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How women have encouraged change in maternity care

Beverley Beech
(Honorary Chair AIMS)

AIMS was founded in 1960

I am going to talk to you about the work that AIMS has done, since it was founded in 1960, to affect the quality of maternity care for the benefit of women and babies. AIMS is a totally voluntary charity, we have no paid staff, we run a helpline, a web site and we publish a variety of books and a quarterly journal. Our income comes from membership and the occasional donations and sales of our publications. There are no health professionals on our national committee. We have been involved in a multitude of campaigns and these are some of them, but I am only going to talk about a few, otherwise we will be here all day.

AIMS was founded when our late President, Sally Willington, wrote to a national newspaper about the way women were treated in hospital. Two national newspapers published her letter, one on the 1st April 1960 and many people considered it an April Fool's joke. Sally was soon deluged with letters from people wanting to do something to change the quality of maternity care the Society for the Prevention of Cruelty to Pregnant Women was established, fortunately it changed its title to AIMS the following year¹.

For many years the attitude in society was that the doctors were the experts and woe betide any woman who challenged the care on offer. Women were patronised, belittled and ridiculed, not only by the medical profession but also by the press. When questioning routine care women would often be asked what evidence they had for their opinions and reminded that 'the majority of women want to birth in hospital' or 'women are happy with their care', how many women do you represent, these are statements that are still made today. It was assumed that the moment a woman set foot inside a hospital she agreed to whatever treatment was decided. This attitude was based on advice from the doctors' Medical Defence Union which stated:

‘The Union does not consider that a maternity patient need give her written consent to any operative or manipulative procedures that are normally associated with childbirth. When she enters hospital for her confinement it can be assumed that she assents to any necessary procedure, including the administration of a local, general or other anaesthetic.’ (Medical Defence Union, 1974)

Some hospitals had this statement printed on the inside cover of the women's case notes, I wrote to the MDU and asked them to send me a copy of the rule, regulation
or statute that supported their statement. They did not have the courtesy to reply but they had removed the statement from their annual report the following year.

By 1982 the childbirth groups were becoming increasingly dispirited about the way in which women were being forced to accept treatment. An AIMS press release stated:

"It is common for women during childbirth to be given drugs against their wishes and without seeking their consent; it is common for procedures, such as routine episiotomy, to be carried out against mothers’ wishes and without their consent"

AIMS arranged a meeting with the Society to Support Home Confinement and the Birth Centre Organisation, to formulate a plan of action. They decided to launch a fund (the Maternity Defence Fund) to sue the medical and midwifery profession for assault. An article was written in our Journal and a press release issued. Almost immediately there was a shocked response from the medical profession, some had difficulty understanding that forcing women to accept treatment they did not want is an assault.

"I don’t understand the word assault here. I’m not dismissing these women. We ARE changing our style, listening to their wishes. We have piped music, pictures on the walls, grans [grandmothers]in the labour wards.”

Assaulting women in childbirth continues, and is a world-wide problem, but now in Europe we have the Human Rights Act so we can also challenge the hospitals under that legislation, but whatever the legislation when a woman says NO, ignoring her decision is an assault.

**Fathers in the labour ward**

An early AIMS campaign was to enable fathers to be with their wives or partners during labour. Men were, usually, excluded from the labour ward to the extent that one woman handcuffed herself to her husband to ensure that he remained with her.

*We asked …..if the DHSS would put out a memorandum on the rights of fathers in maternity hospitals (to be present during labour and delivery, to pick up their babies), but were once again told that such a directive would impinge on the rights of staff to excercise [sic] their clinical judgment. (AIMS Quarterly Newsletter, June 1976, p9)*

I should add here that AIMS has a reputation for being hard hitting, we always ask nicely at first, but if we do not get the kind of action we want then we will consider other tactics. For instance, handing out information leaflets, producing our own books and now that we have Facebook and Twitter the options are even greater and a quick questionnaire often provides information to encourage change.

For example: when we asked why so few women were using the hospital’s pool to labour or give birth in the water we were told that women did not want to do that.
One of our members devised a questionnaire and went to the local shopping centre one weekend and approached 50 women with tiny babies and asked them about the pool. It emerged that the majority had no idea there was a pool, a few thought it was for private patients, some had been told that it was not in use, and the only woman who used it was a local antenatal teacher. In the meantime, we had developed a strategy with the National Childbirth Trust representative who gathered research evidence to support water birth and together we challenged the hospital which then changed its policies, and those midwives who wanted to increase the numbers of women using the pool were able to press for change within the hospital.

Changing medical and midwifery practice does not happen overnight, it is rather like wearing down a stone, one has to be persistent and, if little changes, one has to find other ways of provoking change. AIMS is rather like the canary in the mine, we have detected problems long before the medical profession has noticed and by networking with other organisations, alerting the press the issue becomes more obvious.

**Home Birth**

A persistent campaign, which continues today, is for those women who want to birth at home to be able to do so. Up until 1972 up to 50% of women gave birth at home, but the publication of the Peel Report in 1970, which recommended that ‘sufficient facilities should be provided to allow for 100% hospital delivery’ resulted in a drive to ensure that every woman delivered there. Ironically, one of AIMS’ campaigns, in the 1960s, was for more maternity beds, so that, at a time of bed shortages, those women who needed, or wanted, to give birth in hospital would be able to do so. The Peel Report, however, produced no evidence at all that this would benefit women and babies and no women were asked for their views. By 1974 the home birth rate had dropped to 4.1%

In 1974 Margaret Whyte, decided that something needed to be done to safeguard the option of home birth’ (AIMS Journal, March 1976, p12) so she founded the Society to Support Home Confinement. She wrote a four-page leaflet telling women what their rights were and suggested a standard letter that a woman could send to the hospital informing them of her intention to birth at home. AIMS joined her campaign and handed out her leaflet to anyone who was having problems getting a home birth. At that time, AIMS could only challenge the pressure to force women into hospital by pointing out that a woman had a right to stay at home for the birth if she chose to do so. This tactic did not change until Marjorie Tew published her research showing that in every single risk category, but one (those at Very High Risk), were safer having their babies at home. (1978).
This data, however, was ignored by the establishment, but what we did was stress the woman’s right to decide where she would give birth.

It was not until 2014 when the BirthPlace Study was published that Marjorie Tew’s analysis was vindicated and supported by this new research evidence. A retrospective cohort study published in 2015 of 1228 women in Iceland found that home birth is safe for women and babies and more likely to result in straightforward vaginal birth.

Place of Birth

Which brings me to the whole issue of place of birth. In the UK it is possible to choose to give birth at home, in a Free-standing Midwifery Unit, an Alongside Midwifery Unit or an Obstetric Unit. The majority of women give birth in an obstetric unit, usually large and centralised, and the other ‘choices’ depend upon whether the other units actually exist in their area.

The BirthPlace Study compared all the planned homebirths and planned midwifery unit births over a 2 year period and then compared them to matched sample of women birthing in obstetric units over the same period of time.

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<td>5</td>
<td>3</td>
</tr>
<tr>
<td>AMU</td>
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</tr>
<tr>
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The study took a composite outcome for babies, because the sample size of nearly 65,000 births would not have been large enough to have the power to show any differences in babies dying – 32 babies.

The study did not show any difference in the composite outcome for babies born in midwifery units, or for subsequent babies born at home, but did show an increase in the outcome for first babies born at home, but it was very clear that the risk of these adverse outcomes remained very small. What was shocking was the very much worse...
outcomes for low risk women if they birthed in an obstetric unit, outcomes that will have an effect on that women for the rest of her life, on her ability to feed and look after that baby, on her ability to become pregnant again, to have another safe and low risk pregnancy and birth. These included not just instrumental, surgical births and episiotomies, but blood transfusions and general anaesthetics.

Obstetric care in large centralised obstetric units damages thousands of women every year and much of it is unrecorded. There are, for example, no statistics gathered about postnatal depression, post traumatic stress and I should particularly mention that in the UK the 2000 to 2002 Confidential Enquiry into Maternal and Child Death revealed that the leading cause of maternal death was suicide after childbirth and within one year of delivery—greater than thrombosis, infection, haemorrhage, and other well-known causes, and it left many orphaned children. This discovery led to better identification and treatment, but not to prevention of primary causes, some of which we believe are due to traumatic interventions and insensitive treatment in childbirth.

In the latest report maternal suicide has been pushed into second place. AIMS has been pressing for maternal suicide statistics to be collected up to five years, because we know that women will carry the anguish of their birth experiences far longer than just a year before taking their lives.

### Challenging the medical evidence

AIMS members, very early on in the organisation's existence started to read medical papers and were astonished to find that very little medical practice was supported by good quality research evidence, indeed in many cases, by no research at all.

### Episiotomy

An early challenge to medical interventions involved routine episiotomy. The procedure was widely used in the USA but it was not adopted in the UK until the 1960s when it began to rise dramatically.

By 1967 episiotomies had reached 25% and by 1978 it had reached 53.4%. Some
London Teaching Hospitals had a 98% episiotomy rate and AIMS has examples in the files of women who were given episiotomy after the baby was delivered because the midwives were afraid of criticism for failing to do one. Needless to say, there was no good research showing the benefits of episiotomy, it had been introduced following a persistent medical campaign without any evidence demonstrating benefit when used routinely. AIMS began lobbying the Department of Health and asking for the evidence of benefit. Women’s concerns about episiotomy were also given greater prominence when the National Childbirth Trust published two booklets written by Sheila Kitzinger which were based on women’s experiences of episiotomy and the physical and emotional aspects (Kitzinger, 1981 and Kitzinger, 1981). These surveys made it very much more difficult for obstetricians to dismiss women’s complaints as ‘anecdotal’.

The growing criticisms of routine episiotomy resulted in a midwife, Jenny Sleep, being enabled to conduct a study of episiotomy, one of the first research studies conducted by a midwife. Her study found that routine episiotomy did not prevent tears, did not protect the baby, did not prevent infections and furthermore gave us a research paper that we handed over to women who did not want episiotomies (Sleep J, 1984). The women then started quoting the research to the professionals. We also advised them to ask one specific question when being told that they had to agree to a specific procedure – ‘Can you give me a copy of the research paper that supports what you are saying, I will then read it and let you know my decision?’ So often there is no research to support the advice.

**Induction of labour**

As long ago as 1974 our current President, Jean Robinson, wrote an article in The Times newspaper drawing attention to ‘conveyor belt system’ and how strongly women objected to being induced. At that time induction was sold to women with a promise that the birth would be over quickly. The staff were not concerned with the pain and distress an induced labour causes. The objective was the get the women through the labour ward as fast as possible. Despite user objections induction of labour is as prevalent now as it was then, but the reasons have changed. Now women are told that their pregnancies have gone over 40 weeks and their baby could die without an induction - no-one is checking how many babies have died because they were induced. AIMS was so concerned about how badly informed women are about induction that we have produced a book to enable them to make an informed decision. Indeed AIMS has produced a whole series of books from Am I Allowed? which tells women what their human rights are to Birth After Caesarean for those women who want a vaginal birth after a previous caesarean section.
Induction of labour has an impact on birth experience and the health of women and their babies, and so needs to be clinically justified. It may be less efficient and is usually more painful than spontaneous labour. Epidural analgesia and assisted delivery are more likely to be needed if labour has been induced. (NICE quality standard QS60 Published April 2014)

Caesarean Sections

There is no health improvement for either mother or baby when caesarean section rates exceed 10% (WHO, 1985).

The rise in caesarean sections is an international disgrace, in the UK there are hospitals where the caesarean section rate has exceeded 30%. If men had major abdominal surgery and it was established that two thirds of the operations were unnecessary or avoidable there would be a national outcry. In the UK we have an expression ‘you cannot see the wood for the trees’. It means that you are so involved you cannot see why this is happening.

The situation brings to mind a wonderful midwife, Tricia Anderson, who wrote this:

‘But just imagine that one day, quite a long time ago, a group of well-meaning scientists decided that they wanted to study how cats give birth. So they asked anyone who had a cat, that when she went into labour to bring them to their laboratory - a brightly-lit, noisy, modern scientific laboratory where scientists could study them, by attaching lots of monitors and probes, surrounding them by strange technicians constantly coming in and out with clipboards. In the laboratory, the labouring cats could hear the sound of other cats in distress, and there were no private dark corners for them to retreat to, but only rows of brightly-lit cages under constant scrutiny of the scientists.’

Over time the scientists concluded that cats did not know how to birth and none of them had seen a normal birth because that is not what happens in that environment. Just as zoologists, many years ago, realised that birds and mammals do not behave naturally in a caged environment the time is long overdue that our doctors and obstetric nurses realise that women do not birth naturally in a large, centralised, obstetric units.

Normal Birth

Which brings me to one of AIMS most successful campaigns because it provoked doctors and midwives to think about what a normal birth actually is. In 1997 I wrote an article in the AIMS Journal ‘Normal birth does it exist’ in which I pointed out that very few women experienced a normal birth in hospital because of the amount of
intervention to which they were subjected. It was not uncommon for women to tell us that they had an horrendous delivery the last time and they ‘never want to have a normal birth ever again’, but when they explained what happened in their ‘normal birth’ it became clear that there was nothing normal about it. It transpired that the women had gone into hospital at the first twinge, had then been told that either the labour needed starting off, or that as the labour had slowed down a drip would be put up to ‘get you going again’. Before long the pain of induction or acceleration was intense, and made worse by continuous electronic fetal monitoring, which required the woman to lie on the bed and remain still. The women started asking for pain relief and eventually an epidural would be set up. If the woman was lucky she might be able to push the baby out, but would probably have an episiotomy in the process and the placenta would be delivered by active management. The staff would then write ‘normal delivery’ on the case notes. There is nothing normal about this.

I estimated that fewer than 1 in 10 women have a normal birth in our large, centralised, obstetric units. The midwives were horrified and a research midwife Soo Downe undertook a survey of five consultant units in one region to test my claims. She found that only 1 in 6 women expecting their first babies and only 1 in 3 women expecting subsequent babies had normal births. (Downe S et al, 2001). The study excluded from the normal group women who had caesarean operations, general anaesthesia, forceps or ventouse, epidural, artificial rupture of membranes, induction or acceleration of labour, episiotomy. It should be noted that the ‘normal birth’ group in this study still included women who had had electronic fetal monitoring, other drugs in labour and a managed third stage. So the true numbers of normal births are even lower.

For those who want to explore what normal birth actually means and what the effects are I suggest they read Soo Downe’s book Normal Childbirth evidence and debate.

The value of real midwifery

The majority of maternity staff have lost sight of normality. The hospitalisation of birth not only damages women, it also damages midwives. Over time, the midwives lose their midwifery skills. The skill of watching and listening, of being there quietly in the background, available to give reassurance and help and guidance. Instead, midwives have become obstetric nurses. Skilled at putting up drips, monitoring the labour and following the protocols, and those are really needed for those women and babies who have problems, but when it is visited on the fit and healthy this kind of care has resulted in astronomical levels of avoidable and often unnecessary interventions. In my own local hospital the caesarean rates have escalated to 30% and the staff justify this by claiming they have more women with special needs, women who are over-weight or mature. It is
because they are not giving women the kind of supportive, watchful care provided by a midwife who the woman knows and who has attended her throughout her antenatal care, during the birth and postnatally.

Women who receive Midwife-led care:
- Are less likely to have an antenatal hospital admission;
- Have a reduced need for pain relief, episiotomy and instrumental delivery
- Are more likely to have a spontaneous vaginal birth
- initiate breastfeeding.

(Delivering high quality midwifery care, Department of Health, September 2009)

**Continuity of Carer**

Because of our industrialised model of maternity care midwives are struggling to provide continuity of carer, which is vital for enabling women to birth successfully. Our government has realised the benefits of continuity of midwifery care and has made the following statement:

Ensure every woman has a named midwife who will make sure she has personalised one to one care throughout pregnancy, childbirth and during the postnatal period ..... (NHS Mandate, December 2014)

The research is clear: Midwife-led continuity of care
- was associated with several benefits for mothers and babies, and had no identified adverse effects compared with models of medical-led care and shared care. Research demonstrates that personalised care provides the following benefits:
  - 19% less likely to lose a baby before 24 weeks
  - 23% fewer pre-term births
  - 12% fewer instrumental delivery (forceps or ventouse)
  - 16% fewer episiotomies
  - 17% fewer had an epidural or spinal
  - 20% fewer had their waters broken

(Sandall J et al, 2013).

**Action for Change**

The research is now showing the benefits and it is time to demand change. Challenge – ask for the evidence for any proposed intervention Support – you cannot achieve change on your own, develop a network and a local
group
Inform the women – when women know the facts they act upon them
Value lay people – it is women who bring about change and they can do so by asking the difficult questions.
Cultivate the Press – write a letter or ring a journalist to correct any error
Publish – factual information leaflets and books
If at first you do not succeed, try another tactic.
If midwifery is to survive and grow it is YOU who needs to take action, do not leave it to someone else.
AIMS has a wealth of information and we are more than willing to share with anyone, so I urge you to explore their web site and use the information that is there. There is no point in re-inventing the wheel.

AIMS: www.aims.org.uk chair@aims.org.uk
Beverley A Lawrence Beech (Hon Chair AIMS )

Note
3. The largest analysis of nearly 17,000 planned home births in America with a midwife found overwhelmingly positive health benefits for low-risk mothers and babies.
http://www.mana.org/blog/home-birth-safety-outcomes?fb_action_ids=10202308196259545&fb_action_types=og.likes&fb_source=other_multiline&action_object_map=[1414447515467717]&action_type_map=[%22og.likes%22]&action_ref_map=[]
Article first published online: 23 JAN 2015
5. Further research supports the BirthPlace study findings.
A study in Germany of 90,000 births found that the out of hospital births had better

6. BirthPlace Study  
http://www.nets.nihr.ac.uk/__data/assets/pdf_file/0006/84948/SDO_FR4_08-1604-140_V04.pdf


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