FREE FROM HARM

A resource for maternity care workers
on respectful care for all

Created by **White Ribbon Alliance UK**
for the **Safer Beginnings programme**

THE WHITE RIBBON ALLIANCE UK

Charity number: 1143376

FOREWORD

It is the right of every baby being born, every childbearing woman, birthing person, parent, and family, to receive health care without being harmed: by individuals, by the institutions that care for them, and within systems and cultures of care. This right seems to be self-evident, and it is my hope that few would disagree. So why then is harm so pervasive in much of the world and, in relation to this resource, in a nation like the UK? The situation is harmful not only to users of maternity services; there is harm to providers of care too. Midwives and other maternity care workers report poor working conditions, disrespect, psychological distress, moral injury, burn out and PTSD.

If we are to avoid harm, we must be ready to think about our priorities. Continuing to focus almost exclusively on whether a woman and her baby survive leads to harm. Understanding that trauma is not only associated with life threatening events, and that previous life events or current circumstances may render some experiences traumatic (even if they are seen by providers as routine), is essential. This reinforces the importance of treating and relating to every individual sensitively and with respect and compassion. To change a system, we need to peel back the layers. We need to honour each other's stories, thrive in our common humanities and work to advance a common purpose. We need to reframe safety.

Free From Harm, a resource created by White Ribbon Alliance – a locally led, globally connected organisation – helps us understand why, and provides a detailed road map to resolve the deeply rooted problems. WRA has worked with 18 community-based organisations, to explore what has led to widespread dehumanised care within the maternity services. The resource is rich with research, direct experiences, links to videos and podcasts, readings, and reflective exercises. This evidence is drawn from many sources including two of the most recent reviews of failures in care in England.

The aim of FFH might be seen as ambitious; to raise awareness of the need to eliminate violence and minimise harm, and to equip health care professionals with the information and tools to do so. This is seen in its determination not to soften language around obstetric violence, which is a systemic, institutional problem. FFH demonstrates that obstetric violence is a gender issue and part of the spectrum of violence and abuse of women and marginalised people, much of which derives from discrimination and inequalities. These structural, intersectional problems go beyond our NHS. They are embedded in society and require amplification so that they are discussed and treated as a wide social problem.

What is important about this resource and its aim is that it comes from grassroots movements as well as government-initiated reviews of failing services. It is built on principles of human rights, only recently applied to the maternity services. The concepts of respectful care, definitions of consent and human rights, obstetric violence, and trauma informed care are set out clearly. An understanding of these is vital to ensure all are free from harm.

The FFH resource is the foundation of a movement. To have every baby, every childbearing woman/birthing person, parent and midwife emerge from maternity care free from harm is not too much to expect. It is the basis, and expression of, a caring society.

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ACKNOWLEDGEMENTS

We would like to thank our delivery partners for their passion and knowledge; the WRA Board of Trustees for their steadfast support; the Department of Culture, Media and Sport for the vital funding that allowed us to undertake this programme of work; the editorial panel for their valuable feedback and input; Lesley Page for her moving foreword; March With Midwives for its commitment to speaking up for families and maternity care workers; and to everyone who shared their stories and experiences with us, even when they were painful. Your courage and your determination to change maternity care for the better are beautiful reminders of the humanity that unites us all.

Amity Reed

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INTRODUCTION TO FREE FROM HARM

Everyone deserves to live a life free from harm, whether that's at home, at work or school, in public, or whilst interacting with the institutions that provide services for us. This includes the right to be treated equally and humanely when receiving care. If done well, these interactions often have meaningful and positive impacts on our lives; indeed, many thousands of people have wonderful experiences of care every year. However, we know that harm can and does happen within the healthcare sector, including in the maternity services.

The 2022 Ockenden and Kirkup reports on devastating failures of care at maternity units reflect poorly not only on individual hospital trusts but on the system as a whole. Uncompassionate and dehumanised care, poor communication, poor staffing, poor leadership, and low morale are common themes in each report. These failures and their consequences are not down to a few 'bad apples' but deep-rooted and interlinked problems that are occurring all around the UK. The reality is that none of them can be addressed without also addressing the others. And yet, the actions that come out of recommendations for improvement continue to focus almost exclusively on whether mothers and babies survive pregnancy and birth, and on how many more staff can be recruited. But a healthy, functioning maternity care system is about much more than numbers and survival.

At White Ribbon Alliance UK our vision is for a gender equal world in which all people realise their right to good health and well-being, and where maternity care is rooted in respectful care for all. We strongly believe that improving the safety of giving birth in the UK includes not only short-term physical outcomes but long-term emotional and psychological ones too. We also believe that unless the well-being of healthcare professionals is addressed at the same time, cycles of violence and distress will continue to occur. Respectful care for all means for those providing care too.

Trauma and Harm

At present, one-quarter of people who give birth in the UK each year find their experience traumatic in some way, with 1 in 25 of those women developing Post Traumatic Stress Disorder (PTSD) as a result. And while not all birth trauma is caused by disrespectful or abusive treatment, a significant proportion is. Trauma in the perinatal period can lead to a variety of complications and negative outcomes for families' health and well-being and, consequently, for public health and society in general.

We also know that ethnic minority women are at a much higher risk of experiencing maternal morbidities and mortality, with Black women at a 4x greater risk of dying in the childbearing year and Asian women at a 2x greater risk than their white peers. Black babies are also at a significantly increased risk of stillbirth, premature birth and neonatal death compared to those born to white women.

At the same time, midwives and other maternity care workers are reporting record-high levels of stress, vicarious trauma, and burnout. In the 2018 WHELM study, one-third of midwives reported feelings of depression and/or anxiety, two-thirds were experiencing work-related burnout, and more than 60 percent were seriously considering leaving midwifery in the next six months. These figures have undoubtedly worsened further since the Covid-19 pandemic. In the last year, nearly 500 midwives have left the profession altogether, with many more leaving their jobs to move into healthcare-adjacent roles.

In the face of these statistics, it's difficult to deny that widespread harm is occurring and having a catastrophic impact on people's lives. Urgent action is necessary to address the mounting crises.

The Safer Beginnings Programme

White Ribbon Alliance UK launched a programme of work called Safer Beginnings in October 2021. Funded by the Department of Culture, Media and Sport, this programme aims to improve the maternal health outcomes and postnatal safety of over 70,000 women across England, Wales and Scotland, of whom 13,350 are from ethnic minority groups, with a focus on reducing obstetric violence, domestic violence and FGM.

As part of the Safer Beginnings programme, we have worked with 18 delivery partners in the creation of new content and resources to support maternity care workers and the people in their care. More information on these organisations and access to their resources can be found here

Editorial Note

Some of the material contained within this resource may evoke difficult feelings or challenge existing views, but we hope that it can be a springboard for the honest conversations that need to take place in order to make maternity care safer and more satisfying for everyone. We also hope that it will be received in the spirit with which it was conceptualised and created: one of positivity, empowerment and looking towards the future, where respectful care for all is no longer a goal, but a reality.

Support Resources

A list of organisations that offer support for those affected by the issues raised in this resource are available here:

How to Get Help - Signposting for Trauma and Harm in Maternity

AIMS AND USES OF THE RESOURCE

The Free From Harm (FFH) resource is for anyone working within maternity care services, though its focus is primarily on midwives. This is because midwifery is the more marginalised occupation in the maternity services, with a majority female workforce, a significant proportion of which are also from ethnic minority groups.

The aim of FFH is not only to raise awareness of the need to eliminate violence and minimise harm in the perinatal period, but to equip healthcare professionals (HCPs) with the information and tools to do so.

Engaging with the FFH resource goes beyond just reading the information it contains though. We encourage everyone who is committed to helping maternity care become a more inclusive, compassionate space to engage fully with the additional resources, training offers, and community-building ideas outlined here. We also want to encourage conversations amongst colleagues and leaders, about what changes can be made at the personal, community and institutional levels. To aid this, we have included reflective questions that readers may wish to work through privately or in small groups.

Towards the end of the resource, we have also included the **Free From Harm Declaration**, which outline the values that all humans deserve to life a life free from harm. If this declaration is realised, we can expect improvements in perinatal experiences and a reduction in harm. We encourage those committed to delivering respectful maternity care to adopt and share these amongst staff, reinforcing the values that are central to a rights-based system of health care.

HUMAN RIGHTS IN HEALTH CARE

Introduction

It is important to understand the framework of human rights as they relate to women and birthing people receiving care, and to also be aware of midwives' rights at work. Understanding these rights is fundamental to effectively advocate for people receiving and providing care, as they explain the legal and ethical basis upon which one's actions can be justified.

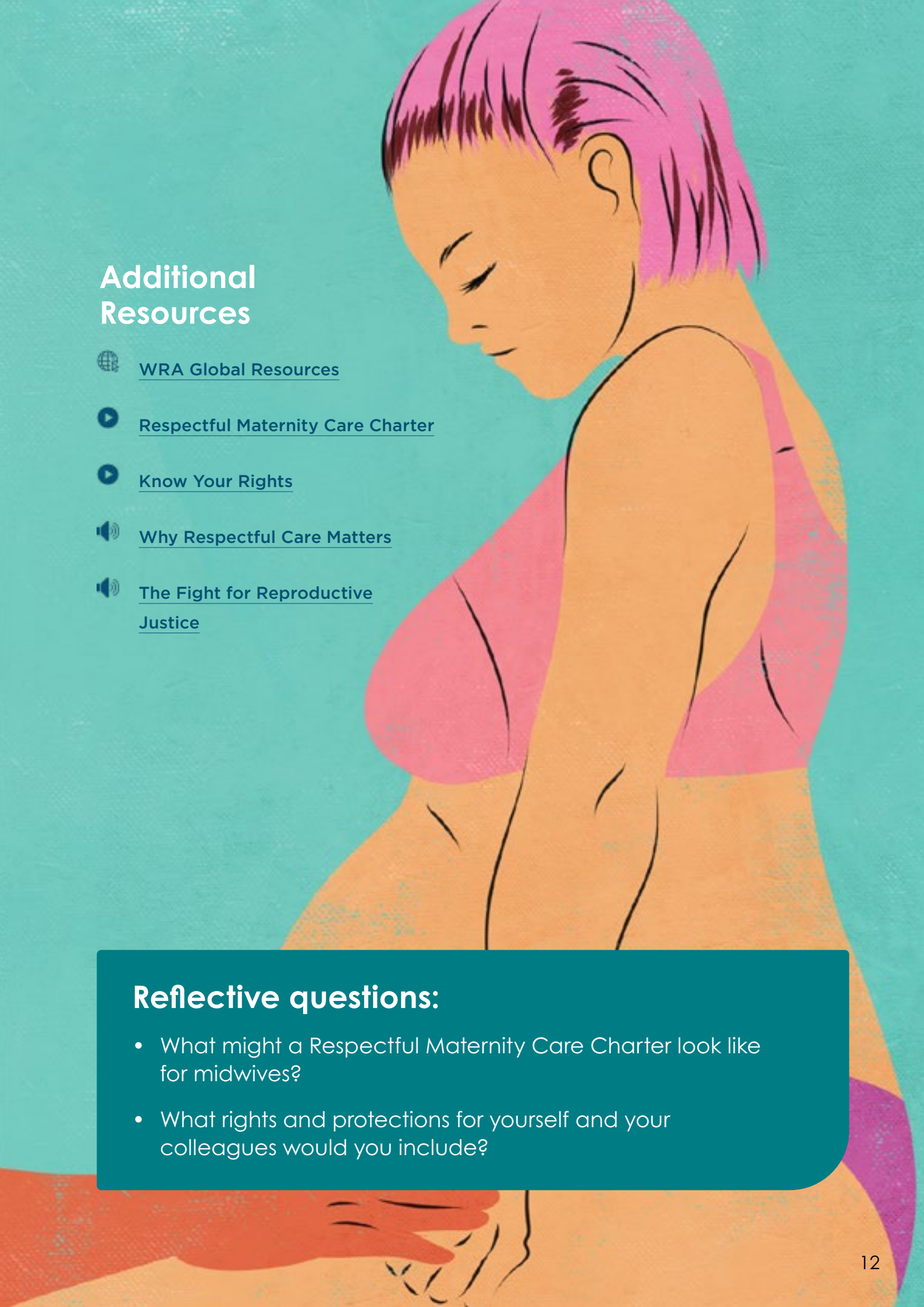
The Respectful Maternity Care Charter

In 2011, White Ribbon Alliance created and launched the Respectful Maternity Care Charter, a declaration of rights for mothers and newborns.

The Charter addresses the issue of disrespect and abuse toward women and newborns who are utilising maternal and newborn care services and provides a platform for improvement through:

- Raising awareness for women's and newborns' human rights guarantees that are recognised in internationally adopted United Nations and other multinational declarations, conventions and covenants;
- Highlighting the connection between human rights guarantees and healthcare delivery relevant to maternal and newborn healthcare;
- Increasing the capacity of maternal, newborn and child health advocates to participate in human rights processes;
- Aligning women's demand for high-quality maternal and newborn care with international human rights law standards;
- Providing a foundation for holding governments, the maternity care system and communities accountable to these rights;
- Supporting healthcare workers in providing respectful care to women and newborns and creating a healthy working environment.

Access the full Charter here.



Additional Resources

- WRA Global Resources
- Respectful Maternity Care Charter
- Know Your Rights
- Why Respectful Care Matters
- The Fight for Reproductive Justice

Reflective questions:

- What might a Respectful Maternity Care Charter look like for midwives?
- What rights and protections for yourself and your colleagues would you include?

Consent

When it comes to consent for treatment, the responsibility to get things right can be overwhelming at times. After the landmark ruling of Montgomery v Lanarkshire, ensuring that informed consent is facilitated has become more important than ever. But though it can seem like a tricky subject based on complicated laws and medical ethics, one with many grey areas, the foundation of consent is simple.

If we look at the emerging models of consent for sex, which emphasise gaining an 'enthusiastic yes' rather than relying on a 'forceful no', we can see how some of the principles are quite similar and could be applied to maternity care as well. Those whose consent is being sought need to feel safe in their ability to say yes or no, and to know that their decision will be respected. In scenarios where physical contact is being initiated by one person towards another, it is the initiator's responsibility to gain consent before touching the other person, through an assessment of their verbal and body language.

Part of consent being Freely given is that there is no pressure or expectation of a certain answer being given or decision being made; it is simply a question being asked – 'Would you like X? Can I do Y?' Reversible means that the person is free to change their mind at any time, no matter how far into the situation they are, and Informed meaning they have all the information available to make decisions that feel right for them. Enthusiastic means just that: consent should never be hesitant or only given because a person doesn't possess the confidence or language to express their discomfort, or because they are too frightened to do so.

Planned Parenthood's **FRIES** model emphasises that consent should meet five criteria:

Freely Given,
Reversible,
Informed,
Enthusiastic and
Specific.

Careful observation of body language is paramount here. And Specific is an important principle of consent too – just because someone says yes to one interaction does not mean they have automatically given consent for subsequent interactions too.

Similarly, pregnant women and birthing people need a sense of safety and agency when being asked to consent to an examination, treatment or procedure. They not only need to understand the risks and benefits of any particular action, but to be comfortable in their environment and with their caregivers. Knowing that their choices and rights will always be respected and that they can change their minds at any time gives women the confidence to take a full and active role in the decision-making process, which can be a hugely positive experience and influence their sense of autonomy in other areas of their lives going forward.

As with sexual intimacy, it's crucial that the absence of 'no' is not the only method of assessing consent. If observed carefully, body language and subtle cues might indicate a lack of consent, even if verbal agreement has been given. It is also important for midwives to consider the inherent power imbalance between HCPs and those seeking care - which is even more dangerously skewed for ethnic minority women - and exacerbated by the vulnerability of pregnancy and birth.

Direct, honest communication – without bias, manipulation or coercion, no matter how subtle or unconscious – is paramount to providing respectful care.

Reflective questions:

- When you are giving consent for yourself, what sorts of phrases, actions and environments make you feel most comfortable?
- As a care provider, how can you better implement some of the principles of enthusiastic, informed consent into your practice?
- If there are any words or phrases you routinely use when gaining consent or undertaking intimate exams, how can you evaluate whether the people in your care find them helpful, neutral or harmful?

Care Outside the Lines

An important part of using a human rights framework to deliver care is understanding how to adequately support anyone who makes an informed decision to decline certain aspects of the recommended pathway or who requests care that is 'outside of guidance'. The first thing to remember is that guidelines are just that: guides, or suggestions. They are not hard-and-fast rules that require strict rigidity or enforcement; they are meant to act as a guide for the conversations that need to take place between expectant parents and their caregivers. If, after a thoughtful, factual and supportive conversation, a person has chosen to decline any part of the care being offered, that is their legal and human right and should be treated as such, with no further attempts to convince them otherwise.

Using the principles of informed consent and bearing in mind the ethos of respectful care demonstrated throughout this resource, it should be clear that coercion is not an appropriate response to those choosing pathways outside the institution or the practitioner's usual scope of practice.

Coercion includes omitting or skewing statistics, giving personal opinions on what a person should do, or using manipulative tactics to influence their decisions. Implying or outright telling someone that their legally protected choices will harm or have a high chance of harming their baby is unacceptable practice. Scaring a mother into compliance is part of obstetric violence, whether we believe the risks to her baby are valid and likely or not.

Dealing with Professional Discomfort

Midwives and doctors may experience feelings of fear or worry about being blamed when they are supporting care outside the lines. However, many of those worries can be alleviated by knowing that respecting and facilitating informed decision making is the gold standard of care and is legally protected under the law.

If uncomfortable feelings and fears do arise around a birthing person's informed choices, these feelings should be addressed privately, away from the expectant parent. Midwives can seek support from a Professional Midwifery Advocate (PMA), who can help guide them through challenging situations. Alternatively, a union rep, trusted colleague or external organisations like Birthrights may be able to aid or support HCPs through any tricky issues that may come up.

It is midwives' professional and moral duty to safeguard women's choices and to uphold their rights, just as midwives would want their own rights protected.

We mustn't let fear becomes the primary emotion driving our actions: fear diminishes trust and respect, irreparably harming the midwife-mother relationship and birthing people's self-agency.

Additional Resources

- Birthrights: Human Rights in Maternity Care
- Birthrights: Consenting to Treatment
- Birthrights and GMC: What Does Informed Consent Mean in Maternity Care?
- Claire Feeley: Practising Outside of the Box Whilst Within the System
- RCM: Informed Decision Making
- RCOG: Obtaining Valid Consent
- Hannah Dahlen: Birthing Outside the System

Human Rights for Midwives Matter Too

Just as pregnant people are vulnerable to human rights buses when receiving care, midwives are also subject to gender-based discrimination and abuse in the workplace.

Though there are different factors and power structures at play within each group, both experience inequality and harm.

When midwives' rights are discussed, it is often in relation to pay, education and training standards, employment rights, and professional autonomy. And while these issues are of course important and urgently need addressing, it isn't as often that we talk about how midwives are being harmed, individually and collectively, in terms of their physical, emotional and mental health.

A Crisis in Midwifery

Though we've known for many years that midwives are under ever-increasing pressure at work, the publication of the WHELM study in 2018 clearly demonstrated the extent to which midwives are suffering, both personally and professionally, with unprecedented levels of anxiety, depression, work-related stress, and burnout reported.

Efforts to combat low levels of morale and well-being with 'self-care' promotion and 'resilience' training have largely been ineffective, with more staff than ever reporting they are thinking of leaving. Midwifery's rate of attrition is amongst the worst in health care, with nearly 60 percent of those surveyed by the Royal College of Midwives (RCM) in 2021 stating that they would like to leave the NHS in the next year. Midwives clearly feel that their needs are not being met at work, nor are the needs of the families they care for.

Reflective question:

If your human rights and working conditions were better protected, how might that positively influence the care you give and your own well-being?

Protecting Midwives' Rights

The proficiencies set out for midwives by the Nursing & Midwifery Council (NMC) are founded in human rights values and include the duty 'to anticipate and to recognise any changes that may lead to complications and additional care needs; these may be physical, psychological, social, cultural, or spiritual...' We believe that the same considerations need to be taken into account when evaluating midwives' working conditions and ability to perform their duties with the care, compassion, commitment, competence, communication and courage (the 6 C's) they trained for and want to provide.

If midwives and other maternity care workers are not being given regular access to rest and toilet breaks, food and water, a fair and reasonable workload, and the support necessary from management to ensure their emotional well-being and safety, then their rights are also being violated in contravention of human rights and employment law. That this way of working has become normalised in the NHS does not make it acceptable, nor should anyone be expected to work in those conditions without complaint.

Working in a high-stress and high-trauma environment, with low support and low morale, has severe personal consequences for staff, not to mention the knock-on effect on patient care and safety.

It's time for a conversation and a framework that considers not only midwives' responsibilities towards ensuring birthing people's human rights are upheld, but one in which midwives' human rights are protected and upheld alongside them. It is only when everyone in maternity care is being treated equally, fairly and kindly - and being listened to, cared for and respected - that we can ever hope to affect change.

Additional Resources

- NMC: The Code
- RCM: Flexible working guidance
- RCM: Standing up for high standards
- ICM: Bill of rights for women and midwives

OBSTETRIC VIOLENCE AND ITS IMPACT

Before we can begin to make progress on reducing the harms of obstetric violence, first we must understand what it is, how to recognise it, and what the impact is on those who experience and witness it.

Origin and Usage of Obstetric Violence

The term 'obstetric violence' (OV) originated in Venezuela (where there is very little midwifery presence) in 2007, as a legal response to mistreatment during childbirth. Much of the academic and humanitarian work that emerged from this response continued using the term, though it is contentious and has been debated. Some researchers and care providers prefer to frame the issue as one of 'disrespect and abuse' rather than violence, though feminist analysis often highlights the fact that because birth is experienced solely by women and non-binary people or trans men with biologically female reproductive systems, OV is a form of sex or gender-based violence and must be recognised as such in order to successfully combat it.

Feminist anthropological research by van der Waal et al. also asks us to consider the importance of preserving the origin and meaning assigned to OV. The authors state: "It is often argued that the term risks alienating healthcare workers by indicating intentionality, prompting defensive reactions instead of enhancing obstetric care. Obstetric violence should, however, first and foremost be regarded, and judged, as a feminist activist keyword that addresses a structural problem in reproductive healthcare from the viewpoint of its victims."

As a people-led movement for a gender-equal world, White Ribbon Alliance believes it is essential that we continue to have nuanced, sensitive discussions on this topic but, at the same time, resist the urge to soften language around behaviours and systems that cause trauma and harm. Therefore, while we acknowledge that not everyone will identify or be comfortable with the term 'obstetric violence', it is the most appropriate term for the purposes of this resource and our aims.

Additional Resources

- Obstetric Violence: Realities and Resistance From Around The World
- Dehumanized, Violated, and Powerless

Definitions and Categorisations

In 2010, researchers identified seven categories of disrespect and abuse in facility-based childbirth, to help identify what is meant by obstetric violence.
They are:

- **Physical abuse**
- **Non-consented care**
- **Non-confidential care**
- **Non-dignified care**
- **Discrimination**
- **Abandonment of care**
- **Detention in facilities**

While these classifications help to describe obstetric violence, it still does not answer the question of precisely what it is. In 2014, a report by Freedman et. al for the World Health Organization (WHO) attempted to move beyond descriptions and more broadly define what we mean by 'disrespect and abuse'. Is it dependent on the caregivers' intentions? Is it defined by birthing people's subjective interpretations? Can actions or behaviours still be categorised as abuse if it is not experienced or viewed as such due to its normalisation within the culture?

The authors state:

> " As a starting point for research and action, we define disrespect and abuse in childbirth as interactions or facility conditions that local consensus deems to be humiliating or undignified, and those interactions or conditions that are experienced as or intended to be humiliating or undignified. "

Dehumanised Care

As part of the International Confederation of Midwives (ICM) Respect Toolkit, a video presented by Professor Soo Downe portrays a scene of obstetric violence from a woman's point of view, demonstrating how poor communication, physical mistreatment, and uncaring and paternalistic attitudes can lead to a situation in which the person giving birth is dehumanised.

CONTENT WARNING:

Though the scene is a dramatisation using actors, viewers may find it distressing.

Click here to watch the video

Reflective questions:

- Have you ever been involved in or witnessed a situation similar to this one?
- If so, how did it make you feel? How do you think it made the other people in the room feel?
- What sorts of factors or reasons do you think might lead to situations like these happening?

Individual and Structural Obstetric Violence

The table on page 22 gives an overview of how disrespect and abuse play out at different levels within maternity care systems, which helps us to see the complex layers of OV, even when it is normalised. It also helps to clarify that OV is a much wider problem than individuals being unkind or abusive; it is a systemic, structural problem that reaches far beyond interpersonal interactions into the entirety of the system, including the organisational cultures that harm midwives and other HCPs working within it.

Looking at this image, it's easy to see why we often focus on what's right in the centre, the 'bullseye' that is easy to identify. But the most obvious problem is not always the most pervasive. The further away from the centre the problems lie, the more difficult they can be to name. It is easier to call out physical abuse that happens right before our eyes and much harder to call out coercion or bullying, especially if it's subtle or occurring within an established hierarchy where we don't have as much power as others within it.

Fig. 1. Defining disrespect and abuse of women in childbirth

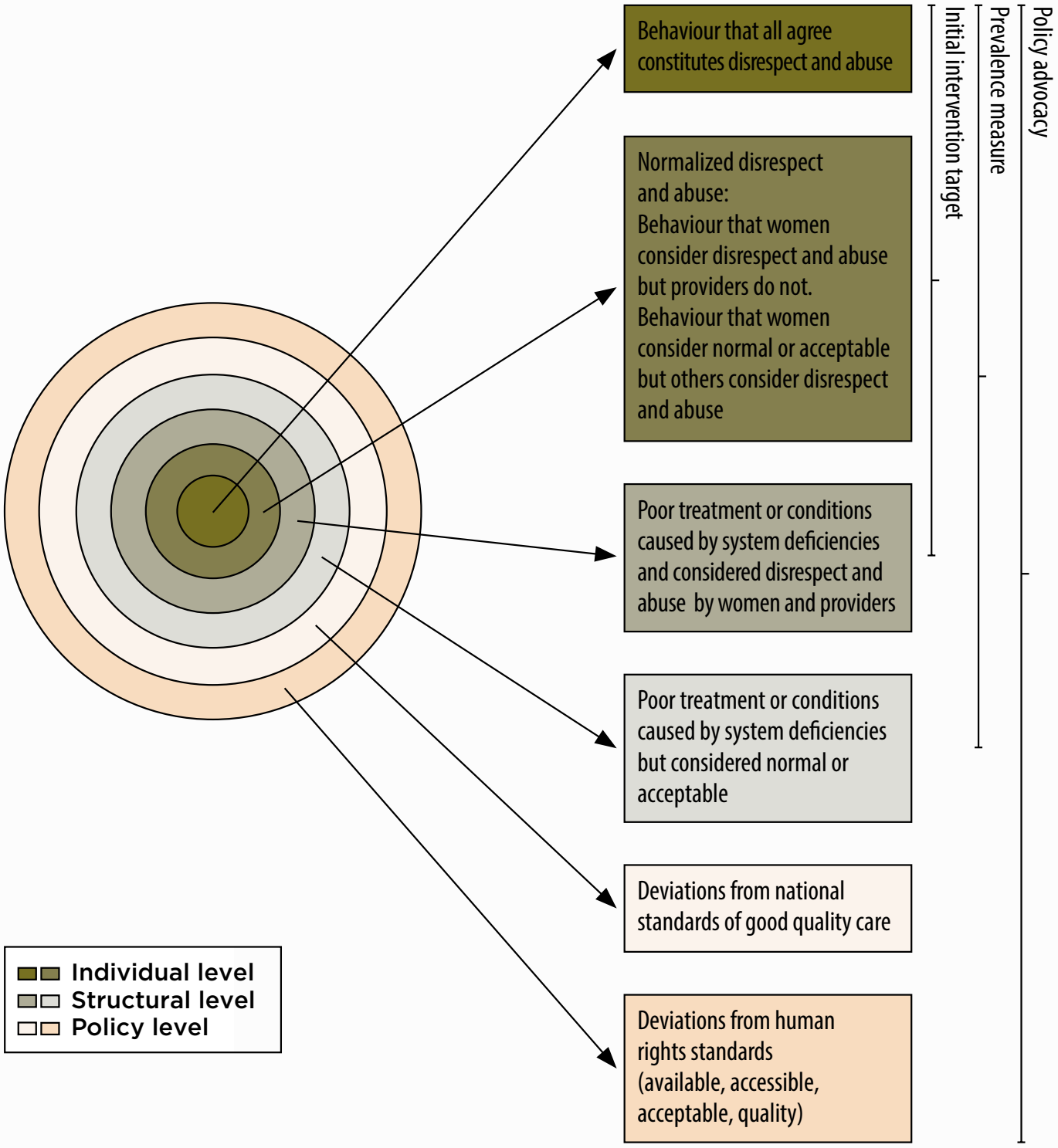


Fig. 1: Freedman et al. Defining disrespect and abuse of women in childbirth: a research, policy and rights agenda. Bulletin of the World Health Organization (2014).

The Impact of Obstetric Violence

Obstetric violence likely contributes to:

- Maternal mortality disparities that mean Black women die at a rate four times greater than their white counterparts, and Asian women at twice the rate
- Rising rates of birth trauma, postnatal depression, and PTSD
- The vicarious trauma, moral injury and emotional distress experienced by midwives, resulting in higher-than-average rates of mental health mental health disorders, substance misuse, and suicide than the general public
- The alarmingly high attrition rate in midwifery, which weakens the profession and threatens its autonomy

The importance of identifying, acknowledging, and addressing obstetric violence in maternity care is more urgent now than it has ever been.

Not only is it traumatising many thousands of women every year, but it is also traumatising HCPs working within a harmful system.

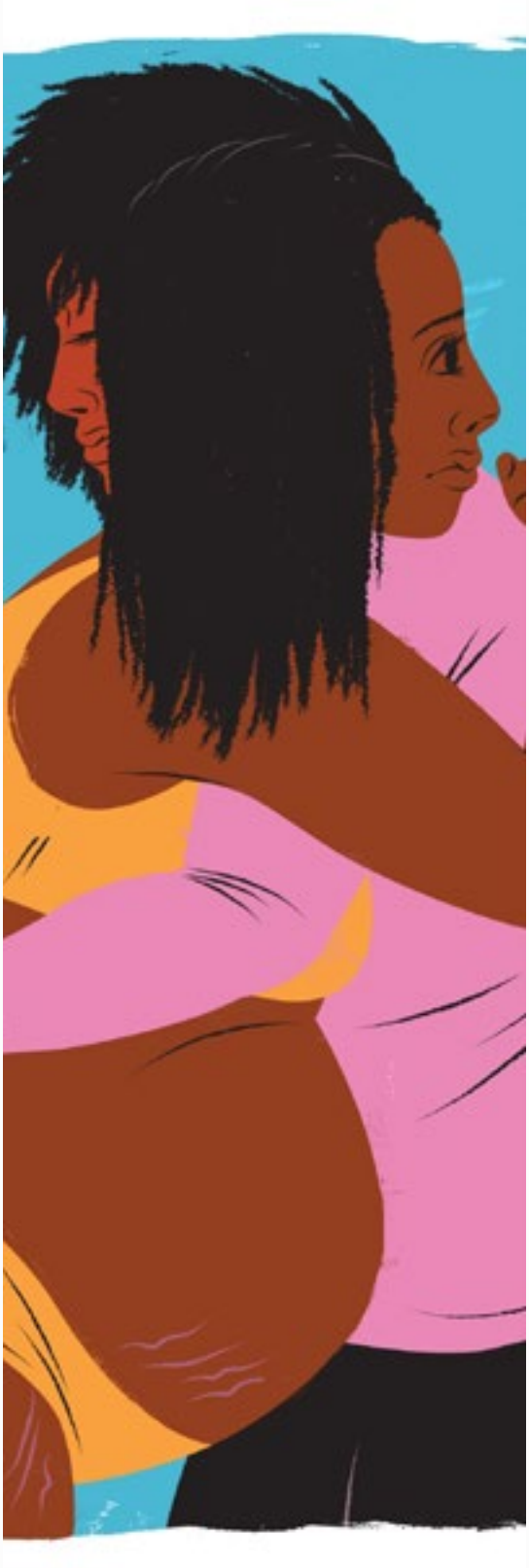
This is not an issue that only concerns a handful of people. OV is a systemic, pervasive and avoidable harm and it is the responsibility of all of us to work together to eradicate it. Blame and pointing the finger elsewhere does nothing to take accountability and only wastes time that would be better spent solving the problem.

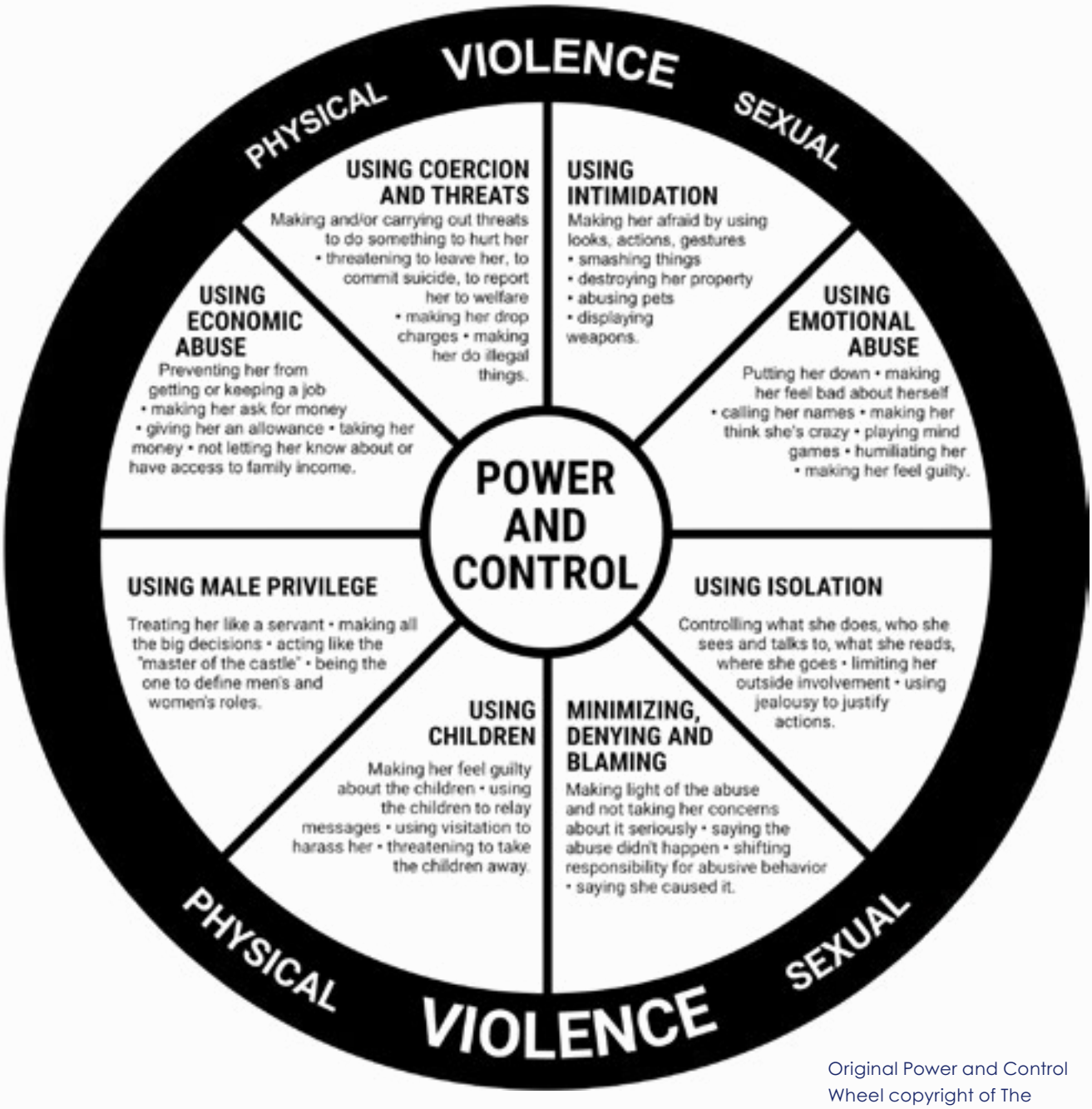
Gendered Conditioning and Intersectional Identities

Though many (but not all) of us receiving and working in midwifery care are women and we may feel we understand what it is to be oppressed for characteristics beyond our control, we are all still vulnerable to ingrained ideas of gendered behaviour and subject to the same discriminatory behaviours we witness within our own social and cultural groups. This is further compounded by any other minority identities we or others may have, such as race, nationality, sexuality, religion or gender.

Even if we are not consciously aware of it, we have all been conditioned by society to value and prioritise white male bodies, ideas, opinions and experiences over those of other groups. And though there is an increasing awareness of the harm and inequality this has caused, and action has begun to redress these historic imbalances, the work it entails is not easy or quick. Eradicating injustices requires time, energy, passion, and a commitment to change from all of us, in every corner of society.

The first step towards progress is coming together to identify a problem that we want to address and looking at it from all angles, through a lens of compassion, honesty, and a willingness to engage in meaningful conversation. We hope that by placing obstetric violence into the context of other forms of gender-based abuse, we can see more clearly how it manifests.





Power and Control

The diagram to the left shows the original Power and Control Wheel, created by the Domestic Abuse Intervention Programs. It demonstrates very effectively the many ways in which abuse and violence manifest in relationships where there is a power imbalance, particularly when that imbalance is influenced by gender. This model is used around the world, in helping both those who perpetrate and experience domestic violence to recognise these actions as harmful. Learn more about The Duluth Model here.

Obstetric Power and Control Wheel

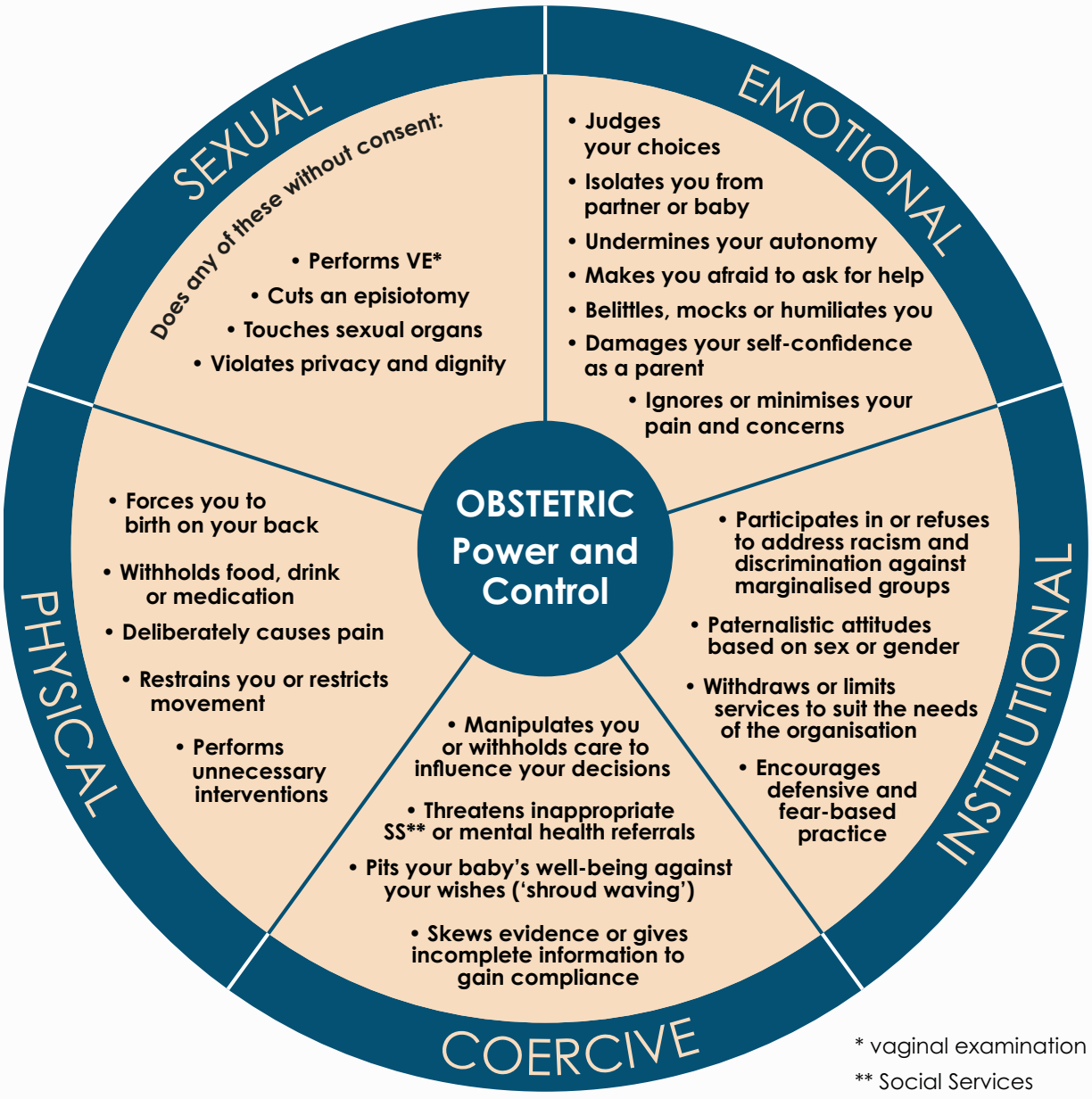
We have created an approved adaptation of wheel to demonstrate how Obstetric Violence is also a form of gender-based violence, outlining the ways in which power and control can be exerted, often unconsciously, over women giving birth. This does not mean that women (including midwives) are incapable of inflicting harm, but that the paternalistic nature of the obstetric model of care and the hierarchies within it are the primary drivers behind behaviours that inflict violence on birthing people. By placing Obstetric Violence in this context, it becomes clearer to see how OV manifests and is experienced.

Workplace Power and Control Wheel

The second wheel we have created outlines acts of harm and abuse inflicted by the maternity services on the midwives and other healthcare professionals working within it. This demonstrates how the system itself, in its current state, is violent and harmful to maternity workers too. It is important to name and call out these abuses not only because it is causing direct harm to healthcare staff, but because we cannot hope to achieve compassionate, respectful, and safe care for women and babies if staff are not being shown the same kind of compassion, respect and care that they deserve to experience at work.

Support organisations and resources can be found on Page 8

OBSTETRIC
POWER AND CONTROL WHEEL



* vaginal examination

** Social Services

Adaptation of the original Power and Control Wheel approved by The Domestic Abuse Intervention Programs TheDuluthModel.org

WORKPLACE
POWER AND CONTROL WHEEL

Adaptation of the original Power and Control Wheel approved by The Domestic Abuse Intervention Programs TheDuluthModel.org

STORYTELLING: IN THEIR OWN WORDS

White Ribbon Alliance believes in the power of storytelling to connect people, foster positive relationships, and enact change. By sharing our own experiences and listening to others with an open mind and heart, we become more engaged in conversations and in our communities. When we hear each other, we can begin to understand each other. Storytelling comes with its own challenges though, which need to be addressed in a thoughtful and sensitive way.

Challenges

Hearing someone speak about upsetting things that have happened to them and the harms that they've experienced as a result can be very difficult, especially if their negative experience was due to the behaviour of those listening, or people known to the listeners. Receiving these stories may evoke a variety of feelings and reactions, some of which will be challenging to process. What's important is how those initial feelings are dealt with and responded to.

Honouring an experience and respecting its significance to the storyteller begins with understanding that intent and impact are two separate things.

Regardless of anyone's intentions with their language or actions, if it has a negative impact on the person it is directed towards, it is harmful and should be recognised as such.

Intent vs Impact

Acknowledging that OV is largely an institutional and societal problem rather than a collection of individuals intentionally harming people is an important step if we want to address it head-on. Equally as important is accepting that the impact of our actions is separate from the intent behind them. Being able to put aside personal feelings, beliefs, and interpretations of events is crucial as we seek to minimise harm, now and in the future. Instead, we should listen to, believe, and empathise with those who are affected.

Additional Resources

- Impact vs Intent by Nyanga Uuka
- Intent vs Impact | Understanding the Difference

Stories of Obstetric Violence

The quotes displayed on the subsequent pages are from people who have experienced obstetric violence. Their stories were submitted via They Said To Me, an organisation dedicated to providing a safe space for pregnant and birthing women and people, to give voice to the coercion and abuses happening within maternity services.

Content warning:
These stories may be difficult to read, particularly if you have suffered birth trauma or are currently struggling with vicarious trauma from witnessing similar abuses. Please take good care of yourself and seek support if needed.

Support organisations and resources can be found on Page 8

“ I cried ‘Please stop. Please stop.’ She never asked for consent. ”

“ The consultant said to me ‘If you were my daughter you would not still be pregnant now, you would have had your section weeks ago’ as he tried to coerce me into a caesarean section at 40+3. At 41+2 he said ‘Do you want your baby to die, is this why you don’t want the caesarean? ”

“ She asked me where I was giving birth, I said I was aiming for a home birth and she laughed at me. For the rest of the appointment she made me feel so small. When I said goodbye, she said, ‘Yes, see you in the labour ward’. ”

" I asked to discuss the evidence for intervention in FGR (they wanted to induce me), the doctor said 'I'm not interested in evidence. I'm interested in lives', shutting down my right to make an informed decision. "

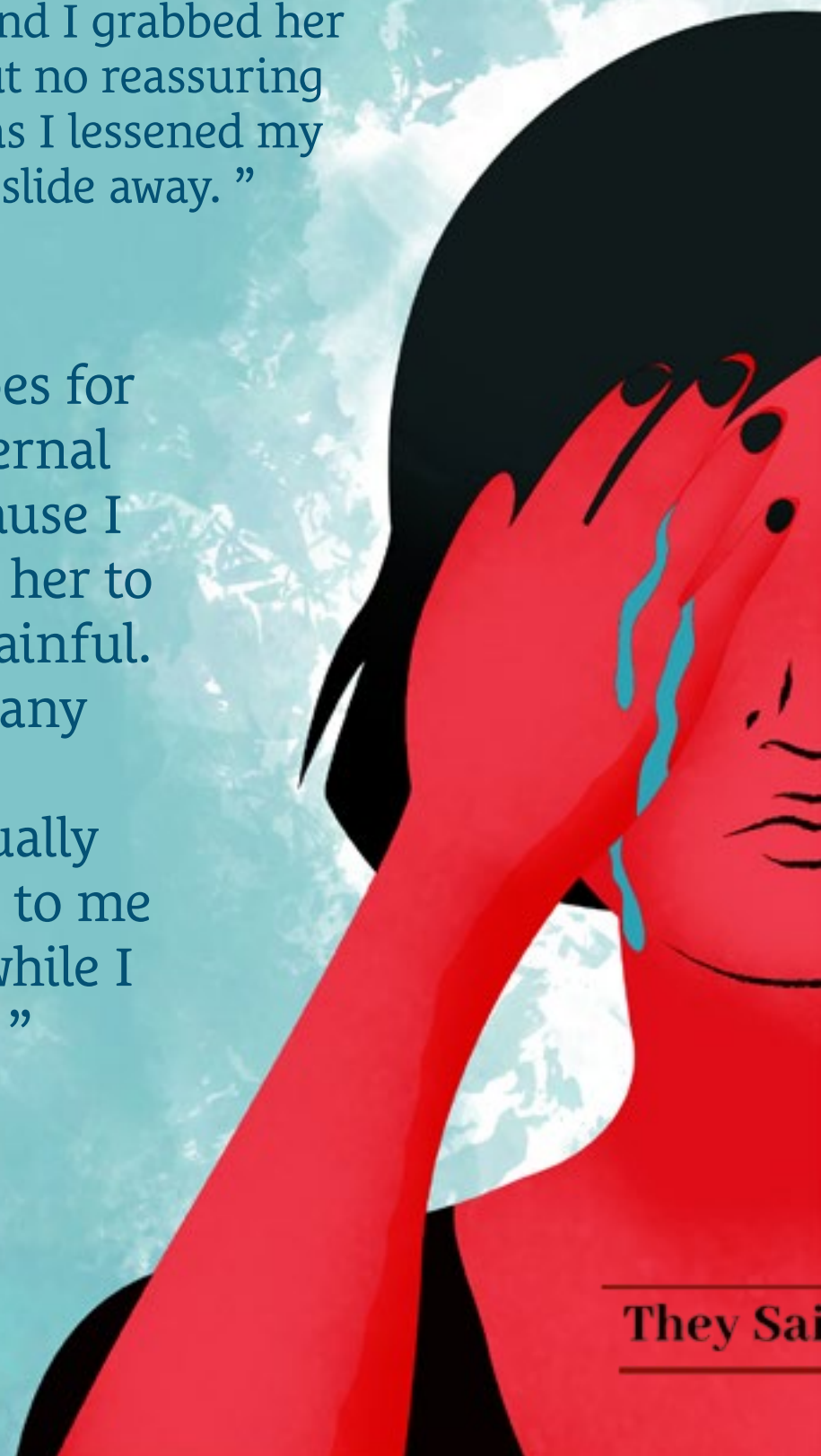
" The fingers need to get in there and really stretch the cervix, so much so that some people call it a 'stretch and weep' (her words!). She was smiling/laughing at this, she said she was only being honest. "

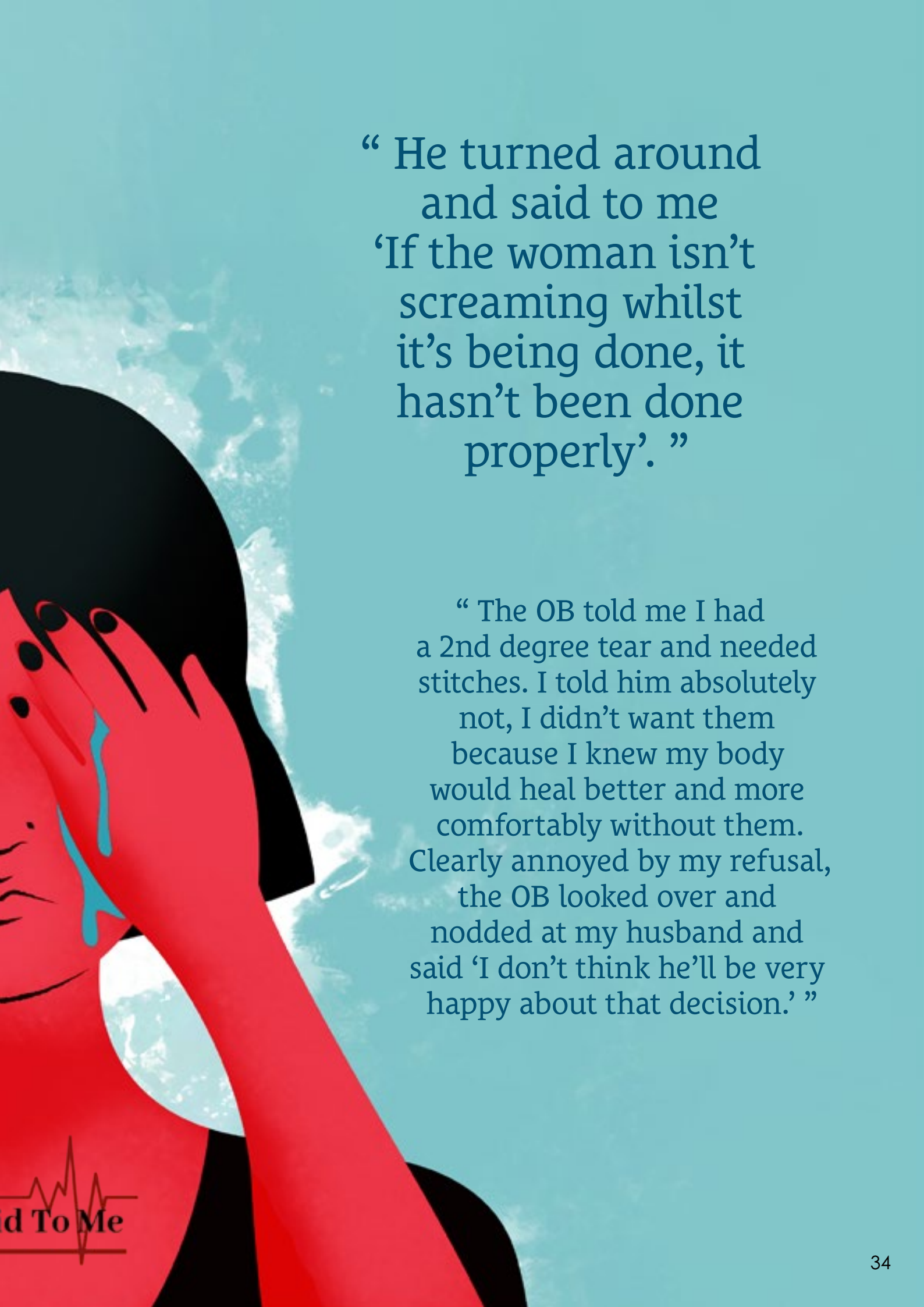
"The argument about VE's went on and on and on, I repeated that I'm a survivor of sexual assault but it continued for over 15 minutes on the same thing."

They Said To Me

“ When I was taken down to the theatre to be prepped to try forceps, I was taken alone and all the practitioners around were chatting, having a laugh over me while strapping me down. I was crying and pleading for one to stay by me, in the end I grabbed her hand, she let me but no reassuring words and as soon as I lessened my grip she tried to slide away. ”

“ It took several goes for her to do the internal examination because I had to keep telling her to stop as it was so painful. She didn’t offer any pain relief . When she eventually succeeded she said to me ‘Oh I did a sweep while I was in there. ”





“ He turned around and said to me ‘If the woman isn’t screaming whilst it’s being done, it hasn’t been done properly’. ”

“ The OB told me I had a 2nd degree tear and needed stitches. I told him absolutely not, I didn’t want them because I knew my body would heal better and more comfortably without them. Clearly annoyed by my refusal, the OB looked over and nodded at my husband and said ‘I don’t think he’ll be very happy about that decision.’ ”

Video Stories

This Birthrights video portrays three women discussing the consequences of traumatic birth and why it's so important to speak up when we experience or witness unkind, unsafe or unethical behaviours.

Another video from the Birth Trauma Association allows us to hear the stories of five different women, all of whom experienced their births as traumatic.

Reflect:

Take a moment now to breathe, recentre and reflect. Sit with the emotions that come up, whatever they may be. Think about the impact these stories have on both those who tell and hear them. Then think about how we can prevent more people from telling stories like these.

Additional Resources

- Maternal Journal
- The Power of Storytelling
- Why Birth Trauma Matters by Emma Svanberg
- Birth Shock by Mia Scotland

Midwives' Stories

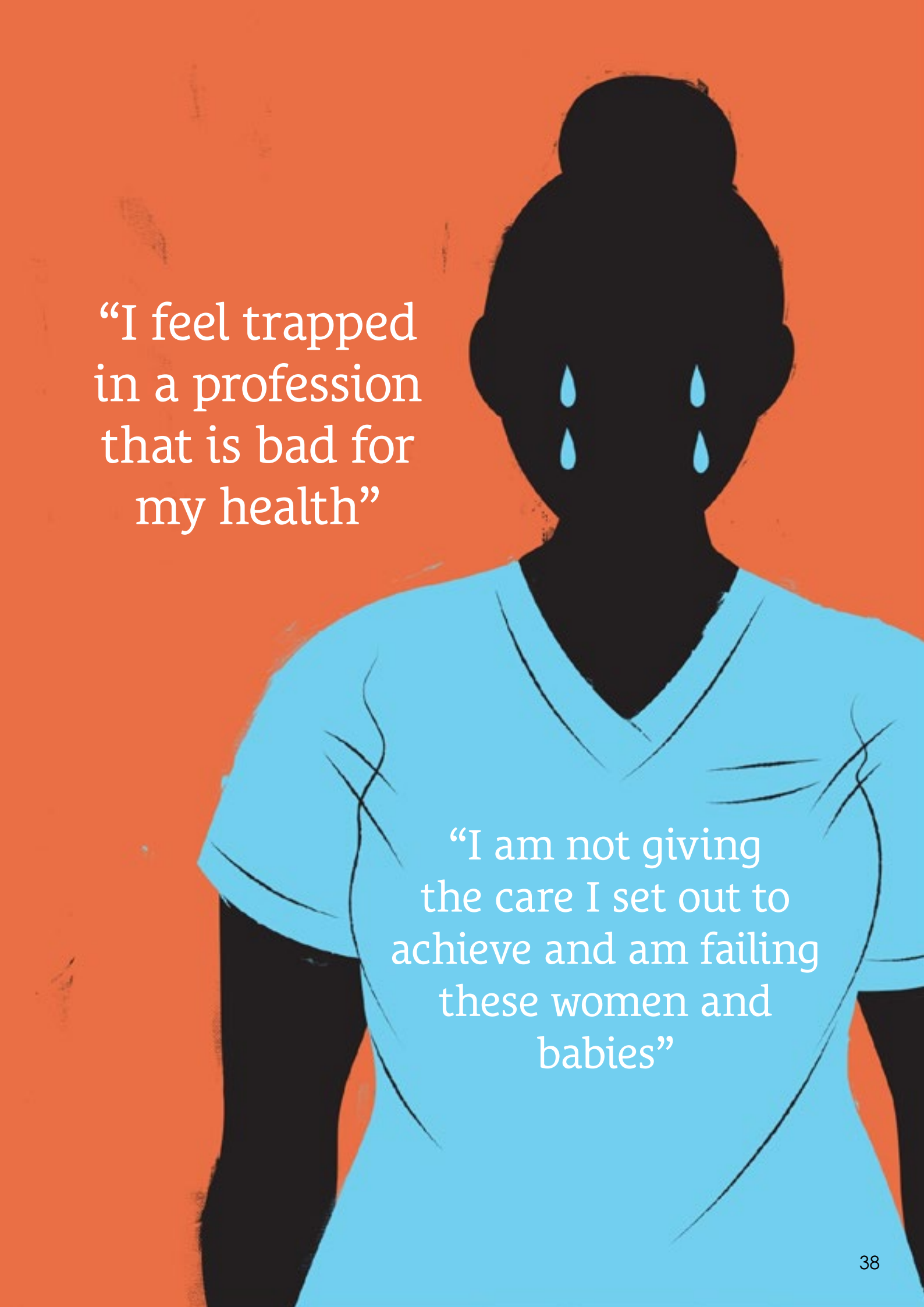
Midwives and other maternity care workers have their own stories to share and traumas to process, whether those experiences are from their personal or professional lives. Just as we must listen to the stories of those who have been harmed while giving birth, so too must midwives' voices be heard and amplified. This is important because if midwives' ideas, feelings and experiences are not included in improvement efforts, the entirety of the problem will never be addressed.

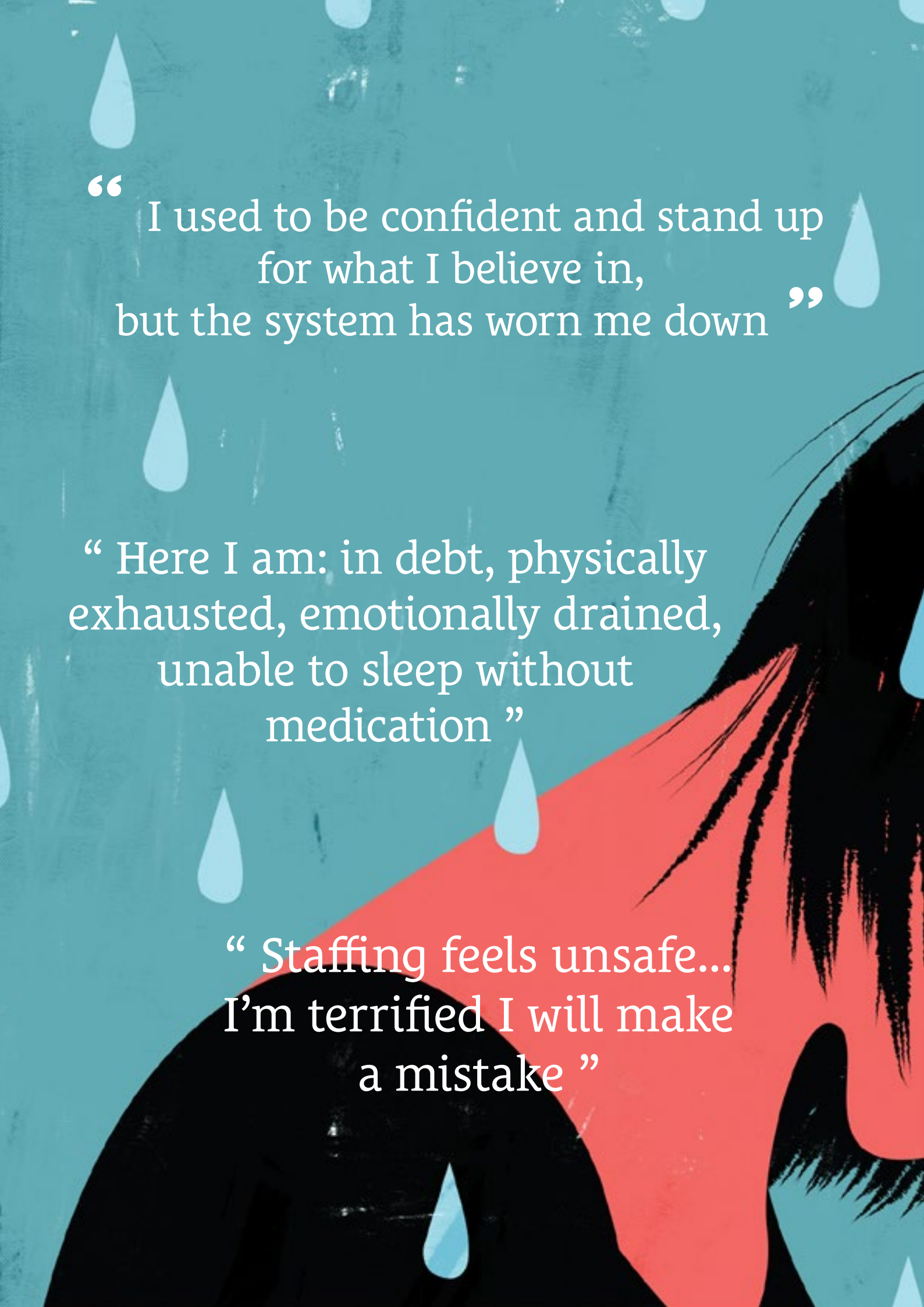
In addition to the institutionalised and gendered violence that midwives are at risk of being subject to in the workplace, we know that vicarious (or 'secondary') trauma is incredibly harmful and impacts many thousands of health care workers every year.

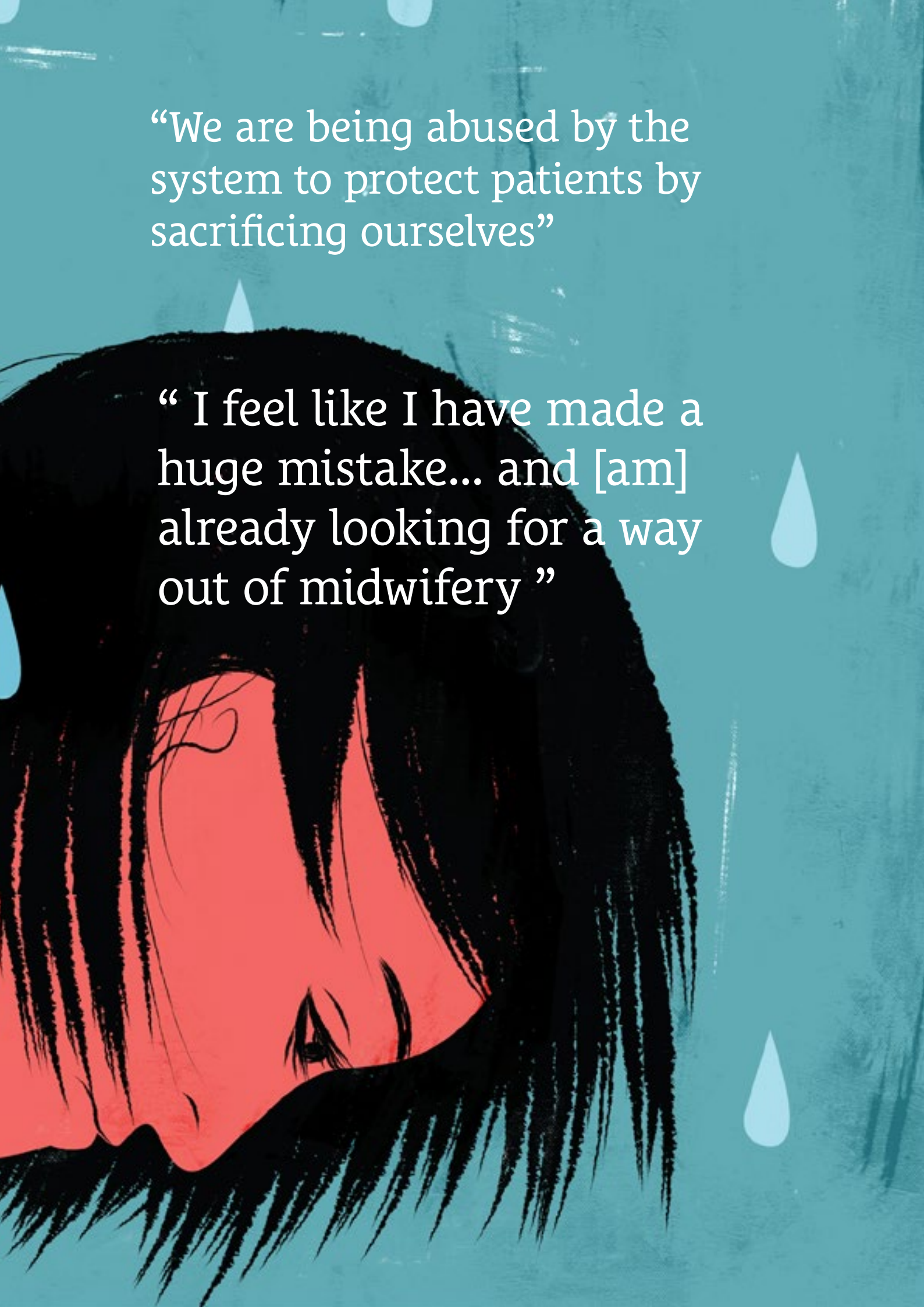
Burnout, PTSD, mental health issues and substance misuse rates are higher in caring professions than in many others, contributing to poor retention rates.

Each year, thousands of midwives spend a prolonged period off work with stress, reduce their contracted work hours in an effort to cope, leave direct care to move into adjacent roles, or remove themselves from the register altogether. When combined with the large number of midwives reaching retirement age, and with recruitment into the profession also struggling to meet demand, it's clear that poor staffing and poor working conditions go hand in hand.

The following quotes were gathered by March With Midwives, a grassroots movement of midwives, parents, birth workers and other healthcare professionals standing in solidarity with one another, demanding change. These stories were submitted anonymously in 2021, when hundreds of midwives began leaving the NHS.


“I feel trapped in a profession that is bad for my health”
“I am not giving the care I set out to achieve and am failing these women and babies”


“ I used to be confident and stand up for what I believe in, but the system has worn me down ”
“ Here I am: in debt, physically exhausted, emotionally drained, unable to sleep without medication ”
“ Staffing feels unsafe... I’m terrified I will make a mistake ”


“We are being abused by the system to protect patients by sacrificing ourselves”
“ I feel like I have made a huge mistake... and [am] already looking for a way out of midwifery ”

“ I have seen colleagues, cry, break down, or literally collapse, unconscious, after shifts with no breaks ”

“ Is this what midwifery has become? A bunch of overworked people, stretched to the limit, just ‘winging it’? ”

“ The workload is unmanageable. Breaks have become a myth, as have finish times ”

Giving Stories Purpose

Hearing these stories and recognising the pain in them demands that we ask: what are we going to do about this? How can we let this continue?

We hope that hearing and reading these stories can help others come forward and share their own, whether personally, within their communities or to the institutions that employ them.

> People need to hear what is happening to women and birthing people who seek skilled and compassionate care to safely guide their babies into the world but end up traumatised instead. People need to hear what midwives and maternity care workers are going through, and how the system's failing of them is central to their own feelings of failure when they cannot provide the care they want to.

Reflective questions:

- What emotions came up for you when hearing these stories?
- What stories would you like to tell?
- What can you personally do to honour and process these stories?

Additional Resources:

- WRA Support Resources Document
- Progress Theatre for Midwives
- Overdue – by Amity Reed
- Nurturing Maternity Staff – by Jan Smith

Further Thoughts

In order to solve the maternity care crisis, we must dig down to the root of the problem, past what is easier to spot on the surface. This is about more than understaffing, poor statistical outcomes and decreased safety – this is about deep moral and emotional wounds. It's about how the medical model of birth is constructed around paternalistic attitudes that discourage autonomous decision-making and shared trust, promoting a deep-seated fear and insidious blame culture that has disempowered generations of mothers and midwives.

The maternity care crisis may have many different, complex layers, but when we peel each one back there aren't any that couldn't be improved by hearing and honouring each other's stories. The power of storytelling lies in finding opportunities to move past fear and blame towards a place where we thrive in our common humanity and work to advance our common purpose.

REFRAMING IDEAS OF SAFETY

" Increasing facility births has contributed to reducing maternal deaths, but this must not come at the price of overmedicalization of childbirth and poorer quality of care for women. Simply surviving pregnancy and childbirth can never be the marker of successful maternity care. Addressing inequalities and promoting respectful maternity care for all women is critical to improve health equity and quality. "

- Dr Mercedes Bonet, Medical Officer at WHO/HRP. Source

At present, 'serious incidents' that require investigation in the maternity services relate solely to physical harms or threats of harm to the body, and to procedural or organisational failings that have the potential to seriously impact upon the delivery of service plans. Similarly, 'poor outcomes' are defined as those that result in unexpected death, illness or injury. Due to how these classifications have been written and the gravitas they've been assigned, the focus of those responsible for overseeing maternity units has primarily become physical safety and administrative management. Consequently, survival rates and short-term outcomes have come to outweigh and overshadow the other incredibly important facets of care: emotional, psychological, social, and cultural safety, and the long-term implications of these on our health and lives.

Midwives and doctors undergo extensive clinical training and mandatory annual updates to ensure a mix of highly skilled, well-rehearsed and multidisciplinary professionals are always present to deal with any unexpected complications in the perinatal period. And indeed, most hospitals are equipped with cohesive, experienced teams who deliver physically safe, competent care. But if all the pieces of the safety puzzle are not in place, we're not getting a complete picture.

A complete picture of maternal and child health would include how the mother experienced her child's birth – how it made her feel and how quickly she recovered; whether she was supported to succeed in her feeding goals; how well she and her partner bonded with their baby and what kind of start they got off to; whether they have social and emotional support within their families and communities as they navigate parenthood; and what the long-term outcomes and implications are for each birthing person and child after this life-changing event.

To read more about why supporting emotional and psychological well-being is so important, and how instrumental it is in creating a system that is safe and respectful for everyone, click here.

Respectful Care is Safe Care

In the recent **Kirkup report** on maternity and neonatal services at East Kent, Key Action Area 2 (pg. 159 of the report) is based entirely around compassionate care and the need to recognise that technical care is not enough.

> ### Key Action Area 2: Standards of clinical behaviour – technical care is not enough
>
> **The problem**
>
> **6.12** Caring for patients in any setting requires not only technical skills but also kindness and compassion. This is no less true for mothers and babies in maternity care. Yet we heard many graphic accounts, from staff as well as families, that showed just how far from the required standards behaviour had fallen at the Trust. Previous experience has shown the danger in assuming that such serious lapses of such a distressing nature are restricted to one trust alone.
>
> **6.13** Failing to meet basic standards of clinical behaviour has obvious effects on colleagues and those receiving care. Unprofessional conduct is disrespectful to colleagues and endangers effective and safe working; it undermines the trust of women. **Lack of compassion significantly affects the wellbeing of women, often leading to unnecessary long-term harm.** When families are treated unkindly in the aftermath of a safety incident, as is often evident, it compounds and prolongs the harm caused by the event itself. Failure to listen directly affects patient safety, as we found repeatedly in the Trust's maternity services, because vital information is ignored.
>
> **6.14** Because compassion is such an integral part of belonging to any caring profession, it is particularly difficult to comprehend how such failures can come about. Whether or not traits of empathy and compassion form part of the selection or assessment of new entrants, the need to be professional and to listen will surely be emphasised as part of initial education and training. What we saw and heard was that it was when clinicians were exposed to the behaviour of senior colleagues that their standards began to slip. The influence of role models, those whose positions more junior staff would aspire to fill one day, can be significantly greater than classroom teaching. If those role models themselves display poor behaviours, the potential is there for a negative cycle of declining standards.
>
> **6.15** Once such a negative cycle is established, it can prove remarkably persistent because of another feature evident in the Trust's maternity services: normalisation. **Behaviour that would otherwise be challenged becomes tolerated, because "that's the way we do things here".** In this way, inexorably, patterns of unprofessional behaviour, lack of compassion and failure to listen become accepted and embedded, to an extent that is genuinely shocking when seen through fresh eyes.

The future

6.19 Compassionate care lies at the heart of clinical practice for all healthcare staff. If some are able to lose sight of that, then it needs to be re-established and re-emphasised. Every interaction with a patient, mother and family must be based on kindness and respect. This will not be achieved through well-meaning exhortation in classrooms or by professional leaders, but through the attitudes and daily behaviour of clinicians themselves, at every level but most particularly those in more senior positions who are role models for less experienced staff.

6.20 Professional behaviour and compassionate care must be embedded as part of continuous professional development, at all levels. It must not be something learned during the earlier academic stages of training, only to be forgotten later.

6.21 There is a need for all staff to acknowledge and accept the authority of those in clinical leadership roles. These are not sinecures to be done for a couple of years on a rotating basis: they are integral to the effective and safe functioning of services. While some clinicians accept this, it is clear that many do not. Those in clinical leadership roles need to have the skills and time to carry them out effectively.

6.22 Reasonable and proportionate sanctions are required for employers and professional regulators so that poor behaviour can be addressed before it becomes embedded and intractable. The existence of such sanctions would itself act as a deterrent to the defiant reactions to challenge exhibited by an unreasonable minority.

6.23 The importance of listening to patients must be re-established as a vital part of clinical practice. This will require it to be embedded not only in continuous professional development, but also in the academic components of early training. The rapid rise in technical and diagnostic possibilities understandably puts pressure on academic curricula, but this must not be to the detriment of skills such as listening.

Recommendation 2

- Those responsible for undergraduate, postgraduate and continuing clinical education be commissioned to report on how compassionate care can best be embedded into practice and sustained through lifelong learning.
- Relevant bodies, including Royal Colleges, professional regulators and employers, be commissioned to report on how the oversight and direction of clinicians can be improved, with nationally agreed standards of professional behaviour and appropriate sanctions for non-compliance.

from: Kirkup report

The report and associated recommendations clearly state that implementing, modelling and supporting compassionate care is not just a 'nice to have' extra or something that can be taken for granted simply because it should already be a central tenet to all caring professions.

Safety is compromised at all levels while disrespect and abuse, including obstetric violence, are allowed to continue with little consequence. In order to minimise avoidable trauma and harm and to prevent further tragedies from occurring, leaders and staff at all NHS hospital trusts must prioritise compassionate care and be prepared to take radical action to ensure its implementation across the board.

The **Ockenden Report** made similar recommendations only a few months prior to Kirkup, outlining the key areas for change that all hospitals should adopt to improve standards of care and safety. Among the 15 Immediate and Essential Actions (pg. 160 of the report) were two that we'd like to highlight:

7. Multidisciplinary training

Staff who work together must train together
[In particular, these points are relevant]:

- All trusts must mandate annual human factor training for all staff working in a maternity setting. This should include the principles of psychological safety and upholding civility in the workplace, ensuring staff are enabled to escalate clinical concerns. The content of human factor training must be agreed with the LMS.

- **There must be mechanisms in place to support the emotional and psychological needs of staff,** at both an individual and team level, recognising that well-supported staff teams are better able to consistently deliver kind and compassionate care.

15. Supporting families

Care and consideration of the mental health and wellbeing of mothers, their partners and the family as a whole must be integral to all aspects of maternity service provision

- Maternity care providers must actively engage with the local community and those with lived experience to deliver services that are informed by what women and their families say they need from their care.

- **There must be robust mechanisms for the identification of psychological distress,** and clear pathways for women and their families to access emotional support and specialist psychological support as appropriate.

- Access to timely emotional and psychological support should be without the need for formal mental health diagnosis, as psychological distress can be a normal reaction to adverse experiences.

- Psychological support for the most complex levels of need should be delivered by psychological practitioners who have specialist expertise and experience in the area of maternity care.

from: Ockenden report

By prioritising actions that enhance and support compassionate, individualised, and harm-free care, hospital trusts can ensure they are meeting the requirements set out by the **CQC Inspection Framework for Maternity**. In particular, a human rights-based model of care should focus on the following 'Key lines of enquiry':

> ## Effective
>
> **E1.** Are people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence [sic]
>
> **E3.** How does the service make sure that staff have the skills, knowledge and experience to deliver effective care, support and treatment?
>
> **E6.** Is consent to care and treatment always sought in line with legislation and guidance?
>
> ## Caring
>
> **C1.** How does the service ensure that people are treated with kindness, dignity, respect and compassion, and that they are given emotional support when needed?
>
> **C2.** How does the service support people to express their views and be actively involved in making decisions about their care, support and treatment as far as possible?
>
> **C3.** How is people's privacy and dignity respected and promoted?
>
> ## Responsive
>
> **R1.** How do people receive personalised care that is responsive to their needs?
>
> **R2.** Do services take account of the particular needs and choices of different people?
>
> ## Well-led
>
> **W3.** Is there a culture of high-quality, sustainable care?
>
> **W7.** Are the people who use services, the public, staff and external partners engaged and involved to support high-quality sustainable services?

from: QQC Inspection Framework for Maternity

These documents all provide clear, direct evidence that respectful care needs to be prioritised as a matter of urgency, and that it must be done within multidisciplinary teams and professions. Working in isolation from one another is inefficient, unproductive and dangerous for all involved.

Rising Maternal Mortality

The most recent statistics published by MBRRACE show that maternal mortality in the UK has risen by 19 percent overall in the period between 2018-2020. The report also found that suicide rates during pregnancy and up to six weeks after birth has tripled, making it the number one direct cause of maternal deaths alongside heart disease. In the year after a pregnancy has ended, suicide and ill mental health now account for 40 percent of maternal deaths, also making it the most common direct cause of maternal mortality in that period. Not pre-eclampsia or post-partum haemorrhage. Not sepsis, diabetes, or pulmonary embolism (PE). *Suicide*. And people from more deprived areas and with a history of childhood trauma or domestic abuse are at a much greater risk than anyone else.

This is what happens when people experience poor mental health with no (or not enough) support, potentially compounded by birth trauma. This is what happens when trauma-informed care is not being facilitated across the board, and when a human rights-based framework of care is not prioritised and implemented. This is the result of systematic and long-standing failures of the government to adequately fund, staff and resource maternity services, and all of the NHS.

The time for action is long overdue. This is a crisis that can no longer be ignored if we are to avert it.

UNSAFE CARE

Unsafe care is...

- a system that is narrowly focused on survival, whilst causing widespread harm in many other ways.
- ignoring the psychological and emotional harm being done to women and birthing people.
- prioritising procedures and policies over people.
- committing, enabling, minimising or denying the existence of obstetric violence.
- not acknowledging that institutionalised racism and discrimination against people of minority groups and identities (including gender-diverse and LGBTQ+ people) contributes to a variety of negative outcomes and perpetuates divisions within our society.
- expecting staff to be 'resilient' to vicarious trauma, with no meaningful support in place.
- forcing midwives to work in chronically understaffed and poorly managed wards, with no regard to their health, safety or human rights as workers.
- silencing or punishing those who try or decide to speak up (whistleblowing).
- allowing blame and fear to fester on maternity units, through bullying and hierarchical control.

THE GOOD NEWS IS....

Safe care...

- is something we can achieve by putting respectful treatment at the top of the agenda in maternity care.
- does not always require expensive technology or equipment; its main requirements are knowledge, compassion, support and commitment.
- improves both the short and long-term health of mothers and babies, which benefits all of society.
- is giving midwives the tools, skills and autonomy they need to provide the gold standard of care they trained and promised to provide.
- improves retention within the workforce, reducing the risks of chronic understaffing.
- is cost effective: reducing prolonged hospital stays, intensive care treatment, and lawsuits brought by the families damaged by poor care.
- is satisfying care – it makes us feel happy and good about ourselves.
- is excellent care, in all its facets and forms.

Reflective question:

- What would safe care look like to you?

BE THE CHANGE

People from every possible identity, background, socioeconomic status, and circumstance require access to maternity services. Equally, a vast array of personalities, experiences and beliefs are represented within the maternal health workforce. It's inevitable that at times we might feel quite different from those we interact with. But regardless of the differences between us, it's important that we don't rely on stereotypes to make assumptions about someone when we first meet them.

Unconscious Bias

> Unconscious bias is when we make judgments or decisions on the basis of our prior experience, our own personal deep-seated thought patterns, assumptions or interpretations, and we are not aware that we are doing it.

Everyone holds certain unconscious biases. Whether we're aware of it or not, we are conditioned from the time we're born to hold certain beliefs about people who we believe are different from us. That means that people from minority groups are more likely to be on the receiving end of negative biases and to experience discrimination as a result. When discrimination is not addressed it leads to widespread health inequalities, which contribute to an increased risk of unsafe care for the most marginalised people in society. By acknowledging our unconscious biases and learning more about the impact of institutional discrimination, we can begin to unpack our culturally ingrained responses and, consequently, work to minimise incidences of harm.

Reflective questions:

- What unconscious biases might you hold about the people you care for?
- What can you do to address these?
- How might you handle situations where colleagues are demonstrating bias or being openly discriminatory?
- If your trust doesn't offer training around unconscious bias, equality and diversity, or cultural competence, what steps can you take to educate yourself and others?

Additional Resources

- All4Birth: An introduction to culture, race and bias in midwifery care
- Reducing the inequality of outcomes for women from BAME communities
- Birthrights: Inquiry Into Racial Injustice and Human Rights in Uk Maternity Care
- What We Need to Thrive: Experiences of Ethnically Marginalised Midwifery Professionals in the Workplace
- Cultural Safety and Unconscious Bias in Maternity Care
- Unconscious Bias - MidwiferyHour

Trauma-Informed Care

Trauma doesn't often fit into neat categories, nor is it always easy to define. The common factor in trauma is that it is experienced as such, with the cause sometimes bearing little relation to the consequences. A traumatic experience doesn't have to be life-threatening to significantly and negatively impact someone's life.

Trauma-informed care has become something of a buzzword, shorthand for how we discuss ways of behaving and relating to one another. In maternity care, it might manifest in discussions around traumatic birth, postnatal depression or mental health struggles, but it can also include childhood abuse, parental neglect, bereavement, substance misuse, or domestic and sexual violence, amongst many others. It should also be recognised that accessing health care at times of high vulnerability can itself be traumatising, becoming compounded and magnified many times over if that care feels disrespectful or disempowering in any way.

A Universal Practice

Whilst it is good practice to ask about and account for previous traumas that a person might have experienced in their lifetime, it should also be recognised that some people will choose not to disclose their history to HCPs, meaning it is not always possible to identify those for whom a more sensitive approach is vital. With 1 in 4 women experiencing abuse or violence of some kind in their lifetime, we know that not everyone is open to sharing their experiences or talking about the impact it's had on their lives. Therefore, the best approach is to treat everyone accessing health care as if they might be holding unspoken traumas within them, and to demonstrate (through actions and language) that the care they are receiving is safe and respectful.

At its core, a trauma-informed approach is about providing care through a human rights lens, one that considers an individual's specific needs and the cultural context within which they live. It is about creating an environment where trust and mutual respect can flourish, creating the conditions for a safer, more satisfying and humane experience for all involved.

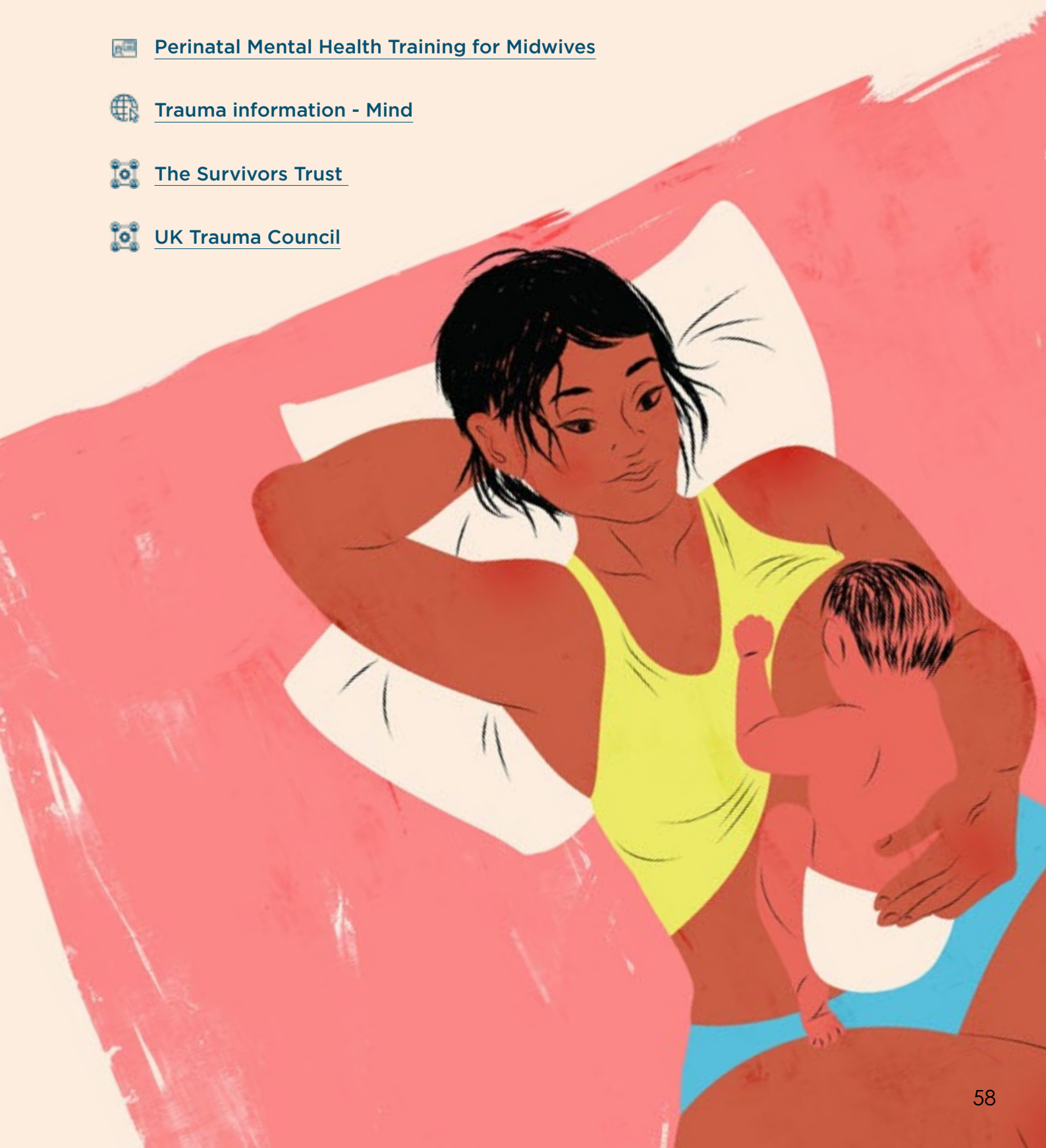
As with any other skill, developing a trauma-informed approach requires education, practice and support. We encourage everyone working in maternity services to educate themselves by engaging with best practice documents and learning tools, a few of which we have listed below. Leaders, managers, educators, and learning facilitators are also strongly encouraged to provide the time, training, and support that will allow HCPs to develop these vital skills.

Reflective question:

- What changes can you make to your practice to ensure it is trauma-informed and sensitive to individual needs?

Additional Resources:

- A good practice guide to support implementation of trauma-informed care in the perinatal period
- Perinatal Mental Health Training for Midwives
- Trauma information - Mind
- The Survivors Trust
- UK Trauma Council



Building Community, Holding Space

Having a community of people to talk to and share common experiences with is vital to both personal and professional development. This includes having the space and time to process and reflect on the emotions that come with working in healthcare.

This might look like going to a PMA for guidance, confiding in a trusted colleague, talking to a mental health professional, or forging connections with other birth workers in the local community (e.g. doulas, antenatal educators, pregnancy yoga instructors, practitioners of complementary therapies, postnatal support groups, breastfeeding counsellors, lactation consultants, independent midwives, birth trauma specialists, perinatal mental health service providers, and so on).

Despite the 'us and them' mentality that has become pervasive in some places, many lay birth workers relish the opportunity to get to know and support the midwives in their area. Not only does creating links between these groups build a sense of community and strengthen relationships, but it also gives midwives a more well-rounded view of the services available to support the families in their care, outside of those provided by the maternity sector.

Finally, we would also point readers to The Point of Care Foundation, whose mission is to 'humanise healthcare'. The Foundation achieves this by working to improve patients' experiences of care and increase support for the staff who work with them. It provides a variety of toolkits, programmes and training for healthcare staff, the most well-known of which are Shwartz Rounds.

Reflective questions:

- What benefits might both you and the people in your care receive if you had regular access to community networks and emotional support?
- How can you reach out to other birth workers in your community?
- If you don't have access to professional support or support within the workplace, in what other ways can you facilitate your own debrief process after a traumatic event or difficult shift?

Schwartz Rounds

Schwartz Rounds are a group reflective practice forum which provides an opportunity for staff from all disciplines to reflect on the emotional aspects of their work. Regular attendance has been shown to reduce feelings of isolation and stress at work as well as fostering a greater sense of compassion with patients and collaboration with colleagues.

Participating in Schwartz Rounds if your Trust provides them - and asking for them to be implemented if it doesn't - is an excellent way to explore the emotional toll of care work and how sharing those stories and hearing others too can build a sense of compassion, trust and morale amongst staff.

Resources:

Film demonstrating what a Round is like

Film depicting the results of the National Evaluation of Rounds

NOT THE END, BUT THE BEGINNING

Whilst there are many complex factors that have contributed to how the current situation arose (including chronic understaffing and underfunding of the NHS, a pervasive blame culture, and fear-based practices that undermine women's choices and midwives' autonomy), there is an urgent need to begin repairing the damage that's been done. We must do this work now and we must do it well, with open hearts and minds.

There are so many mothers, families, babies, midwives, doctors - people - who need hope that things can and will change, now more than ever. Together, we can be that change, be that hope, and create a future where we are all equipped with the power, autonomy and skills necessary to have agency over our lives.

If you have read this resource and would like to share it others, you can do so by visiting the WRA website where it is available via Open Access, free for anyone to read and download. We encourage you to read through the external resources we have mentioned and linked to as well, to gain an even deeper, richer understanding of the issues explored and laid out here.

Further Training

Birthrights – Training for HCPs on rights-respecting care

Make Birth Better – The birth trauma training programme

British Institute of Human Rights – Training programme

The EW Group's Inclusive Culture Pledge

Stonewall – Inclusive workplaces training

The NHS Staff Council – Equality, diversity and inclusion training: a good practice guide

FREE FROM HARM DECLARATION

1 I know my human rights

- I understand that i have the right to live in a world free from harm.
- I know that gender-based violence is rooted in inequity and power, that men and boys can be victims too, and that all of us deserve better.

2 I can identify signs of violence and harm

- I know what violence and abuse look, sound and feel like in relationships, in my work and within my body.
- I know what consent and healthy boundaries are and that they should be the norm.
- I know what abuse is, I know when to avoid or remove myself from harm.
- I know how to keep myself safe from secondary harm when supporting others.

3 I deserve and demand better

- I know I did not, do not, and will never deserve or accept that harm committed against me is my fault.
- I do not accept being silenced and know how to call on allies for support.
- I know how to be an ally, advocate and champion for justice and equality.
- I know I have the right to speak out and how to raise my voice and deserve to be heard.

4 I can heal and so can the world around me

- I understand that my past trauma, the laws or norms in my family or society, do not make me wrong.
- I understand that history, tradition, religion and culture are not an excuse for harm.
- I am worthy and deserving of love and respect, and I love and respect those I deem worthy.

5 I know how to help make change

- I know how to speak up , amplify the voices of my allies and how to help others find their voice.
- I know how to use my individual voice, experience and skills to make change in the world.
- I know i don't have to do this alone, that I am supported, believed, and part of a worldwide movement of people who make no apologies, no excuses and have no time to waste in building a world free from harm.

Ask, Listen, Act (ALA) Movement

White Ribbon Alliance is a people led movement for sexual and reproductive health and rights and we invite you to join us by becoming a member of our Ask, Listen, Act (ALA) Movement. By joining the movement, you become part of the alliance to advance sexual and reproductive health and rights in the UK and internationally. The ALA Movement is a community and a space for advocacy - it brings together the work of many campaigns and efforts for improvements, and your voice is a vital part of that network.

Please join today to be part of the future of speaking truth to power on issues of sexual and reproductive health and rights

Be Free From Harm Campaign

WRA's next step on this journey or White Ribbon Alliance is the #BeFreeFromHarm campaign. #BFFH calls for a people-led movement of activists, individuals, organisations, institutions and networks to stand together as a movement to claim, demand and create a culture of non-tolerance towards gender-based violence. We do this by asking, listening to and acting upon real people's experiences, concerns and solutions to drive change locally, nationally and globally.

The goal of the work will be to build a world where our campaign manifesto becomes the way we all live: Free From Harm. Connect with WRA-UK to join the movement

Additional Resources

There are many other ways to get involved in activist and advocacy spaces too. Below is a list of organisations, grassroots movements, and initiatives focused on advocacy within and around maternity spaces.

- March With Midwives
- All4Maternity
- AIMS
- Association of South Asian Midwives (ASAM)
- Royal College of Midwives (RCM)
- The Motherhood Group
- 5x More
- Raham Project
- Maternity Experience

REFERENCE LIST

Introduction to Free From Harm

1. Ockenden Report – Shrewsbury and Telford Hospital NHS Trust
2. Kirkup Report – East Kent
3. White Ribbon Alliance UK

Trauma and Harm

4. Make Birth Better Survey 2019
5. MBRRACE-UK Maternal Report 2021 – Lay Summary
6. Births and Infant Mortality by Ethnicity in England and Wales 2007 to 2019
7. UK WHELM REPORT – rcm.org.uk
8. Falling NHS Midwife Numbers Show Worrying Trend Says the RCM

The Safer Beginnings Programme

9. Link to PDF of All Delivery Partners' Sites/Resources

Human Rights in Healthcare

The Respectful Maternity Care Charter

1. WRA Respectful Maternity Care Charter
2. Resources | White Ribbon Alliance
3. Respectful Maternity Care Charter: Universal Rights of Women and Newborns
4. Respectful Maternity Care – Know Your Rights
5. Brave Voices, Bold Actions: Women's Health, Rights & You: Violence in the Labor Ward: Why Respectful Care Matters – on Apple Podcasts
6. Brave Voices, Bold Actions: Women's Health, Rights & You: The Fight for Reproductive Justice – on Apple Podcasts

Consent

7. Transforming Consent in Maternity Care
8. What Is Sexual Consent? | Planned Parenthood

Care Outside the Lines

9. Care Outside Guidance – RCM

Dealing with Professional Discomfort

10. A-EQUIP – A Model of Clinical Midwifery Supervision – NHS England

A Crisis in Midwifery

11. UK WHELM REPORT – RCM
12. NHS Staff Survey 2021
13. RCM Warns of Midwife Exodus as Maternity Staffing Crisis Grows

Protecting Midwives' Rights

14. Standards of Proficiency for Midwives – NMC
15. The 6 Cs – NHS England

Obstetric Violence and Its Impact

Origin and Usage of Obstetric Violence

1. Obstetric Violence: A New Legal Term Introduced in Venezuela
2. How Gentle Must Violence Against Women Be in Order to Not Be Violent? Rethinking the Word "Violence" in Obstetric Settings
3. To Use or Not to Use the Term "Obstetric Violence"
4. Making Loud Bodies "Feminine": A Feminist-Phenomenological Analysis of Obstetric Violence
5. Obstetric Violence: An Intersectional Refraction through Abolition Feminism

Definitions and Categorisations

6. Exploring Evidence for Disrespect and Abuse in Facility-Based Childbirth
7. Defining Disrespect and Abuse of Women in Childbirth: A Research, Policy and Rights Agenda

Dehumanised Care

8. The International Confederation of Midwives
9. Respect Toolkit – ICM
10. Disrespectful Care – The Global Picture: Professor Soo Downe

The Impact of Obstetric Violence

11. The Mental Health and Wellbeing of Nurses and Midwives in the United Kingdom
12. Problematic Substance Use: An Assessment of Workplace Implications in Midwifery
13. Figures Spark Call for Inquiry into 'Alarming' Levels of Nurse Suicide – Nursing Times

Power and Control

14. Wheels - Domestic Abuse Intervention Programs
15. The Duluth Model

Storytelling: In Their Own Words

Stories of OV

1. They Said To Me – Words From Within Maternity Services

Video Stories

2. Speak Up, Speak Out –Birthrights
3. Birth Trauma: 5 Women Share Their Experiences – Birth Trauma Association

Midwives' Stories

4. Vicarious Trauma Experienced by Health Care Providers Involved in Traumatic Childbirths: A Meta-Synthesis
5. Midwives in the United Kingdom: Levels of Burnout, Depression, Anxiety and Stress and Associated Predictors
6. MarchWithMidwivesUK

Reframing Ideas of Safety

1. Meeting Women's Emotional, Psychological and Clinical Needs During Childbirth
2. What We Investigate (Maternity) – HSIB
3. Parental Emotional Wellbeing and Infant Development – RCM

Respectful Care is Safe Care

4. Kirkup
5. Ockenden
6. CQC Inspection Framework for Maternity

Rising Maternal Mortality

7. MBRRACE-UK Maternal Report 2022 – Lay Summary

Be The Change

A Universal Practice

1. Global, Regional, and National Prevalence Estimates of Physical or Sexual, or Both, Intimate Partner Violence Against Women in 2018 - The Lancet

Schwartz Rounds

2. Staff Experience - Point of Care Foundation
3. Benefits of Rounds - Point of Care Foundation
4. About Schwartz Rounds - Point of Care Foundation
5. What's involved in Starting Rounds - Point of Care Foundation

Not the End, But the Beginning

Ask, Listen, Act (ALA) Movement

1. **JOIN US** – White Ribbon Alliance UK

safer beginnings

working together for safety in pregnancy and the early years

THE WHITE RIBBON ALLIANCE UK

Co-created by

all4maternity
LEARNING • SHARING • CARING

Approachable Parenting

ASAM
Association of South Asian Midwives

birthrights

BLACK MUMS UPFRONT

DADVENGERS

for baby's sake
break the cycle

JOY CLARKE
FGM Specialist Midwife

JANET FYLE
Midwife

BETTER · MAKE · BIRTH

maternity engagement action
Engaging Perinatal Families For Better Maternal Outcomes

THE MOTHERHOOD GROUP

THE MOTIVATIONAL MUMS Club

MUMMY'S DAY OUT

Mum's Pride

MFF
MUSIC, FOOTBALL, FATHERHOOD

They Said To Me

WHMWI

YOUNG MUMS SUPPORT NETWORK