough to breast feed which I had never done and also expressing my milk. It is the best thing I have ever done!

I feel the support you get from Birth Companions is essential. It's not just the practical support you get but the emotional warmth, sincerity and empathy. They are amazing and I owe so much to them. They really encouraged me and brought out my confidence as a mother. I am now strong positive and determined to be the best mum I can be. I wasn't a failure, I made a stupid choice which I have paid for. I have a beautiful home, three beautiful children and am living life with no regrets just lessons learned. Thank you so much Birth Companions.'

From oppression and control to self-regard and emancipation: One woman's journey of birthplace decision-making

Carol Lambert & Julie Jomeen, Faculty of Health and Social Care, University of Hull · Wilf McSherry, School of Nursing and Midwifery, Staffordshire University

Findings from an Interpretive Phenomenological study grounded in a feminist perspective to promote women's voices, revealed how women may be socially influenced and pressured to conform to authority in birth place choices.

Using semi-structured interviews, 25 antenatal and postnatal women were asked about their experiences, perceptions and choices in the context of their maternity care. The study explored how emancipation and conformity are linked to consider whether emancipation reduces pressure to conform and what the implications of this might mean in a wider sociological context of birth experience. Based on Interpretive Phenomenological Analysis a unique seven stage iterative framework of analysis revealed self and aspects of self emerged as the most significant theme for decision-making.

Emancipation is broken down into antecedents, attributes and consequences, oppression being an antecedent to emancipation and empowerment being a consequence of emancipation (Wittman-Price 2004). Oppression identifies with the terms coercion, repression and domination and the potential for individuals to be dominated, coerced or influenced by authoritarianism (Hollis Martin and Bull 2006) or by gate-keeping decisions about care (Levy 1999).

At this Forum, we provide a snapshot of the lived experiences of Louisa, a multigravida woman booking to a birth centre in the north of England to have her second baby. Louisa had a Factor V Leiden-APC Resistance. Her story, demonstrates how previous experiences of oppression in the context of her life and in her maternity care illuminates a perspective of decision-making from oppression where she was previously coerced in choice and decision-making. This had profound implications upon her self-identity and her transition to motherhood. In her second pregnancy, she was going to do things differently. She made decisions based on what was best for her.

In Louisa's previous pregnancy and birth, she felt controlled and oppressed. As a result of her first experience, the difficulties in bonding with her baby were profound. This was an oppressive situation. She had experienced negative practitioners and never felt she had healed. She felt alone and unsupported.

Her negative experiences were so profound that she would not go back to the hospital to give birth. This was a situation she felt forced into and she felt needed to take matters into her own hands. She voiced this to the consultant, not in a 'holding to ransom' manner, but she explained that the fear of going back to the hospital was more of a risk to her and her baby than being at home with no professional in attendance during the birth - she would free birth.

This time she alleged no one would have control of her or her baby. She gave a moving account of self-realisation; she recognised she needed to bond with her baby and wanting to drink him in and have a bit of him back. She felt injured emotionally by her experiences the first time. Her self-realisation was like an emancipatory enlightenment for her. This gave her the conviction to voice how it would be done next time.

The difference in her second pregnancy was that she felt supported at last by the professionals. She was open about her feelings and fears, she finally had support and she began to heal herself late in the subsequent pregnancy with self-realisation and understanding of her experience, but this only occurred as a result of the experience of oppression.

Free HypnoBirthing Service at Ayrshire Maternity Unit

Donna Last, Midwife and HypnoBirthing practitioner affiliated to The HypnoBirthing Institute

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I work as a midwife at Ayrshire Maternity Unit (AMU) a relatively new purpose built unit which covers a large and diverse geographical area with an annual birth rate of approximately 3,800. Our unit offers aromatherapy, waterbirth and a soon to be initiated reflexology service. Since 2009 we have provided a HypnoBirthing service.

We were, and may still be, the only unit in the UK to offer a full HypnoBirthing service free of charge. To access the course via a private practitioner can cost between £200 and £700 depending on location. We wanted all women in our area to have the knowledge and tools HypnoBirthing provides by setting up a service in our unit. Realistically this could not be offered to all women so we devised a referral criteria whereby those who we perceived would benefit most could be referred via their community midwife, consultant midwife or obstetrician. The criteria, although not exhaustive includes: women with a fear of birth; women with previous birth trauma (actual or perceived); needle phobia; contra-indication to opiate/epidural.

I first came across HypnoBirthing in 2005, when a couple I was with in labour told me that they were using Hypno Birthing techniques. 'Hypno what...?' was my response...followed by 'what do you need me to do?' The answer to my second question was ...'do nothing, except the observations you have to do...' So I sat back and watched a woman work in total concentration and harmony with her body. Her partner attended to her physical comforts, reminding her gently to eat/drink/go to the loo or simply offer words of praise and encouragement. I had tears in my eyes as he told her how beautiful and powerful she was.

Midwives often witness women go within themselves during labour, but I was excited and amazed to learn that this course was available to allow woman to prepare in both mind and body and I wanted to know more.

So, eventually in 2008 along with my friend and colleague, Alison Fyfe, I undertook HypnoBirthing Practitioner training.

The HypnoBirthing philosophy is that, when you have a healthy mum and a healthy baby, birth is a natural physiological process, best left undisturbed, very much akin to our own practice as labour ward midwives. We were excited and enthused by what the course could offer women by way of increasing their belief in their own ability to birth their baby, and also at the strong role it gives to birthing partners along with the emphasis of the trilogy of mum, baby and partner.

With the guidance of our consultant midwife, Geraldine Butcher, we presented a business plan to the HOM, which was approved and we commenced the service in July 2009. Obviously not all of our women have the vaginal birth they hoped for. However the feedback from those who experience a surgical or instrumental birth is still very positive in that they feel in control,

fully informed and involved in the decision making and that HypnoBirthing prepares them for any course their birth may take.

Through audit and parents birth stories we are able to say the service is a success. In fact Alison and I were delighted to be the recipients of the RCM award for Promoting Normality in Birth in 2012!

We now have another 2 midwives trained as HypnoBirthing Practitioners, although not extending the service, as yet, it has reduced the workload on myself and Alison. Alison and I also go into the University of West of Scotland and talk to student midwives about HypnoBirthing and its application.

The most satisfying aspect for me is seeing women full of fear, not enjoying their pregnancy and dreading labour, transform, through their own actions, into feeling empowered, excited and looking forward to labour and the birth of their baby.

Dignity in Childbirth: Where does our allegiance lie? To women within our care and their wishes, or to maternity guidelines determined by the trust which employs us?

Sue Learner, Independent Midwife
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Is our allegiance as midwives, supervisors of midwives, obstetricians and neonatologists, to guidelines and our employers or to women wishing to give birth well, bond with their babies and breast feed?

If each of us answers this question honestly we will know if we can or can't offer women Dignity in childbirth or indeed if we even want to. As a midwife I can only speak for midwives but the same question can be asked by other maternity service professionals.

Within three days of being asked to prepare this submission I spoke to eight women who gave birth with me which involved 14 labours and births. Eleven of these were planned home births, nine of which took place at home, one was a LSCS (the woman's third) while the other was a vaginal hospital birth. The remaining three hospital booked births were straightforward vaginal births. I asked each woman, with no prior explanation, 'What does dignity in childbirth mean to you in five words'? I list the complete responses below in the order in which I received them and using each woman's words only:

Privacy; a sense of control; trusting professionals; time; familiarity of environment; privacy; respect; doesn't feel shameful; truthful; being who you are; autonomy; humour; respect; trust; understanding; trust; respect; tenderness; compassion; communication; space; respect; being listened to; time; choice; no anxiety; warmth; security; happiness; privacy; calm; people that know what they are doing; efficiency/flowing; relaxing; continuity; no interference; being left alone after the birth with your baby; having the people you want around; your midwife not telling you when you shit.

Firstly, if our allegiance is to the guidelines and our employer then, as midwives, what is required of us? I would suggest the following:

- distancing ourselves from women's informed choices in order to keep our eye on the guideline
- putting a block on our own experience and intuition to allow the guidelines to take precedence
- avoiding investigating for ourselves the current research around the specific issue we are dealing with, in relation to a certain mother, as the guidelines have become our bible
- allowing ourselves as midwives to be gently bullied into toeing the guideline line by our colleagues or Supervisor of Midwives and not questioning robustly the relevance of a certain guideline in a certain instance for a certain woman.

As a result of these actions a very common comment from a midwife to a woman is: 'I am obliged to recommend that you follow our guidelines but I understand what you want, and in a sense feel the same myself...but it's your choice and I would have to talk to my Supervisor if you insist on planning something differently and she may want to come and see you'. Walsh (2008) suggests that some women see midwives as institutionalised, with their primary allegiance being to their employer, providing informed consent rather than informed choice. From experience I would go further and suggest that such comments from midwives lead to coercion rather than informed choice or consent.

Secondly, if our allegiance is to women's desire to give birth well, bond with their babies and breast feed, what is required of us? I would suggest the following:

- being well informed on current maternity research and practice and reflecting on anecdotal evidence and experience
- giving responsible and truthful information to women based on this research and evidence and bearing in mind guidelines
- standing by women in their decisions and being able to say 'I am there for you' without qualifying the support in any way
- courage is of essence as the bullying culture towards some midwives who offer this support to women is rife in many obstetric units throughout the UK
- being constantly aware of those universal words women have used in relation to dignity in childbirth: a sense of control, time, being who you are, autonomy, warmth, security, happiness, respect, truthful, understanding, being listened to, tenderness, compassion, choice, continuity, no interference, being left alone after the birth with your baby, privacy, familiarity of environment, space, calm, relaxing, having people you want around.

In conclusion, we all as individual professionals in the maternity services need to look at our allegiances and see if they are compatible with what dignity in childbirth means to women.

How do women with an intellectual disability experience the support of a doula during their pregnancy, childbirth and after the birth of their child?

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Abstract

Background: With increasing numbers of people with an intellectual disability (ID) choosing to become parents, the right support is imperative for a dignified and positive birth experience and subsequent effective parenting. The aim of this study was to gain insight into the experiences of parents who received support from doulas during pregnancy, birth and following the birth of their child.

Materials and Methods: Four women with an ID who received doula support were interviewed before and after the birth of their child. Three doulas were interviewed after the birth about their experiences of supporting women with an ID.

Results: Interview transcripts were analysed using Interpretive Phenomenological Analysis (IPA). Themes were identified from each interview, before an overall analysis of themes from each support phase was undertaken.

Conclusions: Prenatally, the doula was considered helpful and a reliable source of information about pregnancy. Each mother perceived doula support as a means of experiencing a positive birth experience as well as keeping her child in her care. Postnatally, mothers described a trusting relationship with their doula, who enabled them to make informed choices before, during and after the birth.

Introduction

Early intervention during pregnancy including information about pregnancy, birth and childcare in an accessible format and opportunities to learn and practice new skills has been found to have positive consequences for parenting ability in families where one parent has an ID (Llewellyn et al., 2008; Tarleton et al., 2006).

Porter et al. (2012) designed a Pregnancy Support Pack (PSP) for women with an ID as an accessible resource to enable them to make informed choices about pregnancy. They found that PSP was effective in supporting women with an ID during pregnancy, allowing them to make informed decisions about their pregnancy.

In the general population, continuous psycho-social support during labour has been associated with positive benefits such as a shorter labour and less need for medical intervention and caesarean sections.

Doulas are practitioners who can provide such support for parents. A doula is a woman who provides consistent support to another woman and her partner prenatally and postnatally, and is present during the birth. Although the role of a doula varies with every pregnancy as the needs of every woman are different, the key components of doula support fall into four categories 1/ emotional support through the Doula's presence, reassurance and praise; 2/ advice and information provision, ensuring the woman understands and is prepared for each stage of labour; 3/ tangible assistance, supporting a family by helping around the house and empowering parents by offering encouragement and suggestions; 4/ advocacy for the woman, encouraging others to respect her decisions and ensuring the woman's voice is central during her labour.

As an independent practitioner a doula agrees a contract with the mother/ parents regarding the type of support that will be provided. She is on call around the due date so that she can attend the birth.

Kennell et al. (1991) investigated the effect of doula support on labour through a randomised controlled trial. Six hundred women were randomly assigned to one of three groups: a group that received doula support, an observed group where the woman was monitored but not supported, or a control group that did not receive any additional support/observers. The results of this trial indicate that continuous doula support significantly reduces the rate of caesarean deliveries (doula group 8%, observer group 13% and control group 18%). In addition, labour was found to be shorter in the doula group (doula group mean 7 hours, observer group mean 8 hours and control group mean 9 hours).

The benefits of such support may be especially relevant for women with an ID who, due to insufficient or inappropriate services and social isolation, often face the challenges of pregnancy and birth without suitable support except standard medical care. doula support may address their physical, social and emotional needs and improve outcomes for the mother with ID, her child(ren) and the wider family.

In order to pilot this as yet untried approach, a small locally funded project CanDo was launched in Telford and Wrekin to provide pregnant women with ID with the services of a doula who had received specialist training in working with adults with ID.

Method

Procedure

To participate in the study participants had to have an ID, to be pregnant at the time of the study and to have been offered doula support. No formal assessments of ID were carried out but all participants were receiving local ID services, known to have stringent eligibility criteria.

Participants were provided with accessible information about CanDo and the research, and it was explained that they would be interviewed twice, once before and once after the birth. Those who did not want to participate were still able to access CanDo services.

Doulas were recruited through word of mouth and a website (www.doula.org.uk). They had all experienced childbirth themselves and had completed a recognised doula training programme

and in addition attended a training day on working with parents with ID. They also received regular supervision from one of two experienced ID practitioners and attended monthly peer support meetings.

Mothers and doulas were matched to take account of geographical location and personal preferences. Each doula arranged a preliminary visit with the mother during which they introduced themselves and discussed support requirements.

Participants

Four women were asked if they would participate in the research. One woman had her baby earlier than anticipated and was only able to provide a post birth interview. One woman consented to both interviews but disengaged from services following the birth of her child. Two women provided both pre and post birth interviews.

Names have been changed to protect confidentiality. Ages and other identifying features are not specified or have been omitted for the same reason.

Support was provided by three doulas who had received specialist training to work with women with an ID.

Data analysis

The qualitative methodology employed in the current study was Interpretive Phenomenological Analysis, IPA, as described by Smith, Flowers and Larkin (2009).

Results

The themes that were identified from the interviews with the mothers, pre and post birth can be seen in the following Table:

Theme Identified	Title of Theme
Pre-birth	1. Not knowing
	2. doulas can meet our needs
	3. Support with hopes and dreams
	4. Preparing for and coping with pregnancy changes
Post-birth	1. Support received during labour
	2. A trusting relationship
	3. Learning and making informed choices

Interview 1: Pre Birth

Theme 1 Not knowing

All of the women spoke about experiences of not knowing. This related to not knowing what a doula was or how she could help, and to the physical changes that occur in pregnancy.

For Charlotte and Leah this was their first experience of being pregnant. Leah in particular spoke about not knowing about labour as she had not experienced it before:

'Yeah cos when it's your first you don't know what's gonna happen in labour do you. You get worried and that's why she's [doula] going to send me a birth plan and send me leaflets'. (line: 22)

For each mother this was the first time they had doula support. None of the mothers or partners knew what a doula was or how she could support them. For Charlotte the first meeting with the doula had been awaited with anxious anticipation:

'I thought she would come and tell me how to live my life, I felt nervous, and "oh no not another one". It was scary meeting her for the first time'. (line: 92)

Theme 2 Doulas can meet our needs

Sally spoke of how she did not know what a doula was, but signed herself up for support without hesitation. She spoke about wanting all the support she could get as she wanted to keep her child:

'People with disabilities means a lot of support especially support with social services because they think oh because a girl's got moderate learning problems they think can't look after a baby you know'. (line: 19)

Leah was also of the opinion that doula support was particularly suitable for women with ID:

'I didn't know much about it actually, but they, a doula's for people who ain't got ID but they have got, now they do people with ID. I think it's good because if people who've got learning disabilities and don't understand labour and they're scared to ask questions to a midwife, I think it's really good'. (line: 70)

Other mothers spoke about how important it was that the doula supported them in a way that was meaningful to them. Katie requested the doula provide basic childcare information:

'Basically talking to us about what routine the baby's going to be in, what time, what needs to be done, like how to change a nappy or do the bottles or sterilising and what the baby's going to be like'. (line: 126)

It was important for the mothers that doula support helped them to understand their pregnancy and enabled them to find out more, without fear of being perceived as ignorant.

Theme 3 Support with hopes and dreams

Each mother identified what their hopes and dreams were. 'To be a good parent' was identified by Leah, which she felt was achievable with the support from her doula. Charlotte, Sally and Katie were facing child protection proceedings and their goal was that their child remain in their care. For example, Sally stated:

'You know we're a family unit and I well, it'll be a dream come true if the baby, you know, can get to stay with us'. (line: 131)

Doula support was identified by mothers as a way of helping keep their children. Katie described how her doula had provided support tailored to her needs and those of her partner:

‘It was a bit of talk as well as an awful lot of practical, but that’s how we find things a lot better, practical with easy read and writing and help with mumble jumble [jargon]’. (line: 139)

Charlotte spoke about how her doula showed her how to do tasks, emphasising the importance of teaching skills through modelling:

‘She showed me how to hold my baby, how to hold her in a sling and then I could do stuff like housework whilst holding her, holding her close to my heart.’ (line: 62)

Theme 4 Preparing and coping with pregnancy changes

The mothers identified doula support as beneficial for coping with changes during pregnancy and knowing what changes were likely to happen. These included changes in hormones, ‘getting bigger’, and feeling tired.

Sally spoke about her body changing as pregnancy progressed and as this happened she decided to try breastfeeding with doula support:

‘I said that I’m going to be breast feeding so she [doula] says she’ll take me and P up there [local health centre] to have a look at breastfeeding’. (line: 68)

Leah spoke about the advice she had been given to ensure that she could remember all the queries she had:

‘Yeah you can put them down on a piece of paper and ask when your Doula’s there’. (line: 78)

Sally had noticed ‘her hormones changing’ and she explained that this affected her memory and how doula support was beneficial in helping her to remember and develop skills:

‘Is good to have support now with changing hormones, helps me remember new things’. (line: 209)

In summary, in the pre-birth period and in the context of having to cope with a host of new and challenging experiences, these women, aware of their cognitive deficits, experienced the doula as a reliable and safe source of information about pregnancy, birth and the neonatal period. Further, they perceived doula support as a means to achieving the goal which was shared by all four mothers, namely not to have their child removed from their care.

Interview 2: Post Birth

Theme 1 Support received during labour

Katie described a long and difficult labour:

‘I was very discomfort’. (line: 32)

Due to the length of labour two doulas provided constant support for her throughout the five days she was in labour:

'They were always there, always one of them there and they were fantastic, all through the week supporting us'. (line: 50)

The doulas' presence during labour, having someone there to help understand what is happening and who can explain medical terminology, was experienced as reassuring and supportive.

Leah spoke of the value of doula support to prepare her for labour. She was able to identify the start of labour as her doula had explained what the signs were:

'I was in labour, had a show and I was sick then I was on contractions on bed, and then and then started'. (line: 17)

Leah described having to have a caesarean and how her doula had supported her through this:

'They keep me calm, talked me through it, when I went into the room [theatre] doula was there cos mum don't like injections and she [doula] was there calming and told me everything'. (line: 41)

Theme 2 A trusting relationship

None of the four mothers knew what a doula was initially. However, every mother described how she subsequently developed a close relationship with her doula. Charlotte spoke of feeling anxious and unsure of the Doula's role.

Leah expressed the importance of the relationship:

'[The best part of doula support is] me and doula actually, we've made a good bond'. (line: 87)

Theme 3 Learning and making informed choices

Each mother spoke about what they had learnt from their doula. Charlotte spoke about learning enough to enable her to make informed choices throughout pregnancy:

'She talked about labour with me, a normal birth and a caesarean. When she told me about a caesarean I said no way, I wanted a normal birth'. (line: 80)

Katie and partner described the support they received:

'And she asked for the easy reading books and she was showing us all pictures, what's going to happen next and everything. And it's like teaching us words'. (line: 78)

In summary, during the post birth period, the mothers described a trusting relationship with their doula. They experienced doula support as a calming and a reliable source of support during labour and throughout the post birth period. The individualised support allowed women to make informed choices during the birthing process and feeling more knowledgeable about what to expect.

Discussion

Most support for pregnant women with ID tends to be crisis driven and is provided by mainstream services whose workers may not be experienced in ID. In contrast, the support

provided to mothers by CanDo was individually tailored to parents, taking their learning needs into account. The mothers were aware of this and spoke appreciatively about the accessibility of the doula support, including being given 'easy read' versions of information and having complex issues explained without jargon. They felt well prepared for the birth and appreciated the calming presence of the doula during the birthing process, where the doula acted as an informed advocate for the mother and facilitated good communication between the mother and the health professionals.

Tucker & Johnson (1989) highlighted the concept of competence promoting support that enhances a mother's sense of self-efficacy. The parents' accounts in this study indicate that the doulas were successful in providing such support.

The women also spoke about the trusting relationship they developed with their doula. Women with an ID tend to be socially isolated and have poor support networks (Stenfert Kroese et al., 2002) which has been found to predict mental health problems and inadequate parenting (Sterling, 1998; O'Keefe & O'Hara, 2008; McConnell et al., 2009). The accounts of the parents in the current study suggest that the practical and social support provided by the doulas positively influences the experiences of pregnancy and parenting and thus parenting capacity.

Conclusions

The findings of this qualitative research indicate that mothers with ID experience doula support as positive, helpful and informative. Their descriptions of CanDo services indicate it was perceived as competence enhancing and parents reported to feel supported during the birth and in learning new skills and routines and in making decisions for themselves and their babies. They had developed trusting relationships with their doulas and did not feel patronised. These initial results suggest that the doula model of support during pregnancy, birth and the post-natal period can be beneficial for mothers with ID.

The Dignity Advocate

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The Dignity Advocate is a concept derived from a clear need to address concerns regarding dignity within the maternity settings. There is research which examines the issues around dignity, however, much of this focuses on the elderly in the hospital and community settings. There are limited qualitative studies in the UK maternity system and more work needs to be done. This gap in the research coupled with my own observation within the clinical settings prompted me to look deeper into the subject of dignity and examine more specifically at its significance within the maternity services. I have been greatly inspired by the dignity tools and charity networks currently within the social and healthcare systems that aim to promote and preserve an individual's dignity, particularly the Department of Health's campaign to employ dignity champions to promote and support an individual's dignity within health and social care.

Looking more specifically at the maternity services the following is a short demonstration of key areas identified in the research and literature that have inspired the role of the Dignity Advocate.

Firstly the woman herself has great influence in preserving her own dignity. Maintaining a sense of self includes having control of the private sphere and setting appropriate boundaries. Retaining ownership of pregnancy, childbirth and postnatal care are also a means of maintaining dignity (Widang et al, 2008). However, there are women who are less able to assert the preservation of their dignity and may require further support (RCOG 2011).

The Dignity Advocate works within a team to produce illustrated materials promoting the value of dignity within the trust (i.e posters and leaflets). The aim is to provide advice and resources to women and their families. These materials should be made available to women throughout the antenatal period and visually accessible within the relevant clinical settings. Information should include the trust's philosophy with regard to dignity, how to recognise a dignity advocate (discreet symbolic badges worn by the advocates) and contact details of how to access the trusts complaints system should this be necessary.

Dignity Advocates are approachable to women and their families. In particular they are supportive of those women who may be vulnerable and require additional support. They are prepared to take action against compromises to a woman's dignity, applying the philosophy that dignity is a basic human right and there is no valid reason not uphold dignity at all times.

In addition to making patients aware of how important and valued their dignity is, it is key to ensure that staff are also aware of how important their role is. Preservation of dignity requires a multidisciplinary (MDT) approach. The emphasis on dignity should be taught from early on in training and continued through a professional's career and with all members of the team (Aranda and Jones, 2010). Furthermore evidence tells us that women and their families find it easier to maintain dignity in an environment where people around them treat each other with respect (Matthews and Callister 2004). Effective communication is of paramount importance and teams members need to feel supported themselves. It is unreasonable to expect staff to

give compassionate care if they do not feel respected and supported by the organisations in which they work (Meyer, 2010).

The dignity advocate has a key role in providing training, informing and inspiring the MDT. They must be passionate about dignity and have a great understanding of human rights.

- Dignity Advocates must be able to recognise the need for improvements to the service. Suggestions and any areas for concern will then be put forward to the management structures.
- Dignity Advocates must possess excellent communication skills and remain approachable to staff and patients.
- Dignity Advocates are required to work as part of a team who are receptive to change. They will encourage staff members to be part of the Dignity Advocates network which aims to support women, their families and staff. Therefore they will be active in recruiting like-minded individuals who are passionate about dignity in maternity care.

It is key also to look at other specific areas that have led to the development of the Dignity Advocate. We know that women feel most valued and respected when treated as individuals and not as objects (Widang et al, 2008). Women have expressed concerns with regard to the level of involvement they have in their care and a sense of lacking control. Those professionals regarded as proactive in maintaining dignity, were described as providing guidance and supervision (Lyberg and Severunssin, 2010). This further reiterates the need for dignity advocates to provide advice and support women, their families and staff providing care. Many women continue to express concern with regard to their modesty both physically and emotionally. Minimising exposures and examinations is necessary to avoid these compromises to dignity. Certainly from an emotional point of view, women's thoughts and privacy require protecting (Widang et al, 2008). In addition to this, trust essentially is a huge factor in giving women confidence in the care that they receive. Those professionals that treat women with politeness and consideration are quicker to establish relationships of trust (RCN, 2008).

Dignity Advocates will provide training which includes reiterating evidence based research to support dignity in maternity care. Training will include empowering staff with skills to uphold dignity by being aware of a woman's modesty and practical advice to ensure the woman's privacy at all times. Training will be further illustrated by both positive and negative case examples.

In summary, it is clear that the concept of the Dignity Advocate is invaluable to the maternity services. Dignity is a huge area of public interest and a recurring theme within complaints made by women, are concerns raised regarding their dignity. Areas include staff attitudes, lack of modesty, fear of pain and a sense of lack of control over their care. The Dignity Advocates provide a network of passionate individuals who are keen to support and empower women to avoid such issues. They are also available to provide training to the MDT, while informing and inspiring their colleagues.

Welcoming fathers: How Doncaster and Bassetlaw NHS Trust has welcomed fathers/partners/supporters into maternity units overnight

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The Government's Child Health Strategy, launched in February 2009 committed maternity and early year's services to closer engagement with fathers.

Amongst the Strategy's key recommendations was to 'improve fathers' involvement in Maternity services including working with Strategic Health Authorities to support fathers' staying overnight on maternity wards after the birth of their children.'

The Fatherhood Institute had reported on the widespread failure of maternity services to engage effectively with fathers, '*The Dad Deficit: the missing piece in the maternity jigsaw*', (Fatherhood Institute, 2008) and called for fathers to be able to stay overnight on maternity wards to support their partners as many reported feeling fearful, excluded and shut out at a significant point in their lives.

The visiting hours on the postnatal wards at both Doncaster and Bassetlaw sites ended at 20.00hrs for partners or one other designated person regardless of the woman's needs.

This had caused tensions in the past, when birthing partners did not want to go home leaving the new mothers and babies, especially those women who had recently been transferred from the labour rooms and also in the middle of the night.

Complaint meetings with women often involved discussions regarding their feelings of vulnerability following delivery when their partners were not allowed to stay with them.

After discussion with the then Head of Midwifery it was agreed that a trial would be commenced permitting an overnight supporter of the woman's choosing, to stay overnight in the post natal period to enable a more family-centred approach to maternity care delivery.

The aims of the trial were:

- To respond to the needs of women who gave birth and wanted the support of their partners following labour.
- To provide an extended opportunity to facilitate bonding as a family unit.
- To encourage partners to be equals in the care of and decision making about, their infant
- To assist fathers to support their partners with breastfeeding.

Method

A meeting was held between the acting Matron and the ward managers. The feasibility of the trial was discussed and the time periods agreed. Visitor's facilities were also discussed and agreed.

The reasons for the trial were also discussed at ward/floor meetings so that all staff were fully informed and could voice their views. The majority of staff welcomed the proposal after discussion and reassurance.

Community midwifery staff were also made aware of the trial in order that they could promote it by handing out information sheets.

The Obstetric Consultants were made aware of these plans and the rationale for them.

A risk assessment was completed.

A snapshot audit was undertaken on 12th May 2010 by the acting Matron to gauge reaction from both women and their partners

The rationale of the trial was discussed and the information sheets that had been devised were also discussed.

Twenty-three mothers and nineteen partners were audited.

Twenty two mothers were in favour of the proposal and seventeen partners thought that they would like to stay as an overnight supporter from the information provided.

An information sheet for clients was devised and distributed to all ward areas and to the community Midwifery staff.

It was agreed that the trial would commence on 7th June 2010 and end on 4th July 2010.

The father or overnight supporter was given an easy chair at the side of the bed and access to the ward kitchen.

Over the four-week trial period, there were one hundred and eighteen episodes of an overnight supporter being resident on the post natal wards.

Feedback

Following the trial period a further audit was undertaken to gather responses from fathers, women who chose to have a supporter to stay overnight, women who chose not to have a supporter to stay overnight and also staff views.

Thirty-six responses were received from Fathers who chose to be a supporter overnight, Thirty-five (97.22%) gave a positive response and the other one (2.77%) gave no comment at all.

Quotes from the feedback included:

- 'As first time parents it was important for me as the husband, to continue to support my wife. I also found I was able to ask the Midwives as many questions as possible at the time we needed the answers. To be able to do this is invaluable. THANK YOU'
- 'I didn't miss those first valuable hours with my daughter'
- 'Everything was brilliant and the experience of spending time with your new-born is excellent'
- 'I would recommend this to every new dad'
- Thirty-one responses were received from mothers who chose to have an overnight supporter from this group.
- Thirty one (100%) gave a positive response to the trial and all thirty one (100%) said they would also recommend this to other mothers.

Quotes from the feedback included:

- 'I was relieved that I had a choice to choose what was best for me'
- 'I felt more able to relax knowing he was there'
- 'Nice to know I have love and support at hand'
- 'It was a tough night. The moral support and help from my husband was great.'

Sixteen responses were received from mothers who chose not to have an overnight supporter.

Thirteen mothers (81.25%) who did not have an overnight supporter stated that it had had no negative effect on their stay..

Quotes from the feedback included:

- 'I think it's a good idea'
- 'Although my partner didn't stay I still think this is a good idea. I think it's a great idea especially for first time mums.'
- 'I was not disturbed or affected in any way'

Three mothers (18.75%) who did not have an overnight supporter stated that it had negatively affected them.

- 'I felt uneasy going to the toilet overnight even though I didn't see any males on my travels.'
- 'It hasn't affected me personally as I am in a single room, but I wouldn't be so comfortable if I were sharing a 4 bedded ward. A female only environment helps with the less attractive issues with becoming a new mother. And finally would men really help?'

It was clear from the feedback and evaluation that the trial had been positive for the vast majority of women and their partners.

The ward managers reported that staff also felt that the trial had been invaluable for the women and their partners and it had made them aware of the benefits of working in a new way.

The managers and the staff were keen to continue with the arrangements and they have continued since the trial.

Following service redesign in February 2013 and with the foresight of our current Head of Midwifery the service was also extended to include partners of antenatal women being welcomed to stay overnight.

On-going audit and outcome benefits

The majority of women in the postnatal period choose to have their partner staying with them overnight. On-going audit of postnatal women indicates that they require less pain relief and assistance/reassurance from midwifery staff when their partners stay overnight.

The incidence of women in the antenatal period choosing to have their partner stay with them overnight is increasing. Women wish their partners to stay for reassurance and moral support, especially if the woman is establishing in labour.

There have been no formal complaints received from women or their partners relating to either a father or other overnight supporter being present on either the antenatal or postnatal wards, or from partners being asked to leave when they did not wish to do so.

It should be noted however that where women feel more vulnerable, they should be listened to and accommodated elsewhere on the wards if possible.

As services are further redesigned, they should take into account the needs of fathers and adequate facilities should be provided for them.

Services for women escaping domestic abuse: Doula UK and Hestia

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The Background

The Doula UK Access Fund has partnered with London charity Hestia, enabling the provision of free birth and postnatal doula services to women escaping domestic abuse.

Doula UK is a non-profitmaking professional body for UK doulas – laypeople providing emotional and practical support to a woman (or couple) before, during and after childbirth. Doula UK has a Philosophy, sets standards and has a Code of Conduct which all members adhere to, and provides a mentoring and recognition process for new doulas. Doula UK also works to promote the role of doulas, to improve communication between doulas, and to advance our understanding of birth and the postnatal period.

The Doula UK Access Fund covers expenses incurred by doulas who work for clients in their local community, who do not have the financial means to employ a doula, and also helps put families in touch with doulas willing to volunteer in this way.

Hestia is a London charity providing housing and support services for all kinds of vulnerable people and working to improve health and social care services in the local community. Hestia's Domestic Abuse services currently work in 12 London Boroughs providing accommodation for, on average, 230 women and 280 children at any one time. Hestia provide emergency refuge accommodation, second stage accommodation, floating support, outreach and children and family projects, as well as emotional support for women and children and practical support with finding permanent housing and in accessing financial support, healthcare and education.

The Need

Women are at increased risk of domestic abuse in pregnancy and in the early weeks with a newborn baby (CMACE, 2011).

Domestic abuse is the biggest cause of death among women aged 19 to 44 (Domestic Violence London, 2013). Women affected by domestic abuse are at higher risk of dying during pregnancy or the postnatal period than other women, accounting for 12% of all maternal deaths (CMACE, 2011). Often, a woman has no alternative but to flee in order to secure the safety of herself and her children.

Without a project like this, women seeking refuge from domestic abuse have the following threats to their dignity and health:

- Often find it difficult to seek, or to maintain contact with, maternity and/or other health services (CMACE, 2011), leading to poorer health, the indignity of not understanding about what is happening to them and a lack of antenatal education about birth and parenting.

- Often have to attend appointments and classes alone, or accompanied only by other children, when other women do so with partners.
- Are likely to have poor support networks for pregnancy, birth and life with a new baby.
- Are likely to have to cope with labour and birth without a known companion who can stay with them throughout.
- Would have the indignity of having to cope alone during early labour and get themselves to their chosen place of birth alone, whether or not they are able to do normally simple tasks to maintain their dignity, such as get themselves dressed, keep themselves clean and communicate their needs.
- May be at higher risk of experiencing various indignities during birth and of suffering from Birth Trauma because they: are less likely to be informed about their choices; are unlikely to have an advocate to help them make their wishes known; have a lack of support; and are more likely to have a history of abuse that could affect their experience of labour & birth.
- Are also at higher risk of developing postnatal depression and of struggling postnatally (NHS Choices, 2011). Without support, life with a newborn baby is very undignifying for many women as even basic tasks like showering and getting dressed become impossible and a new mother's self-esteem can be badly knocked.
- Are less likely to successfully breastfeed even if this is their choice (Doula UK, 2012) and, as these women often have little to no financial resources, could have the indignity of relying on aid in order to feed their baby.

The Project

Doula UK members offer free birth and postnatal doula services to women through Hestia, ensuring that those on the run from abuse in the home have experienced and consistent help through their pregnancies, births and first weeks with a new baby.

The doulas will, as appropriate:

- Help women access antenatal care and education.
- Attend appointments with a woman so that she does not have to do so alone.
- Help a woman access resources that she may not otherwise be able to afford.
- Go to the woman as soon as she is needed during labour, ensuring that they feel supported and can have their dignity protected during early labour when they would otherwise be alone.
- Accompany the woman to her chosen place of birth and will stay with her until after the baby is born, providing emotional and practical support and helping ensure their clients wishes and needs (which may well be complex because of a history of abuse) are met and their dignity is respected.
- Help with the baby's first feed.

- Provide practical and emotional support postnatally, helping the mother improve her dignity and self-esteem.
- Support the mother's infant feeding choices, increases the likelihood of her successfully establishing breastfeeding if this is her choice (Doula UK, 2012).

The Future

Following the success of the partnership with Hestia, in future Doula UK would like to partner with further organisations providing services to vulnerable women, helping to protect the dignity of vulnerable women across the UK as they experience pregnancy, birth and life with a newborn.

Expecting Change: The case for ending the detention of pregnant women

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The Medical Justice report 'Expecting Change: The case for ending the detention of pregnant women' (<http://www.medicaljustice.org.uk/images/stories/reports/expectingchange.pdf>) presents an analysis of the immigration detention of pregnant women. The results show that the current policy of detaining pregnant women is ineffective, unworkable and damaging.

The Home Office does not know how many pregnant women are detained. Without knowing or recording how many are detained, it is difficult to see how the Home Office is able to implement its own policy of detaining pregnant women in only very exceptional circumstances.

The primary purpose of detention is removal, yet this research and a previous Medical Justice audit show that only around 5% of pregnant women were successfully removed. This is because in the majority of cases, there is no medically safe way to return them.

Following the case of Chen (*R (on the application of Yiyu Chen and Others) v Secretary of State for the Home Department* (CO/1119/2013)) earlier this year, the Home Office is now unable to use force on pregnant women, save to prevent harm to the woman herself. Given that the use of force, which the Home Office had deemed essential, is now unlawful, pregnant women should no longer be detained as there is now an even smaller prospect of removal.

Experts agree that travel to malarious areas should be avoided because pregnant women have an increased risk of developing severe malaria and a higher risk of fatality compared to non-pregnant women. Home Office policy outlines that women should be offered malaria prophylaxis prior to their removal. In all the cases where anti-malarials were offered, Yarl's Wood healthcare team failed to follow the relevant medical guidance.

The data results show that the healthcare pregnant women receive is inadequate. There is evidence that the level of care falls short of NHS equivalence and the National Institute for Health and Care Excellence (NICE) standards. Immigration detention introduces discontinuity in women's care and the stress of detention can impact on their mental health and their pregnancy.

Asylum seeking women have poorer maternity outcomes than the general population. Many women in the sample were victims of rape, torture and trafficking. However, there appeared to be no appreciation by Yarl's Wood healthcare staff that even without complications, this is a group of vulnerable women who need to be managed as complex cases.

People can be held in immigration detention indefinitely and the decision to detain is not subject to automatic judicial oversight. Self-harm, hunger strikes and reports of assault and racism are common. In four separate cases in the past two years, the High Court has ruled that the care of four detainees amounted to inhuman and degrading treatment. Detention is no place for a pregnant woman.

According to the Independent Monitoring Board, 93 pregnant women were held in Yarl's Wood in 2011. With limited prospects of removal, it is our recommendation that the government should stop detaining them. Detention is not serving any purpose: the costs are great and the damage to women's health can be dramatic.

Our Expecting Change report was based on analysis of full Home Office files and healthcare records of 20 pregnant detainees that Medical Justice has assisted.

Cases include:

- Maria was restrained and forcibly removed to her home country by four escorts. A few months after her return, she suffered a stillbirth.
- Aliya developed acute psychosis after she was prescribed anti-malarial medication in anticipation of her forced removal.
- Anna who had complained for three weeks about abdominal pains was sent to A & E where she miscarried with two guards in attendance. She subsequently attempted suicide and was admitted into a psychiatric ward.

The report contains further and more detailed case examples showing some of the adverse outcomes suffered by the women in the sample.

Recommendation to end the immigration detention of pregnant women

Medical Justice, supported by the Royal College of Midwives, the Royal College of Obstetricians and Gynaecologists and the Royal College of Psychiatrists Working Group on Mental Health of Asylum Seekers and Refugees are recommending the end of the immigration detention of pregnant women.

This recommendation is in line with Asylum Aid's Charter of Rights of Women Seeking Asylum that is supported by 337 organisations.

The government's response to our Expecting Change report

Prior to publication of the report, Richard Fuller MP conveyed the main findings of our research and our recommendation to the Immigration Minister, asking that he and Medical Justice meet with the Minister to discuss.

The Immigration Minister responded in writing on 6th June 2013, stating that '... we are unable to vouch for the accuracy of Medical Justice's figure about the number of pregnant women entering detention who are subsequently removed from the United Kingdom. However, should those figures be accurate, they demonstrate that only a small number of pregnant women are being detained, in line with detention policy, compared with the overall numbers of women in detention. ... I do not believe it would be appropriate for me to meet them at this stage.'

Lord Roberts of Llandudno asked a parliamentary question asking what assessment the government have made of the findings of Expecting Change and whether they will amend current legislation so that pregnant women cannot be detained for immigration purposes.

He received an answer on 24th July 2013 stating ‘.. The Home Office does not accept the conclusions in the recent Medical Justice report, not least because the report is based on a small sample of women over a period of more than three years. There are no plans to change the current policy on detention of pregnant women.’

- Initial campaigning actions towards ending the detention of pregnant women includes:
- Adjournment debate - Richard Fuller MP has tabled an adjournment debate on 5th September 2013. Medical Justice is writing to a number of MPs, providing a briefing document 4and asking them 5to participate.
- Meet with the Immigration Minister – together with Richard Fuller MP, we are continuing to pursue a meeting with the Minister
- Media coverage – so far media coverage has included the Huffington Post, the New Statesman, Open Democracy, the Scotland Herald and Private Eye. We are trying to get further coverage.
- Stakeholder group meetings – we are trying to re-establish the Detention User Group Medical Sub-Group meetings with the Home Office, all of which have been cancelled by the Home Office since January 2012, and to have pregnant women in detention on the agenda.
- Litigation – we have been discussing potential cases with Bhatt Murphy Solicitors

Medical Justice’s request of the Dignity in Childbirth Forum

We would welcome any contribution to the above activities and suggestions for new ones.

Supporting young mums: Just for Kids Law

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Just for Kids Law is a leading charity advocating on behalf of vulnerable young people, approximately 20% of whom are young parents.

Young mums often feel particularly isolated – alienated and judged by their peers by virtue of being pregnant and by other parents due to their youth. Many of the young mums we work with have little in terms of support, and many have been through the care system. These circumstances often raise child protection concerns for the local authority, whether appropriate or otherwise. Traumatic experiences in childhood are a far less distant memory for younger mums and can be triggered throughout pregnancy and childbirth.

Medical professionals must take a holistic approach, viewing these young mums as both new parents *and* young people midway through the complex processes of adolescent development. This session will draw upon Just for Kids Law's experience working with young parents to identify considerations and practical tools for those responsible for ensuring dignity in pregnancy and childbirth.

Deaf Nest Project: Improving childbirth and pregnancy experience for a deaf couple: Empowering, Enabling and Supporting

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Introduction

'As a deaf boy, the artist struggled to understand the connection between words and images. His discovery of language came when he grasped that the fingerspelled word 'B- A-L-L' matched the picture of a ball, and the door of enlightenment opened for him. Before, his mind was a desert. After, his vision was transformed by primary colors- red, blue, yellow- which were to change his life. The flower in full bloom is William's rendering of the moment of discovery: 'I understand!'

L.K.Elion My Eyes are My Ears; Homage to Harry R. Williams

Hearing loss is a major and growing public health issue, currently affecting more than 10 million people in the United Kingdom (Action on Hearing Loss, 2011). It has significant personal (Royal National Institute for the Deaf (RNID), 2011) and social costs (Sheld, 2006). What evidence is available indicates poorer physical health among deaf people (Sign Health, 2008). Kochkin and Rogin (2000) study shows strong correlation between hearing loss and physical, emotional, mental and social wellbeing. Furthermore, Young (1990) and Oliver (2004) argue that issues such as, anxiety, depression, isolation and lessened self-esteem constitute a form of 'social oppression' or 'social death', rather than being 'just' quality of life issues.

Deafness/deafness ('D/deaf') (women who use sign language and women who may lip-read and/or use hearing aids) is unique in that it crosses barriers of age, gender, economic status and ethnicity (Fusick, 2008). It is particularly complex in the context of the 'disabled/abled binary' (Skelton & Valentine, 2003). Generalisation is unhelpful since impairment is individualised and manifests itself in emotional, psychological, social, and physical dimensions of a person's life (RCN, 2007). The psycho-emotional barriers D/deaf women and their families encounter include discriminatory health and social support services (Oliver, 2009), and limited access to information (Munoz-Baell & Ruiz, 2000). Those social barriers not only erect restrictions to participation in the normal life of the community (Marks, 1999), but also place limits on women's psycho-emotional wellbeing. For instance, feeling worthless, of lesser value, stressed or insecure (Thomas, 1999).

Communication is the most serious barrier for people with hearing loss. It plays a central role in underpinning informed consent and informed choice (Bramwell, Harrington & Harris, 2000). In order to make informed choices, a woman needs accurate and accessible information (RCM, 2008). Iqbal (2004) recognised that deaf parents are unable to access information and this is mainly due to staff inability to communicate in sign language or because of a lack of deaf awareness. Elaborating this theme, Price (2012) utilises the idea that any communication barriers may compromise the quality of care. Other have followed a similar path when thinking about the importance of obtaining informed consent (NMC, 2008) and ensure D/deaf women's rights and expectations are met under the Patient's Charter and

Equality Act 2010 (Scullion, 1999). For example, in his deliberations on the specific social needs of D/deaf women, Atkin et al. (2002), state that D/deafness presents additional barriers such as being socially and morally more vulnerable. D/deafness may undermined women's confidence and make it difficult to sustain a positive self-image (Atkin et al., 2002). The most recent 'Saving Mother's Lives' report (CMACE, 2011) has again identified the links between social exclusion and vulnerability and adverse pregnancy outcomes.

Additionally, there are huge barriers to access health services and lack of integration between them. British Sign Language (BSL) interpreter is not always available to attend every antenatal, intrapartum and postnatal appointment. The presence of the interpreter is crucial to interpret findings, communicate any concerns couple may have and most of all to ensure informed choice is provided. 'Midwives can learn sign language' (Kelsall et al., 1992). This is not to replace the interpreter but to enable the basic communication when the interpreter is not present.

Childbirth can be an empowering and embracing life experience for a woman and her family. For this to be a positive and fulfilling experience, midwives and other healthcare professionals need to be empowered and enabled to deliver care that is woman-centred to meet individual needs, at the same time as being evidence-based. 'Embracing diversity is key to change' (Rotheram, 2007).

'Deaf Nest' project will attempt to produce good practice guidances, to seek ways to remove barriers and to explore ways to make adjustments that are both creative and flexible to meet the needs of a deaf couple.

Facts

Hearing loss currently affects more than 10 million people in the UK. It is estimated that by 2031, 14.5 million people in the UK will have hearing loss. This is a potential public health crisis, yet has been ignored.

- Hearing loss has high personal and social costs, and it is an expensive and neglected topic.
- Hearing loss is under-researched and unrecognised.
- Hearing loss is a public health issue and people experiencing hearing loss have significant clinical and social needs.
- There is a failure in wider society to respond to communication needs of people with hearing loss. £1.34 million has been spent on research about hearing loss compared to £49.71 million spent on research on cardiovascular conditions for every person affected. (The Royal National Institute for Deaf People, 2011)
- Based on statistics from 1992, midwives are caring for approximately 700 deaf women who gave birth in the UK every year and this number is raising every year. (Devlin, 1992)

Primary Objectives

- Overcome prejudice and barriers by increasing public awareness and offering equal choices to services users.
- Promote deaf awareness for midwives by organising regular workshops, service users days and conferences. This will enable engaging and building trusting relationship with Deaf women.
- Explain how midwives can learn sign language and be innovative by using adaptive and creative approaches to meet individual needs of deaf women.
- Describe an effective provision of help to deaf mothers and their families by focusing firmly on the experience of the woman's journey through childbirth and transition to the motherhood (this will involve setting up a consultation group in the Manchester Deaf Centre).
- Identify and assess needs and support needed by effective referral, and development of good practice guidances, information leaflets and practical suggestions.
- Strengthening an effective provision of care to deaf couple by promoting culture of inter-professional collaborative practice.
- Provide accessible and accurate up-to-date information to enable informed choice.
- Comply with the Equality Act 2010.

Statement of Need

There is little literature available on providing maternity care to deaf women and their families (Bramwell; Harrington & Harris, 2000). The lack of relevant literature suggest that deafness and pregnancy are two concepts rarely considered together. Is it assumed then that deaf women do not want to become parents? (Rotheram, 2007). Despite the most recently available statistic which shows a dramatic increase in hearing loss, a little has been said or done in relation to pregnancy and childbirth. The pregnancy book available cost of £14.99 for deaf parents, but is given free to other pregnant women, and is an example of inequality in care provision. There is an acute need to train midwives and other medical staff in deaf awareness and associated communication skills. Classes in basic Sign language and better teaching aids and video material should be available both for midwives and hearing-impaired parents.

The public health role of the midwife is recognised as being central to supporting women's physical, social, and psychological wellbeing (O'Lunaigh & Carlson, 2005). The guidance of professional conduct (NMC, 2008) stresses the importance of facilitating choice, control and woman-centred care. This is further emphasised by the Equality Act 2010 with its reference to the duty of care concerning access, quality of service, communication and disability awareness. The key principle here is an understanding of the problems faced by D/deaf women and their families when accessing maternity services (Jackson, 2011). D/deaf and hearing-impaired parents are disadvantaged group (Deaf Parenting UK, 2007). Consequently, it is more important that ever that midwives contribute to the development of appropriate

policies that protect D/deaf women's autonomy and ensure equal access to all services without barriers (Bramwell et al., 2000).

Midwives must adopt a position of 'determined advocacy' (Oliver & Sapley, 1999) for women's civil rights under protective laws such as the Equality Act (2010), and be prepared to assume non-traditional roles (Fusick, 2008). An essential component of midwifery care is to protect D/deaf women's dignity. The basis for this component includes trust, ongoing dialogue, enduring presence and shared responsibility (Berg, 2005). Jackson (2011) in her research into D/ deaf women's experience of maternity services concluded that many D/deaf women would like to be included in the normal care provision and that continuity of care it's an important factor to achieving a woman-centred approach. Similarly, the Royal College of Midwives (RMC, 2008) stated that every woman has the right to receive individualised, safe and high quality maternity care. The Royal National Institute for Deaf People survey (2004) of patient experiences certainly supports this view.

Moreover, Williams & Martin (2006) emphasise the careful thought given to working in a partnership with other professionals and voluntary organisations. Joined-up care through the antenatal, intrapartum and postnatal periods by an integrated multi-disciplinary team is particularly important (Wates, 2005) in order to provide midwifery care tailored to the individual needs (Brown, 2003). This perspective in relation to D/deafness leads to use of professional interpretation services as highlighted in the latest CMACE (2011) report.

Midwives must acknowledge the limitations of their own competence, knowledge and scope of professional practice (NMC, 2012), and ensure the presence of a British Sign Language interpreter to allow D/deaf women to fully access the information available to them (RCN, 2007; NMC, 2008). The presence of the interpreter is crucial to interpret findings, communicate any concerns a couple may have and most of all to ensure informed choice and confidentiality (NMC, 2012). In the absence of an interpreter, midwives need to be innovative in enhancing their communication skills (McKay-Moffat, 2007). 'Midwives can learn sign language' (Kelsall et al., 1992). This is not to replace the interpreter but to enable basic communication when the interpreter is not present (McAleer, 2006).

Finally, there needs to be more awareness among midwives about caring for women with unseen disabilities, such as D/deafness (Lynn, 2008). The challenge is not only to see each woman as an individual but to also be aware of the impact impairment may have on her life (McKay-Moffat, 2007). The first recommendation concerns the importance of taking a positive approach to the pregnancy of a D/deaf woman where emotional support is as important as practical support (Rogers, 2006). In fact, midwives need to integrate the model of care with the vision represented by the six Cs of care, compassion, competence, communication, courage and commitment (NHS Commissioning Board website, 2012).

Project Description

The project will initially be delivered in partnership with Manchester Deaf Centre and 'Deaf Health Champions' whose aim is to 'improve personal experience, equality of access, choice and control over health care for D/deaf people'. 'Deaf Health Champions' similar to 'Deaf Nest' share the same values and recognise that Deaf people experience communication barrier and are often excluded form health and social care. It was agreed support from partner agencies

including: Deaf Health Champions, UK Council on Deafness, Sign Health, Merseyside Society for Deaf People and Deaf Vision Cumbria, to ensure quality and effectiveness of program.

The 'Deaf Nest' project includes components designed to ensure dignity and address deaf couple's needs in the journey of childbirth. One important component is to set up a consultation group in the Manchester Deaf Centre to make sure woman's and family's 'voice' is heard. This involves communicating and listening to Deaf people experience of childbirth and involving them to bring about change. First pilot group will commence in June 2013 and will be delivered in duration of 6 weeks. The pilot group will be then evaluated and final consultation group planner for future groups will be produced in order to start sessions in Merseyside and Cumbria run by local volunteers. The pilot group consist of two parts. First is educating Deaf parents and the second is educating midwives and other maternity health professionals.

Integral to this is promoting deaf awareness for midwives by organising regular workshops, service users days and conferences. The main purpose of midwife role in the project will be to bring evidence-based, expertise knowledge to the program.

Moreover, the project aims to improving deaf access to information by producing visual aids, leaflets, flash cards and videos for antenatal, intrapartum and postnatal education. These will contain basic up-to-date information specific to each stage of pregnancy, presented in british sign language.

Additionally, the project seeks to:

- Create, www.deafnest.com, a website with all learning materials produced and obtained from other supporting agencies. These will include: videos, leaflets, guidance, pictures, recent news. The primary objective is to create a space where all information will be available for free for deaf people as well as health professionals.
- To promote 'deafNest' via Facebook, Twitter and youtube.
- Organise 1st Study Day of Deafness Awareness for Midwives in the University of Salford on 9th of April 2014.
- Work in a collaboration with Youth Group from Manchester Deaf Centre to produce promotional video 'Every child matters', with deaf children signing the song using British Sign Language.
- Work in a collaboration with Software Engineering Department at the University of Salford to design a new software to transfer sound of fetal heartbeat to vision and vibrations.
- Produce videos with British Sign Language Interpreter.
- Produce guidance and support pack for midwives, including quick reference diagrams.
- Produce communication aids for deaf parents, including quick reference flash cards.
- Organise fundraising event and use money to produce 'deafNest' pack to be available for each Trust nationally.

Conclusion

This paper has given an account of the principles on which the 'Deaf Nest' project will be based. One of the most significant findings to emerge from this project is the importance of taking the time to understand women's concerns and adjusting the practice to incorporate the unique needs of deaf families (Jackson, 2011). This underpinning knowledge is essential to achieve woman-centred and individualised care.

Midwives are autonomous practitioners accountable for the standard of care they provide. They are legally and professionally obligated to establish and maintain a relationship based on trust with those in their care. Moreover, they play a key role in exchanging information and understand deaf women's needs in order to act as an advocate and helping to overcome the barriers than can be created by deafness (Jackson, 2011).

Pregnancy and motherhood are major life events for all women, not least for D/deaf women. Nevertheless, D/deaf women need to be accepted and supported in their choice to become parents and to be cared for and treated like every other woman (McKay-Moffat & Rotheram, 2007). 'Deafness implies diversity, and diversity in relation to hearing loss needs to be acknowledged, understood and, most importantly, respected' (Munoz-Baell & Ruiz, 2000, p. 44).

The medicalisation of childbirth: emotion, care and coping

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Childbirth matters for women. Carrying, giving birth to, and caring for a child is still one of the biggest transformations for women, in their lifestyle, movement, physical constraint, identities, sense of self and emotional scope (Wolf 2001, Elliot et al. 2009).

My presentation is based on two years of ethnographic research, biographical exploration, and interviews with 27 mothers with children under the age of 5 in Walthamstow, East London. Overall, the research is interested in experiences of risk and risk taking in relation to bringing up children, and as it has developed has emerged as a critique of current and popular theories, which put forward the view that our culture is dominated by risk-avoidant parenting. As part of this research however, mothers reflected upon their experiences of pregnancy and birth, and how this prepared them for motherhood. This presentation will focus on these findings, and the themes that will be explored are as follows:

- Differential narratives of pregnancy and birth
- The impact of heightened expectations around birthing
- Discourses of trauma, whether experienced as a result of medicalisation or independent of it
- Guilt arising from traumatic and/or medicalised births and natural, uncomplicated births
- 'Natural birth' and empowerment
- The importance of support and acts of emotion care
- Outcomes when private medical care sought
- The impact of birth on parenting ... uncertain causation.

My biography

I have been a Lecturer at the Open University, based in the Faculty of Social Sciences, since 2005, prior to which I was a Senior Lecturer at Roehampton University.

I have written a range of books and articles on racial exclusion and the night-time economy, licensing law, security and crime and criminal justice. I currently doing ethnographic research based in Walthamstow, East London interrogating theories of risk and risk-avoidant parenting and have recently published some of this research in the journal *Children's Geography*. I host and post on a blogging and social forum called Walthamstow Parents Online (walthamstowparentsonline.ning.com).

Is this the moment to turn failure into success?

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The Birth Trauma Association is a charity that works for, and supports, families who have been affected by traumatic experiences in childbirth. Most, but not all, trauma can be prevented with better care and by respecting women's autonomy and enabling them to feel in control. The BTA has handwritten letters from women spanning a period of over 30 years. The following comments, written recently, are typical of those we receive. Notably, they mirror exactly the type of comments received back in the 1980s, demonstrating that, sadly, very little has changed.

'I felt raped, violated and humiliated. Forms were pushed in front of me to sign, what choice did I have? I don't believe that was consent. My baby was cut from my body – I dissociated in grief and terror. The impact on my life has been devastating. I feel a failure as a woman, as a mother, my self esteem has vanished.'

'I begged for pain relief, I had been in labour for hours and was in 'white' pain but my epidural never came. I was thrashing about like a wounded animal, deprived of dignity, deprived of care, all my rights as a human stripped away. Even with my legs in stirrups and my most intimate parts bared to the world, I was told I wasn't in pain when I was stitched. I was, I was in terrible pain but no one listened.'

These two quotes are from women with very different perspectives on birth. The first wanted the opportunity to give birth without drugs in the most natural way possible. The second wanted the benefits of modern technology and effective pharmacological pain relief. These women wanted different birth experiences but both wanted their choices to be respected and in both cases, their trauma resulted from a failure to do just that.

At the BTA, we believe that we cannot allow ourselves to be side-tracked into a debate about birth ideology ('normality' versus medicalisation). The core issues of personal dignity and autonomy are far too important for this. But we note that debate in this area frequently reflects personal perspectives about the 'right' kind of birth. But what is 'right' depends on what matters to us as individuals. If we have a horror of perineal trauma, an elective caesarean is a perfectly reasonable choice. If it is important to give birth in familiar surroundings where we feel comfortable, a homebirth is a sensible choice. The core issue is that we have our choices respected.

For too long, there has been a failure to acknowledge the essential truth that unites us. The BTA believes we must start campaigning together on those fundamental issues we all agree on: a woman's right, through accurate information, to make decisions about her body, her child and how she gives birth and to be supported by caring and respectful health care professionals.

We have an opportunity at this Forum on October 16th 2013 to mark a turning point – let's do it!

Respectful care in statutory training

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Queen's and King George Hospitals' maternity services is striving to improve the quality of care for women. The maternity education team, supervisors of midwives and governance team at Barking, Havering and Redbridge University Hospitals NHS Trust (BHRUT) in collaboration with White Ribbon Alliance for Safe Motherhood (WRA) are playing a significant role in influencing and raising awareness of the importance of treating pregnant women with dignity and respect during maternity care.

Disrespect and abuse in childbirth is a known global issue. Not only is it an issue in developing countries, it is also an issue in developed countries. One of the key issues highlighted in the Care Quality Commission (2010) report on BHRUT maternity services was the lack of support provided to meet women's and families' needs. Consequently the issue of treating women with dignity and respect is at the forefront of the maternity service's agenda. The maternity education team, supervisors of midwives and the governance team are well placed and have the potential to contribute significantly to the maternity and wider trust strategies to improve the quality of care that women receive during the perinatal period.

To address this issue the maternity education team, supervisors of midwives and the maternity governance team have joined forces with WRA and incorporated the WRA Respectful Maternity Care Charter into the mandatory training within maternity services. Mandatory means that all midwives and obstetric staff have to attend annually and the sessions are run on a bi-monthly basis. Therefore, the majority of maternity staff has an opportunity to attend.

The session kicks off with a presentation and gives a global perspective of the women's experience in maternity care systems. The emphasis is made on the seven major categories of disrespect and abuse that child-bearing women encounter during maternity care.

This is followed by the education team and supervisors of midwives providing the local perspective of women's experiences based on real complaints from women about their care. This is done via a presentation, with quotes from complaints as well as two role-plays. At the end of the play the Respectful Maternity Care video 'Break the Silence' is shown.

The message is snappy, powerful and thought provoking. The sessions are attended by the Director of Midwifery who reiterates the importance of treating women with dignity and respect and also shares some positive feedback from women. Already we are seeing improvements. Complaints are down and women are reporting good care. We will continue to further improve the care that we provide to women and their families.

Feedback from staff has been very positive. The sessions have enabled healthcare professionals to talk about the issue of treating women with respect, to challenge bad behaviour and promote good quality care. We would like to encourage other hospitals/trusts to adopt the Respectful Maternity Care Charter on fundamental human rights of childbearing women and incorporate it into their training.

References

By title of project

The role and influence of key professionals in the decision-making processes of pregnant girls

Barn, R., and Mantovani, N. (2007) Young mothers and the care system: contextualizing risk and vulnerability, *British Journal of Social Work*, 37(2), 225-243

Clemmens, D. (2003) Adolescent motherhood: A meta-synthesis of qualitative studies, *American Journal of Maternal/Child Nursing*, 28(2), 93-99.

Duncan, S. (2007) What's the problem with teenage parents? And what's the problem with policy, *Critical Social Policy*, 27(3), 307-334.

Respectful, evidence-based care for women with a high BMI

Abenhaim H and Benjamin A (2011) Higher caesarean rates in women with higher BMI: are we managing labour differently? *J Obstet Gynaecol Can* 33(5):443-448.

Acosta C, Bhattacharya S, Tuffnell D, Kurinczuk J, Knight M (2012) Maternal sepsis: a Scottish population-based case-control study. *BJOG* 119:474-483.

Alfirevic Z, Devane D, Gyte GML (2013) Continuous cardiotocography (CTG) as a form of electronic fetal monitoring (EFM) for fetal assessment during labour. *Cochrane Database of Systematic Reviews*, Issue 5. Art. No.: CD006066. DOI: 10.1002/14651858.CD006066.pub2.

Amy NK, Aalborg A, Lyons P, Keranen L (2006) Barriers to routine gynaecological cancer screening for White and African-American obese women. *International Journal of Obesity* 30:147-155.

Buckley S (2004) Undisturbed birth – nature's hormonal blueprint for safety, ease and ecstasy. *MIDIRS* 14(2):203-9.

Buckley S (2009) Gentle Birth, Gentle Mothering. *Celestial Arts*.

Denison FC, Norwood P, Bhattacharya S, Duffy A, Mahmood T, Morris C, Raja EA, Norman JE, Lee AJ, Scotland G (2013) Association between maternal body mass index during pregnancy, short-term morbidity and increased health service costs: a population based study. *BJOG* 10.1111/1471-0528.12443.

Cluett ER, Burns E (2009) Immersion in water in labour and birth. *Cochrane Database of Systematic Reviews*, Issue 2. Art. No.: CD000111. DOI: 10.1002/14651858.CD000111.pub3.

Evans B (2006) 'Gluttony or sloth': critical geographies of bodies and morality in (anti)obesity policy *Area* 38(3): 259-267.

Furber CM, McGowan L (2011) A qualitative study of the experiences of women who are obese and pregnant in the UK Midwifery 27:437-444.

Furness PJ, McSeveny K, Arden MA, Garland C, Dearden AM, Soltani H (2011) Maternal obesity support services: a qualitative study of the perspective of women and midwives. *BMC Pregnancy Childbirth* 11:69.

Grotegut C, Paglia M, Johnson L, Thames B and James A (2011) Oxytocin exposure in women with postpartum hemorrhage secondary to uterine atony *American Journal of Obstetrics and Gynecology* 204(1): 56.e1-56.e6. doi: 10.1016/j.ajog.2010.08.023.

Gupta JK, Hofmeyr GJ, Shehmar M. (2012) Position in the second stage of labour for women without epidural anaesthesia. *Cochrane Database of Systematic Reviews*, Issue 5. CD002006.

HOC (2004) Health Select Committee Report: Obesity The Stationery Office, London.

Hodnett ED, Gates S, Hofmeyr GJ, Sakala C. (2012) Continuous support for women during childbirth. *Cochrane Database of Systematic Reviews* 2012, Issue 10. Art. No.: CD003766.

Hollowell J, Pillas D, Rowe R, Linsell L, Knight M, Brocklehurst P (2013) The impact of maternal obesity on intrapartum outcomes in otherwise low risk women: secondary analysis of the Birthplace national prospective cohort study. *BJOG* DOI: 10.1111/1471-0528.12437.

Inch S (1984) *Birthrights* Pantheon Books.

Lamaze International (2013) 5 Healthy Birth Practices www.lamaze.org

Lawrence A, Lewis L, Hofmeyr GJ, Styles C (2013) Maternal positions and mobility during first stage labour. *Cochrane Database of Systematic Reviews* 2013, Issue 8. Art. No.: CD003934. DOI: 10.1002/14651858.CD003934.pub3.

Leap N, Sandall J, Buckland D, Huber U (2010) Journey to Confidence: Women's Experiences of Pain in Labour and Relational Continuity of Care. *Journal of Midwifery & Women's Health* 55(3):234-242.

Mander R (2011) Time to put up or shut up? *AIMS Journal* 23(4) www.aims.org.uk/Journal/Vol23No4/putUpOrShutUp.htm.

Mulherin K, Miller Y, Barlow F, Diedrichs P and Thompson R (2013) Weight stigma in maternity care: women's experiences and care providers' attitudes *BMC Pregnancy and Childbirth* 13 (19) www.biomedcentral.com/1471-2393/13/19.

National Institute for Health and Clinical Excellence (2012) Patient experience in adult NHS services: improving the experience of care for people using adult NHS services NCGC www.ncbi.nlm.nih.gov/books/NBK115230/pdf/TOC.pdf

Reed B (2008) An unplanned hospital birth! *The Practising Midwife* 11(12):24-26-31.

Russell S, Fyle J, Costa-Fernandes M, and Stockdale J (2010) A Growing problem: does weight matter in pregnancy?

Netmums/Royal College of Midwives l.nmimg.net/images/A_Growing_Problem_Nov2010.pdf

Sandall J, Soltani H, Gates S, Shennan A, Devane D. (2013) Midwife-led continuity models versus other models of care for childbearing women. Cochrane Database of Systematic Reviews, Issue 8. Art. No.: CD004667. DOI: 10.1002/14651858.CD004667.pub3.

Singleton G, Furber C (2013) The experiences of midwives when caring for obese women in labour: A qualitative study. *Midwifery*, available online at www.sciencedirect.com/science/article/pii/S0266613813000764

Talge, N. M., Neal, C., Glover, V. et al (2007) Antenatal maternal stress and long-term effects on child neurodevelopment: how and why? *Journal of Child Psychology and Psychiatry* 48: 245–261. doi: 10.1111/j.1469-7610.2006.01714.x.

Tracy S, Sullivan E, Wang A, Black D, Tracy M (2007) Birth outcomes associated with interventions in labour amongst low risk women: A population-based study *Women and Birth* 20(2):41-48.

Uvnas-Moberg K (2011) *The Oxytocin Factor : Tapping the Hormone of Calm, Love and Healing*. 2nd edition. Pinter & Martin Ltd.

Vireday P (2011) Maternal obesity: a view from all sides. www.scienceandsensibility.org/?p=3030.

Williams V (2011) Is the 'high risk' label helpful? *AIMS Journal* 23 (4) www.aims.org.uk

Birth Stories: A project to help students understand the lived experience of parenting with a disability

Donna, S (2010) *Surprising, Inspiring Birth* Chester-le-Street Fresh Heart Publishing

Gallagher, D.W. Sinclair, M. & McConkey, R. (2010) Lived experiences of motherhood Disability, pregnancy and parenthood No.68 p.15

Gregory, B (2011) Breaking through the barriers *Midwives* Issue 3 pp 30-32

Lawler, D (2010) Women with disabilities: the midwife's role and responsibilities the *Practising Midwife* vol 13; Issue 1: 20-13

Moffatt – McKay, S (ed) (2007) *Disability and Childbirth* London Elsevier

Morris, J. & Wates, M. (2006) Support for disabled parents and parents with additional support needs *Adult Services Knowledge Review* 11 London Social Care Institute for Excellence

Royal College of Nursing (2007) *Pregnancy and Disability* London RCN

Royal College of Obstetricians and Gynaecologists (2011) *Saving Mothers' Lives report – reviewing maternal deaths 2006-2008* London RCOG

Thomas, C (1997) Having a baby; some women's reproductive experiences *Midwifery* 13; 202-9

Thomas, C. (1998) Becoming a mother; disabled women (can) do it too *MIDIRS Midwifery digest* 8(3); 275-8

Walsh-Gallagher, D. Sinclair, M. & McConkey, R. (2012) The ambiguity of disabled women's experiences of pregnancy and childbirth and motherhood: a phenomenological understanding *Midwifery* 28 (2) pp156-162

Williams, J & Gregory, B (2012) Open Education Resources for Interprofessional Working in Midwifery *British Journal of Midwifery* 2012:119:3

H.M.S.O. (2010) *The Equality Act* UK Stationery office

Choosing a caesarean

1. National Institute for Health and Care Excellence. Caesarean section (update). CG132. 2011. www.guidance.nice.org.uk/CG132.

2. BMJ letter, August 7, 2013; NICE says a planned caesarean section SHOULD be offered to women who request it. *PM Hull*. www.bmj.com/content/347/bmj.f4649/rr/656733

3. BMJ letter, August 7 2013; Refusal to follow NICE caesarean guidance is unjustified. *PM Hull*. www.bmj.com/content/346/bmj.f3814/rr/656821

4. National Institute for Health and Care Excellence. Caesarean section. QS32. 2013. www.guidance.nice.org.uk/QS32.

5. New NICE Quality Standard Reinforces Support for Maternal Request. (11 June 2013) www.cesareandebate.blogspot.co.uk/2013/06/new-nice-quality-standard-reinforces.html

6. Midwives Worth their Weight In Gold. July 31, 2013 www.cesareandebate.blogspot.co.uk/2013/07/midwives-worth-their-weight-in-gold.html

7. WHO Admits: There Is No Evidence For Recommending A 10-15% Caesarean Limit. October 29, 2009 www.medicalnewstoday.com/releases/169058.php

8. New RCOG guidance urges CCGs to increase births without epidurals and reduce caesarean rates to 20%. (24 August 2012) www.electivecesarean.com/images//12-aug-24%20rcog%20ccg%20press%20release%20final.pdf

9. BMJ letter, February 14, 2013. Reducing mortality is not as simple as low cesarean rate good, high cesarean rate bad. *PM Hull*. www.bmj.com/content/346/bmj.f108/rr/630974

10. Draft NICE Quality Standard, January 2013. Stakeholder comments from electivecesarean.com on pages 6-14. www.nice.org.uk/nicemedia/live/13987/64084/64084.pdf

11. National Institute for Health and Care Excellence. Clinical Audit Tool. Implementing NICE caesarean guidance. 2013 www.guidance.nice.org.uk/CG132/ClinicalAudit/MaternalRequestForCaesareanSection/doc/English

Caseload scheme for vulnerable women

Boy A, Salihu H M. 2004. Intimate partner violence and birth outcomes: a systematic review. *International journal of fertility and women's medicine*. 49(4):159-64

Cantwell R, Clutton-Brock T, Cooper G. 2011. Saving Mother's Lives: reviewing maternal deaths to make motherhood safer 2006–2008. *British Journal of Obstetrics and Gynaecology*. 118(1); 1–203

Centre for Maternal and Child Enquiries (CMACE). 2011. Saving Mothers' Lives: reviewing maternal deaths to make motherhood safer: 2006–08. The Eighth Report on Confidential Enquiries into Maternal Deaths in the United Kingdom. *British Journal of Obstetrics and Gynaecology*. 118(1):1–203

Commission for Healthcare Audit and Inspection. 2006. Investigation into 10 maternal deaths at, or following delivery at, Northwick Park Hospital, North West London NHS Trust, between April 2002 and April 2005. London: Healthcare Commission.

Department of Health. 1993. Changing Childbirth. Part 1. Report of the Expert Maternity group. HMSO, London.

DOH. 2004. National Service Framework for Children, Young People and Maternity Services: Maternity services. London.

DOH. 2007. Maternity matters: choice, access and continuity of care in a safe service. London. HMSO

DOH. 2012. The Mandate; A mandate from the Government to the NHS Commissioning Board: April 2013 to March 2015. HMSO

Goldenberg R L, Culhane J F, Iams J D. 2008. Epidemiology and causes of preterm birth. *The Lancet*. 5;371(9606):75-84

Hatem M, Sandall J, Devane D, Soltani H, Gates S. 2008. Midwife-led versus other models of care for childbearing women. *Cochrane Database for Systematic Review*. 4:CD004667

Hodnett E D. 2008. 'Continuity of caregivers for care during pregnancy and childbirth (Cochrane review)' In: *The Cochrane Library*, Issue 2, 2004

Houweling T, Ronsmans C, Campbell O, Kunst A. 2007. Huge poor-rich inequalities in maternity care: an international comparative study of maternity and child care in developing countries. *Bulletin for World Health Organisation (WHO)*. 85(10);745-754

King's Fund. 2008. Safe Births: everybody's business. An independent inquiry into the safety of maternity services in England. London: King's Fund. pg2.

King-Hele S, Webb R T, Mortensen P B, Appleby L, Pickles A, Abel K M. 2009. Risk of stillbirth and neonatal death linked with maternal mental illness: a national cohort study. *Archives of Disease in Childhood, Fetal and Neonatal Edition*. 94(2):105-110

Marmot, M. 2010. Fair Society, Healthy Lives (The Marmot Review): Strategic Review of Health Inequalities in England Post 2010. London.

NHS Commissioning support for London. 2011. Improving maternity care in London; A framework for developing services.

NICE. 2010. Pregnancy and complex social factors: A model for service provision for pregnant women with complex social factors. London: NICE.

Redshaw M, Heikkila K. 2010. Delivered with care: a national survey of women's experience of maternity care. National Perinatal Epidemiology Unit. Oxford. Available from: www.npeu.ox.ac.uk/files/downloads/reports/Maternity-Survey-Report-2010.pdf -accessed on 12/09/2013.

Rowe R, Garcia J. 2003. Social class, ethnicity and attendance for antenatal care in the United Kingdom: a systematic review. *Journal of Public Health Medicine*. 25(2)113–119.

Royal College of Obstetricians and Gynaecologists (rcog). 2001. The National Sentinel Caesarean Section Audit Report. London: RCOG Clinical Effectiveness Support Unit.

Sandall J, Soltani H, Gates S, Shennan A, Devane D. 2013. Midwife-led continuity models versus other models of care for childbearing women. *Cochrane Database of Systematic Reviews*. Issue 8;5

Winterton, N. 1992. House of Commons Health Committee, Second Report, Maternity Services, Vol 1, HMSO.

World Health Organisation (WHO). 2008. Infant mortality and birth weight. accessible at apps.who.int/ghodata - accessed on 7/7/2013.

From oppression and control to self-regard and emancipation

Aronson, E., (2008). *The Social Animal*. 10th edn. New York: Worth Publishers.

Hollins Martin, C.J. and Bull, P., (2006). What features of the maternity unit promote obedient behaviour from midwives? *Clinical Effectiveness in Nursing*, (9S2), e221-e231.

Lambert, C., (2013) *The influence of self in women's decision-making about birthplace*. Unpublished thesis. University of Hull.

Levy, V., (1999b). Protective Steering: A grounded theory study of the processes by which midwives facilitate informed choices during pregnancy. *Journal of Advanced Nursing*, 29(1), 104-112.

Wittmann-Price, R.A., (2004). Emancipation in decision-making in women's health care. *Journal of Advanced Nursing*, 47(4), 437-445.

How do women with an intellectual disability experience the support of a doula?

Aunos, M., Feldman, M. & Goupil, G. (2008). Mothering with intellectual disabilities: Relationship between social support, health and well-being, parenting and child behaviour outcomes. *Journal of Applied Research in Intellectual Disabilities*, 21, 320-330.

- Booth, T. & Booth, W. (1994). Working with parents with mental retardation: Lessons from research. *Journal of Developmental and Physical Disabilities*, 6, 23-41.
- Booth, T. & Booth, W. (2004). Brief research report: Findings from a court study of care proceedings involving parents with intellectual disabilities. *Journal of Policy and Practice in Intellectual Disabilities*, 1, 179-181.
- Campero, L., Garcia, C., Diaz, C., Ortiz, O., Reynoso, S. & Langer, A. (1998). 'Alone, I wouldn't have known what to do': A qualitative study on social support during labor and delivery in Mexico. *Social Science & Medicine*, 47, 395-403.
- CHANGE (2008). *You and Your Baby. A Guide to Looking After Babies in Easy Words and Pictures*. CHANGE Publications: UK
- Collins, N., Dunkel-Schetter, C., Lobel, M. & Scrimshaw, S. (1993). Social support in pregnancy: Psychosocial correlates of birth outcomes and postpartum depression. *Journal of Personality and Social Psychology*, 65, 1243-1258. Doula UK: www.Doula.org.uk
- Hodnett, E., Gates, S., Hofmeyr, G. & Sakala, C. (2003). Continuous support for women during childbirth (Cochrane Review). *The Cochrane Library*, Issue 3, Oxford: Update Software.
- Hufft, A. (1992). Psychosocial adaptation to pregnancy in prison. *Journal of Psychosocial Nursing and Mental Health Services*, 30, 19-22.
- Kayne, M., Greulich, M. & Albers, L. (2001). Doulas: An alternative yet complementary addition to care during childbirth. *Clinical Obstetrics and Gynaecology*, 44, 692-703.
- Kennell, J., Klaus, M., McGrath, S., Robertson, S. & Hinkley, M. (1991). Continuous emotional support during labor in a US hospital. *Journal of the American Medical Association*, 265, 2197-2201.
- Lantz, P., Low, L., Varkey, S. & Watson, R. (2005). Doulas as childbirth paraprofessionals: Results from a national survey. *Women's Health Issues*, 15, 109-116.
- Llewellyn, G., Mayes, R. & McConnell, D. (2008). Editorial: Towards acceptance and inclusion of people with intellectual disability as parents. *Journal of Applied Research in Intellectual Disability*, 21, 293-295.
- Llewellyn, G. & McConnell, D. (2002). Mothers with learning difficulties and their support networks. *Journal of Intellectual Disability Research*, 46, 17-34.
- Macintyre, G. & Stewart, A. (2011). For the record: the lived experience of parents with a learning disability- a pilot study examining the Scottish perspective. *British Journal of Learning Disabilities*, 40, 5-14.
- Mayes, R., Llewellyn, G. & McConnell, D. (2008). Active negotiation: Mothers with intellectual disabilities creating their social support networks. *Journal of Applied Research in Intellectual Disability*, 21, 341-350.
- McConnell, D., Dalziel, A., Llewellyn, G., Laidlaw, K. & Hindmarsh, G. (2008). Strengthening the social relationships of mothers with learning difficulties. *British Journal of Learning Disabilities*, 37, 66-75.
- Oakley, A. (1988). Is social support good for the health of mothers and babies? *Journal of Reproductive and Infant Psychology*, 6, 3-21.
- O'Keeffe, N. & O'Hara, J. (2008). Mental health needs of parents with intellectual disabilities. *Current Opinions in Psychiatry*, 21, 463-468.
- Pascali-Bonaro, D. & Kroeger, M. (2004). Continuous female companionship during childbirth: A crucial resource in times of stress or calm. *Journal of Midwifery & Women's Health*, 49, (suppl. 1), 19-27.
- Porter, E., Kidd, G., Murray, N., Utyman, C., Spink, A. & Anderson, B. (2012). Developing the pregnancy support pack for people who have a learning disability. *British Journal of Learning Disabilities*. Advance online publication. doi: 10.1111/j.1468-3156.2011.00713.x
- Schroeder, C. & Bell, J. (2005). Labor support for incarcerated women: The Doula project. *The Prison Journal*, 85, 311-328.
- Smith, A., Flowers, P. & Larkin, M. (2009). *Interpretative Phenomenological Analysis: Theory, Method and Research*. Sage: London.
- Stenfert Kroese, B., Hussein, H., Clifford, C. & Ahmed, A. (2002). Social support networks and psychological well-being of mothers with intellectual disabilities. *Journal of Applied Research in Intellectual Disabilities*, 15, 324-340.
- Sterling, J. (1998). *Determinants of Parenting in Women with Mental Retardation*. The Fielding Institute, Ann Arbor: MI
- Tarleton, B., Ward, L. & Howarth, J. (2006). Finding the right support. A review of issues and positive practice in supporting parents with learning disabilities and their children. The Baring Foundation and The Norah Fry Research Centre, Bristol.
- Tucker, M. & Johnson, O. (1989). Competence promoting vs. competence inhibiting social support for mentally retarded mothers. *Human Organisation*, 2, 95-107.
- Ward, L. & Tarleton, B. (2007). Sinking or swimming? Supporting parents with learning disabilities and their children. *Learning Disability Review*, 12, 22-32
- Wilson, J. & Leasure, R. (1991). Cruel and unusual punishment: The health care of women in prison. *The Nurse Practitioner*, 16, 36-39.
- Zhang, J., Bernasko, J., Fahs, M. & Hatch, M. (1996). Continuous labor support from labor attendant for primiparous women: A meta-analysis. *Obstetrics & Gynaecology*, 88, (4, part 2), 739-744.

The Dignity Advocate

- Lyberg A, Severinsson E. (2010) *Fear of childbirth: mothers' experiences of team midwifery care: a follow-up study*. *Journal of Nursing Management* Vol 18 (4): pages 383-390
- Matthews R, Callister L. (2004) *Childbearing women's perceptions of nursing that promotes dignity*. *Journal of Obstetric, Gynaecologic and Neonatal Nursing*. Vol 33 (4): Pages 498-507

Meyer J. (2010) *Promoting dignity, respect and compassionate care*. Journal of research in Nursing. Vol 15 (1): Pages 69-73

RCN. (2008) *Defending dignity – challenges and opportunities for nursing*. [online] www.rcn.org.uk/data/assets/pdf_file/0011/166655/003257.pdf.

RCOG. (2011) *High quality women's health care: a proposal for change*. RCOG Press: London.

Widang I, Fridlund B, Martensson J. (2008) *Women patients' conceptions of integrity within health care: a phenomenographic study*. Journal of Advanced Nursing. Vol 61: Pages 540-548.

Services for women escaping domestic abuse

Centre for Maternal and Child Enquiries (CMACE). *Saving Mothers' Lives: reviewing maternal deaths to make motherhood safer: 2006–08. The Eighth Report on Confidential Enquiries into Maternal Deaths in the United Kingdom*. BJOG 2011;118 (Suppl. 1):1–203.

Domestic Violence London. 2013. *What is Domestic Violence/Introduction*. www.domesticviolencelondon.nhs.uk/1-what-is-domestic-violence/. Accessed 26 August 2013.

Doula UK. 2012. *Doula UK Survey Shows Doulas Have Significant Impact on Birth and Breastfeeding*. www.doula.org.uk/content/doula-uk-survey-shows-doulas-have-significant-impact-birth-and-breastfeeding. Accessed 26 August 2013.

Hodnett, ED., Gates, S., Hofmeyr, GJ. & Sakala, C. *Continuous support for women during childbirth* Cochrane Database of Systematic Reviews 2007, Issue 3.

NHS Choices. 2011. *NHS Choices: Feeling depressed after childbirth*. www.nhs.uk/conditions/pregnancy-and-baby/pages/feeling-depressed-after-birth.aspx. Accessed 15 Feb 2013.

Deaf Nest Project: Improving childbirth and pregnancy experience for a deaf couple

Action on Hearing Loss (2011). *Facts and figures on deafness and tinnitus*. London: The Royal National Institute for Deaf People.

Bahan, B., Hoffmeister, R. & Lane, H. (1996). *A journey into the deaf-world*. United States of America: DawnsSignPress.

Berg, M. (2005). *A Midwifery Model of Care for Childbearing Women at High Risk: Genuine Caring in Caring for the Genuine*. Journal of Perinatal Education, 14(1), 9-21.

Bramwell, R., Harrington, F., & Harris, J. (2000). *Deafness-disability or linguistic minority?* British Journal of Midwifery, 8(4), 222-224.

Brown, J. (2003). *Good practice*. Disability, Pregnancy & Parenthood International, 42, 8-9.

Centre for Maternal and Child Enquiries (CMACE). (2011). *'Saving mother's lives: reviewing maternal deaths to make motherhood safer 2006-2008'*. The Eighth Report on

Confidential Enquiries into Maternal Deaths in the United Kingdom. *British Journal of Obstetrics & Gynaecology*, 118(S1), 1-203.

Deaf Parenting UK, (2007). *Deaf Parenting UK Annual Report 2005-2006*. London: DPUK.

Devlin, G. (1992). *Breaking the sound barriers*. Nurs Times, 88(46), 26-28.

Fusick, L. (2008). *Serving Clients with Hearing Loss: Best Practices in Mental Health Counseling*. Journal of Counseling & Development, 86, 102-110.

Equality Act 2010. Chapter 15. London: The Stationery Office.

Iqbal, S. (2004). *Pregnancy and birth a guide for deaf women*. London: RND in association with the National Childbirth Trust.

Jackson, M. (2011). *Deafness and antenatal care: Understanding issues with access*, British Journal of Midwifery, 19 (5), 280 – 284.

Kelsall, J., King, D., & O'Grady, D. (1992). *Maternity Care for the deaf*. Scotland: Scottish Workshop Publications.

Kochkin, S., & Rogin, C. (2000). *'Quantifying the obvious: the impact of hearing instruments on quality of life'*. The Hearing Review.

Lynn, B. (2008). *Campaign for normal birth*. Disability, Pregnancy & Parenthood International, 64.

Marks, D. (1999). *Disability. Controversial Debated and Psychosocial Perspectives*. London: Biddles Ltd.

Martin, J., & Williams, J. (2006). *Good practice...Midwives' insights revisited*, Disability, Pregnancy & Parenthood International, 53, 10-11.

McAlear, M. (2006). *Communicating effectively with deaf patients*. Nursing Standards, 20 (19), 51-54.

McKay-Moffat, S. (2007). *Midwives' skills, knowledge and attitudes: how they can affect maternity services*. In S. McKay-Moffat (Ed.), *Disability in Pregnancy and Childbearing* (pp. 115-138). London: Churchill Livingstone.

McKay-Moffat, S., & Rotheram, J. (2007). *Maternity services and women's experiences*. In S. McKay-Moffat (Ed.), *Disability in Pregnancy and Childbearing* (pp. 49-74). London: Churchill Livingstone.

Munoz-Baell, I.B., & Ruiz, M.T. (2000). *Empowering the deaf. Let the deaf be deaf*. Journal of Epidemiology and Community Health, 54(1), 40-44.

NHS Commissioning Board website, (2012). *Nursing, Midwifery and Care-givers*. Retrieved from www.england.nhs.uk/wp-content/uploads/2012/11/board-5-nurse-strat.pdf

Nursing and Midwifery Council, (2012). *Midwives Rules and Standards*. NMC, London.

Nursing and Midwifery Council, (2008). *Codes and Conduct for Nurses and Midwives*. NMC, London.

Oliver, M. (2004). *If I had a hammer: the social model in action*. In C. Barnes, S. French, J. Swain & C. Thomas (Eds),

- Disabling Barriers- Enabling Environments (pp.7-12). London: Sage.
- Oliver, M. (2009). *Understanding Disability From Theory To Practice*. London: Palgrave Macmillan.
- Oliver, M., & Sapley, B. (1999). *Social Work with Disabled People*. London: Macmillan.
- O'Lunaigh, P., & Carlson, C. (2005). *Midwifery and public health*. London: Churchill- Livingstone.
- Price, C. (2012). Challenges of providing continuity of care to a deaf couple. *Essentially MIDIRS*, 5 (3), pp.47-49.
- Rogers, J. (2006). *The Disabled Woman's Guide to Pregnancy and Birth*. New York: Demos Medical Publishing.
- Rotheram, J. (2007). Resources... Disability, Pregnancy & Parenthood International, 58. Royal National Institute for Deaf People, (2004). *A simple cure*. RNID, London,
- Royal College of Nursing, (2007). *Pregnancy and disability. RCN guidance for midwives and nurses*. RCN, London.
- Scullion, P. (1999). Challenging discrimination against disabled patients, *Nursing Standards*, 13(18), 37-40.
- Shield, B. (2006). 'Evaluation of the social and economic costs of hearing impairment'. A report for Hear. AISBL, Belgium.
- Skelton, T., & Valentine, G. (2003). 'It feels like being Deaf is normal': an exploration into the complexities of defining D/deafness and young D/deaf people's identities. *The Canadian Geographer*, 47(4), 451-466.
- The Royal National Institute for Deaf People, (2011). *Hearing Matters- Action on hearing loss*. The Royal National Institute for Deaf People, London.
- Thomas, C. (1999). *Female Forms: Experiencing and understanding disability*. Buckingham: Open University Press.
- Wates, M. (2005). Good practice... Choice, equity and accessibility, *Disability, Pregnancy & Parenthood International*, 48, 10-11.
- Young, I.M. (1990). *Justice and the politics of difference*. Princeton: Princeton University Press.

