Dominant Discourses Affecting Asylum Seeking Women

Nimat Ahmed Chowdhury - Second-year Student Midwife at Swansea University

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Summary

It is widely accepted that the media can act as an agent of social control. For instance, the media’s depiction of migration as a threat provokes moral panic and negative societal attitudes towards asylum seekers. In this article, Nimat Chowdhury discusses how negative media, political and social discourses influence the quality of care midwives and students provide to asylum-seeking women (ASW), and suggests that negative attitudes towards ASW can be negated through continuity of care (CoC) and inclusive education programmes such as the Maternity Stream.

Introduction

Misconceptions about asylum seekers generate negative attitudes within society, and the midwifery profession is no exception, as dominant negative political, media and social discourses can influence the care provided to pregnant asylum-seeking women (ASW) and birthing people. ASW seek protection under UK law if they have encountered or are at risk of sexual abuse, war or any other threat to their life. The Refugee Council emphasised that ASW and refugees comprise 14% of maternal deaths in the UK, despite only accounting for 0.5% of the population. This over-representation of ASW in maternal mortality statistics suggests that maternity care is not equitable, and that maternity settings need to do more to accommodate the needs of ASW and promote healthy pregnancy outcomes for this vulnerable group.

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Dominant discourses

Political discourse centres the government’s negative outlook on migration to the UK, which is reinforced by the net migration rate being reduced to 9% between 2019 and 2020. Brexit has enabled the government to reduce migration rates with the support of the general public, a decision which was arguably influenced by the refugee crisis and societal disapproval of migration. This political development precipitates negative views and attitudes towards ASW among qualified and student midwives, and promotes a lack of empathy and understanding for ASW-specific needs that hinders the quality of care ASW receive. Asylum seekers’ diverse norms, values and cultures can be perceived as threatening due to the concern that British culture may become marginalised or viewed as inferior. These hypothetical threats contribute to the marginalisation of asylum seekers from the rest of society, and the government reinforces these views by prioritising the British economy over the basic needs and rights of asylum seekers, by imposing restrictions upon voting, employment and housing choices. Sensationalist media stories are known to alter societal attitudes. This sensationalism usually favours governmental rhetoric and supports policies for strict visa and immigration application processes designed to reduce migration rates. The media portrays asylum seekers as individuals that exploit the welfare state, thus maintaining society’s view that they abuse the benefits system when, in reality, asylum seekers are not entitled to mainstream benefits. The dominant influence of the media can also obstruct maternity care staff from
questioning the harmful stereotypes associated with asylum seekers.

‘Moral panic’

Media coverage surrounding immigration is often based upon prejudice and designed to enrage and influence beliefs in favour of a specific agenda. Former prime minister David Cameron’s speech on immigration in 2012 stated there will be no ‘soft touch’ approach towards asylum seekers.8 However, Cameron did not discuss the various reasons for migration to the UK, which had the effect of belittling asylum seekers and creating social tension and hostility towards them. This biased language demonstrates a lack of sympathy towards ASW, irrespective of the validity of their claim for asylum.8 Cohen coined the term ‘folk devils’, as asylum seekers are portrayed as deviant outsiders, unwelcomed by society.9 Stereotypical attitudes, including describing asylum seekers as terrorists or criminals initiates ‘moral panic’, wherein such groups are seen as a threat to society.10 This sentiment encourages hate crimes including physical and verbal abuse that pose risks to asylum seekers’ safety. Midwives must promote accessibility to maternity care by providing safe, inclusive and supportive environments, without hostility or abuse, where every pregnant ASW feels comfortable accessing maternity care.

Changing education

The media has been accused of conflating asylum seekers with migrants,5 but while migrants typically move to other countries for employment purposes, asylum seekers are individuals seeking political refuge and have not been granted refugee status. Student midwives are not immune to barriers to their understanding of asylum seeking, possessing negative attitudes or describing pregnant ASW as criminals.10 Therefore, universities are encouraged to adopt inclusive education programmes that produce student midwives with the knowledge to challenge misconceptions and effectively improve care and pregnancy outcomes for ASW.

Racism and cultural stigmatisation
Immigration is viewed as a national concern in Britain,\textsuperscript{11} which explains why ASW experience prejudice and feel alienated by wider society. In addition, asylum seekers were found to accept and tolerate racism, due to the uncertainty of whether they would be dismissed because of the cultural stigmatisation associated with making allegations of racism.\textsuperscript{12,13} Midwives should provide continuity of care (CoC) for pregnant ASW to encourage a holistic approach, instead of the dominant medical model.\textsuperscript{14} CoC enables advocacy, ensuring racial and cultural stigmatisation are less impactful barriers for ASW when accessing care from the multidisciplinary team.

\textbf{The Maternity Stream}

The complex health and social needs of pregnant ASW are well documented, yet current provision does not meet ASW’s specific needs. ASW are at a greater risk of maternal death because they are less likely to attend antenatal appointments because of language, geographical and financial barriers, thus increasing their risk of poor outcomes.\textsuperscript{15} The Maternity Stream of the City of Sanctuary is a charity working with voluntary and statutory maternity services to adapt care provision to meet pregnant ASW’s needs.\textsuperscript{16}

The Maternity Stream found that some midwives display poor attitudes towards ASW, highlighting the need for education that discourages discrimination. The organisation’s goal is for services to promote inclusive care for all ASW by encouraging them to share their maternity care experiences, and produce posters that are accessible to service users with limited comprehension of written English. By taking these steps to make their services more inclusive, services work towards achieving their ‘Maternity of Sanctuary’
award. Inclusive care provision also acts as a learning tool for students and midwives, as they are encouraged to adapt their practices by listening to ASW’s maternity experiences.

**Conclusion**

Evidence suggests that dominant negative social, political and media-based discourses about migration affect the attitudes and practice of student and qualified midwives.\(^{17}\) Midwives are obligated by the Nursing & Midwifery Council (NMC) to show compassion towards all birthing people, while avoiding stereotypes, prejudice and discriminatory practices.\(^{18}\) CoC, the Maternity Stream and inclusive education programmes can encourage students to challenge discriminatory discourse and become confident when supporting ASW, while promoting inclusivity and improving pregnancy outcomes. **TSM**

### References


Gender Identity: Student Midwifery Beyond the Binary

Mx Ash Bainbridge (they/them) - First-year Student Midwife, University of Worcester
Mx Rowan March (they/them) - First-year Student Midwife, University of Surrey

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Summary

The midwifery workforce is diversifying and is now home to more gender non-conforming midwives (0.4%) than male midwives (0.3%). In this commentary, Ash Bainbridge and Rowan March share their experiences of midwifery training as gender non-conforming people. They shed light on how healthcare students and professionals can improve the experiences of their gender non-conforming colleagues and discuss the importance of inclusive language.

Can you explain your gender identities?
**Rowan:** I go by ‘non-binary’ – someone who identifies with a gender outside of male/man/boy and female/woman/girl. I feel this label fits me best. My gender is somewhere in the middle of male and female, but it isn’t static.

**Ash:** Like Rowan, I understand gender as a spectrum and a person’s gender identity can fall anywhere in relation to this spectrum. My identity is agender, which means I do not identify as a man, woman, or anything in between. As such, I am referred to as a person and my pronouns are gender neutral (they/them/their). Here is an example of my pronouns in use: ‘Ash is a student midwife in their first year of training. They are passionate about informed choice and person-centred care. Do you know them?’

**Why have you changed your name?**

**Rowan:** My deadname (the name I was born with and no longer use) was very feminine and I never really associated with it. People would often call my deadname and I wouldn’t realise they were talking to me! Being addressed by my deadname makes me feel nauseous; choosing a new name that I felt comfortable with made me so much happier. I decided to change my name legally before beginning midwifery training. I felt like I was moving into a new, better, phase of my life and wanted to bring my identity with me.

**Ash:** Unlike Rowan, I have not yet changed my name legally. I have already experienced one name change (my married surname) and found this tricky. I chose to live with my new name before making any formal changes. My old name was weighed down with expectations, many of which were rooted in gender. Selecting a new, gender-neutral name has given me the freedom to shake off these expectations and present myself exactly how I feel – a name with connotations of nature and a gothic edge!

**What value do gender non-conforming students add to the profession?**
Rowan: We add different perspectives. Not everyone who falls pregnant and gives birth identifies as a woman. Being visible as someone other than a woman in a traditionally female-led environment may help others feel at ease with revealing their own identities, or simply feel reassured that they are in a safe space with us.

Ash: I agree. Male and female midwives are important, therefore, gender non-conforming ones are, too. From a perinatal service user’s perspective, care for gender non-conforming people can appear discriminatory and unsafe; a midwife is ‘with woman’ providing ‘woman-centred care’ in ‘maternity’ services.3 By sharing our identities, Rowan, myself and others, are showing gender non-conforming birthing people that members of the LGBTQ+ community are present. We share a universal experience of living beyond a gender binary and our experiences of this are unique. We understand body dysphoria, which some gender non-conforming people experience, and its potential impact on a pregnant person’s choices. We will always ask, for example, which words are most appropriate when referring to a pregnant person’s anatomy: some will want to breastfeed, others chestfeed, and others not mention bodyfeeding at all. In the UK, more than a third of trans* people have avoided accessing healthcare services for fear of prejudice.4 In a bid to evade discrimination, invasive examinations and observations, some people even choose to birth alone.5 As healthcare professionals, we have a responsibility to ensure that all birthing people are, and believe they are, included, well cared for and safe.

What are your most positive experiences so far as gender non-conforming student midwives?

Rowan: For me, I would say how supportive everyone has been. I decided to start university by not hiding who I am. Yes, people slip up, but I can tell that my cohort and lecturers are all trying! My personal tutor even spoke to the university’s diversity team after I spoke with her so that she could have a better idea of what being non-binary means!

Ash: Hearing on the grapevine that students in my cohort are advocating for gender inclusivity. They have
defended using ‘birthing people’ as well as ‘women’ in their summative work, are educating supervisors about correct pronoun usage and challenging assumptions and inaccuracies when appropriate and safe to do so. They are striving for change as allies.

What challenges have you faced?

☐ Male
☐ Female
☒ Non-binary

Rowan: Two particularly stressful challenges stand out for me. First, I was unsure if I would be able to go on placement on time. The online Disclosure and Barring Service (DBS) forms do not cater for the title ‘Mx’ (pronounced mix) printed on my ID forms, leaving me struggling to source a paper alternative. Second, I was provided with a women’s uniform where I had ordered a men’s size. Getting your first uniform is ordinarily an exciting part of being a student midwife, and I felt so disappointed and upset. There is an ongoing struggle of deciding whether to be ‘out’ as non-binary; not knowing how people will respond or if they will be unpleasant. I also really wish people would stop referring to the cohort as “ladies”!

Ash: Deciding whether to wear a bra or chest compressor for long shifts, feeling guilty for using gender-neutral toilets on campus as they are also reserved for disabled users, trying on my uniform with my peers when I was wearing a chest compressor and felt too self-conscious to undress, working through prescribed reading written by transphobic authors, and feeling pressured to discuss my gender identity when I do not feel comfortable doing so. The most frustrating challenge I repeatedly face is being reassured that I ‘need not worry because they have attended LGBTQ+ inclusivity training’ – yet within moments, I am called a ‘lady’ and my pronouns are forgotten. Inclusivity is not a ‘tick box’ exercise. Inclusivity requires consistent learning, empathy, consideration and action.

How can cisgender* colleagues help? (*someone who identifies with their gender assigned at birth)
Rowan: Including pronouns anywhere your name features is a good place to start (email signatures, social media bios etc). If only trans* and non-binary people include pronouns, this signature becomes an identifier of being LGBTQ+. You could even get a badge with pronouns on and wear it on a lanyard or uniform to help normalise this practice. If you are not misusing pronouns intentionally, it is not an issue. I sometimes struggle to conjugate my own pronouns! ‘Trans*’ and ‘queer’ are words that should be used with caution. Some people have had these terms used as transphobic slurs against them or may prefer not to use them for various reasons. Always ask, just in case.

Ash: If you are unsure what or how to use someone’s pronouns – just ask! Mistakes happen and, when they inevitably do, just correct yourself and move on.

Any final bits of advice?

Rowan: Gender is a very individual experience, so do not generalise based on someone else with a similar label. Cisgender colleagues should also never ask invasive questions about gender, transition, sexual preferences or how a person presents. If someone wants to share private details with you, they will.

Ash: In practice, gender non-conforming students and midwives may need support in situations that demand ‘code switching’. Code switching is when speech and mannerisms change to put forward a different identity at a given moment in time. Two examples requiring code switching are discussing pink and blue clothing with parents for whom these colours are significant and declaring the sex of the baby at birth as an important moment for families. Cisgender colleagues can assist by leading these conversations and providing time for gender non-conforming colleagues to process when working in spaces of varying approaches to sex and gender. TSM

Recommended resources
Pronoun acrylic lapel pins:
Rise Up Midwife
https://www.riseupmidwife.com/
$11.50

Books:

Gender: A Graphic Guide


Where’s the Mother?: Stories from a Transgender Dad

Portraying Pregnancy: from Holbein to Social Media

Film

Seahorse: The Dad Who Gave Birth
2019, Jeanie Finlay, BBC, Vimeo

Our Baby: A Modern Miracle
2020, Gussy Sakula-Barry G, Channel 4 4OD.

Workshop

The Queer Birth Club
AJ Silver, https://queerbirthclub.co.uk/

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Midwifery and Gender Discrimination in Ontario, Canada

Joanna Besana - Registered Independent Midwife, Ontario, Canada

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Summary

This four-part series explores the joys and challenges of being an independent midwife (IM). In Ontario, midwives are self-employed, independent contractors paid by the Provincial Government’s Ministry of Health (MOH). They are publicly insured and provide free, accessible care to residents. In this issue of The Student Midwife, Joanna Besana discusses how gender discrimination affects midwives in Ontario.

Gender barriers
In 1994, midwifery in Ontario became governed by the Regulated Healthcare Professions Act. Expert analysis determined appropriate compensation for midwives based on the scope of their practice and comparators to other healthcare professionals offering similar services (obstetricians and family doctors). This analysis highlighted midwives’ vulnerability to gender discrimination as predominantly female professionals providing care to women. Initially, midwives received compensation with increases that were commensurate with the cost of living and similar to other healthcare professionals. However, although midwives’ workload and the complexity of their care provision has increased, the government has not continued the compensation adjustments.¹

Gender discrimination

In 2011, a joint study recommended a 20% equity adjustment to midwifery compensation, but the MOH not only ignored this recommendation, they also froze compensation for Ontario’s midwives.² After repeated failed negotiations, in 2013, Ontario midwives pursued litigation against the Ontario Government with the Human Rights Tribunal of Ontario (HRTO) on the basis of gender discrimination – midwives predominately identify as women and provide care to women, yet no longer received compensation in line with professionals from male-dominated healthcare professions.

A huge win

In September 2018, the HRTO found that ‘MOH systematically discriminated against midwives on the basis of their gender when setting their compensation’,³ and ruled in favour of Ontario midwives. The HRTO ordered the MOH to increase the compensation to midwives by 20%, retroactive to 2011. Additionally, the HRTO ordered a new joint pay equity study to determine the pay gap between current compensation for Ontario midwives versus how we should be compensated. Finally, HRTO instructed the MOH to pay each midwife a one-off ‘injury to dignity’ payment for the years of systematic gender discrimination.³ The MOH
appealed to the Divisional Court but the HRTO decision was upheld unanimously. While a second appeal to the Appellate Court is being considered, MOH has already begun the remedy process, Ontario midwives have received their injury to dignity payments and the initial back-pay is being calculated. Ontario midwives spent years pursuing gender-based equity while the government repeatedly ignored our claims. The decisions of the Tribunal and the Courts reinforce the need for fair and equal compensation regardless of gender. TSM

### References


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### Changing the Narrative: What Student Midwives Need to Know About Deinfibulation

Denise Hall - Senior Lecturer, Kingston University
Krystyna Nowobilska-Dean - Third-year Student Midwife, Kingston and St George’s University

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### Summary

In the final instalment of a two-part series about female genital cutting (FGC)*, Denise Hall and Krystyna Nowobilska-Dean explore deinfibulation as a clinical skill that can be used to facilitate vaginal birth for FGC survivors**. For detailed information surrounding the anatomy of the vulva, the global prevalence of FGC, pretexts underpinning the perpetuation of FGC and arguments for culturally sensitive FGC midwifery education and care, please refer to the first article in this series.¹

*Female genital cutting is used in lieu of female genital mutilation (FGM).

**Individuals affected by FGC are referred to as survivors rather than victims.

### Introduction

Deinfibulation is a minor surgical procedure that re-opens vulval scar tissue caused by type 3 FGC (otherwise known as infibulation). An anterior incision is made through this scar tissue to allow a clear
external view and access to the vaginal introitus and urinary meatus. The resulting edges are then oversewn to prevent re-apposition. Deinfibulation is completed under local anaesthetic as an outpatient procedure or within a birthing room, by a trained practitioner.

**When is deinfibulation performed?**

Elective deinfibulation can be performed preconceptually, perinatally or following childbirth. Although there is a distinct lack of evidence surrounding the optimal timing for deinfibulation, research has shown that intrapartum deinfibulation for birthing people with type 3 FGC may cause a prolonged second stage, increase episiotomy rates, hospital stays, postpartum haemorrhage and the incidence of emergency caesarean sections, suggesting that antenatal deinfibulation improves pregnancy outcomes. FGC survivors should be fully informed about any potential requirement for deinfibulation early on in their pregnancy. Urgent antenatal referral for elective deinfibulation is appropriate if it is required to facilitate vaginal birth and the woman wishes to have the procedure prior to labour during the second trimester. During labour, deinfibulation may be performed with consent to enable adequate vaginal examination/assessment, catheterisation, crowning or prior to assessment for an episiotomy. Following a caesarean section, deinfibulation can be performed with spinal analgesia in situ.

**Who can conduct deinfibulation?**

Any assessment or diagnosis of FGC should involve appropriate interpretation services, chaperones as required and emotional support to prevent re-traumatising potentially vulnerable people. Registered midwives can undertake additional specialist training in deinfibulation techniques, but if there are no specialist midwives available in antenatal or birth settings, appropriately trained obstetricians can perform it. Due to the potential emotional distress of multiple vaginal examinations, deinfibulation or birth, FGC survivors may benefit from the support of both specialist midwives and continuity of carer (CoC), alongside obstetric input if required. Individuals without further comorbidities are suitable for midwife-led care, especially since midwifery-led care has been shown to improve outcomes for late diagnoses of FGC. However, research reflects midwives’ desire for more FGC training, which suggests that improved training and the dissemination of appropriate midwifery care guidelines could improve care provision and offer enhanced protection from FGC for future generations. Despite the apparent benefits of midwifery-led care, student midwives do not receive comprehensive education about deinfibulation. While students are consistently taught mediolateral episiotomy technique and introduced to complex pelvic floor suturing, they are not trained in deinfibulation – a less invasive, more straightforward procedure that can absolve the need for episiotomy for FGC survivors.

**Analgesia**
Adequate pain relief is essential. FGC is frequently performed with no analgesia and genital pain can precipitate psychological trauma. Analgesia should be administered in line with individual needs and can range from general anaesthetic, epidural, spinal, local anaesthetic or Entonox inhalation. Lidocaine 1% can be used as per the midwives’ exemptions during labour. If an epidural or spinal is in situ, the sensory block should be assessed prior to starting the procedure. Diclofenac suppositories can be used post procedure to offer longer-lasting pain relief if not otherwise contraindicated.

Performing deinfibulation
Elective deinfibulation takes 30-45 minutes to complete. The individual’s privacy, dignity and personal preferences (see box 1) must be respected, and they must be given enough information to support informed decision-making.

**Box 1: Individualised reasonable adjustments**

- Consider positioning. Lithotomy stirrups may cause flashbacks to undergoing FGC
- Dimming the lights
- Use an eye mask
- Playing music or a podcast
- Support hypnobirthing or mindful breathing techniques
- Aromatherapy oils for relaxation where appropriate
- Don’t forget the birth partner! Offer them refreshments to promote relaxation
- Spinal or epidural anaesthetic may be appropriate for someone with severe anxiety or pain
- Entonox inhalation should be offered during infiltration if there is no epidural or spinal in situ.
1. Prepare your equipment (see box 2).

2. Position the individual so they are comfortable while allowing clear visualisation of genital structures. Lithotomy may be used if this is agreeable to the woman: ask them to place their bottom at the edge of the bed and direct their knees upwards and upright. Alternatively, rest their knees facing outwards and adjust the pelvis to tilt upwards, releasing pressure on the pelvic floor.

3. Prepare your sterile field, wash your hands, and don appropriate PPE for an aseptic procedure.

4. Obtain consent prior to cleaning the external genital area with sterile water and gauze.

5. Using lidocaine 1%, infiltrate the midline along the scar tissue. If the introitus permits, gently insert two fingers, or use artery forceps, to protect the structures below during infiltration. Wait for one to two minutes, then check anaesthetic efficacy by gently gripping the surrounding areas with forceps.

6. Insert spencer wells forceps into the introitus and open gently. Use this to guide your anterior incision. The incision should end just beyond the urinary meatus, to allow for easy voiding. Use your fingers to feel
7. Inspect the incision site for any bleeding. Very carefully inspect the revealed genital tissue to identify any partial or intact clitoral or labia minora tissue palpable within the scar tissue.

8. Using either continuous or a small number of interrupted sutures, oversew the edges of the incision to promote haemostasis and prevent re-anastomosis.

9. Place a piece of paraffin gauze between the labia and provide a sanitary towel.

10. Ensure clear communication about ongoing wound management and analgesia.

**Postoperative considerations**

The paraffin gauze placed between the labia should spontaneously fall off when the individual first passes urine, alternatively it can be gently peeled away. Good hygiene practices and avoidance of perfumed products in the vulval area should be recommended. The labia should be gently parted daily to prevent re-
adhesion during the healing process. After seven to ten days, the sutures should dissolve; individuals should be advised these may be observed in their underwear or on toilet paper after wiping. Providing information about the signs of infection will help individuals know when to seek medical assistance. Simple analgesia such as paracetamol or ibuprofen, if not contraindicated, should provide suitable comfort during the healing process. Clear communication following deinfibulation is important to ensure ongoing quality of life. Practitioners should advise whether they identified any remaining clitoral tissue upon examination and how this may impact their ongoing intimate relationships. Many type 3 FGC survivors will have had issues with urination throughout their lives; noticeable improvements should be apparent following deinfibulation, such as faster urinary flow and reduced urinary tract infections. It may be appropriate to recommend that individuals inspect their genitals with a mirror to see the changes to their anatomy. Take care to provide non-judgemental information on how intimate relationships may change or require adjustments, such as using extra lubrication when resuming intercourse. Despite a distinct lack of research into the impact of deinfibulation on sexual intimacy, a scoping review found that deinfibulation resolved sexual dysfunction in seven out of eight women.

Conclusion

This article introduces deinfibulation as a key clinical skill for midwives, and should be used to supplement comprehensive specialist deinfibulation training and education. Deinfibulation is a life-altering procedure that can improve the birth experiences and personal lives of FGC survivors. As such, it should be approached with sufficient clinical skill, knowledge, respect and as much dignity as possible for survivors. TSM

References

Widening Access: Is There Space for Men in Midwifery?

Samuel Todd – Assistant Lecturer in Midwifery and Professional Midwifery Advocate, Birmingham City University
Usaama Ssewankambo – Fourth-year Student Midwife, Lira University, Uganda

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Summary

Historically, midwifery has been a female-dominated profession,¹ and there is ongoing debate about whether men should be allowed into birthing spaces, and whether male midwives are what birthing people and families want. However, ‘midwife’ as a professional title means ‘with woman’ rather than ‘women with woman’,² therefore, we should examine whether men experience gender discrimination when studying to become midwives or working in midwifery settings. Sam Todd and student midwife Usaama Ssewankambo discuss what inspired them to become midwives and strategies to make midwifery a more accessible career option for men.

Usaama Ssewankambo: ‘I found it easy to fit in’

I have always wanted to be a healthcare professional, but the thought of being a midwife had never crossed my mind until I completed high school; when my favourite biology teacher and stepmother influenced me to start thinking about a career as a midwife. Immediately after my final exams, my teacher, who doubled as my school’s career guidance counsellor, spoke to me about my career plans and informed me about a new opportunity to study midwifery at Lira University in Uganda. The midwifery programme was open to women and men, and there was the prospect of obtaining a state scholarship to cover the cost of the programme if you achieved the stipulated grades. Prior to this, my stepmother, who is a practising nurse-midwife, had spoken to me about the same opportunity. She believed in my academic ability and was sure I would get the grades to secure a state scholarship for the midwifery programme – and she was right! Despite their encouragement, I was worried about how others would react to my decision to become a midwife. I also kept asking myself: ‘How could a man be a midwife?’ Initially, my friends and some of my family members struggled to comprehend why I chose midwifery. Some of them poked fun at the idea and insisted upon referring to me as a ‘mid-man’ or ‘mid-husband’. Nonetheless, I decided to give it a shot because it was a bachelor’s degree programme. Traditionally, trainee nurses and midwives in Uganda study at certificate or diploma level, so completing a bachelor’s degree would give me a competitive edge in the job market. However, in other countries where bachelor’s degrees are common midwifery qualifications, the prospect of a bachelor’s degree programme alone is unlikely to be enough to attract male applicants.
Unlike Sam, who was the first male to undertake and complete the BSc (Hons) in midwifery at Birmingham City University, I found it easy to fit in when I started my midwifery training because there were quite a few other men on the programme – almost one third of my class were male. My female colleagues were very friendly and welcoming and I was recognised and respected as their colleague, rather than being mistaken for a visitor or somebody’s husband. There is evidence of sexist discrimination towards male students, including lecturers telling students that men should not be midwives because they know nothing about childbearing or women. Although I have only met supportive midwives, midwifery professors and students, this is not the experience of every male student, and universities must have easy, accessible systems for reporting gender-based discrimination. Most clients are happy for me to care for them, but occasionally my presence causes awkwardness. Many women and families refuse to refer to me as a trainee midwife and call me a ‘doctor’ instead, because using this misnomer is presumably more comfortable than accepting my identity as a male student midwife. Even though I am proud to be a student midwife, I do not correct people when they refer to me as a doctor, to prevent exacerbating their discomfort. Whereas these interactions do not have a negative impact upon me personally, they could be de-moralising for other male students. Therefore, universities and practice educators should prepare male students to navigate similar scenarios. Male students and midwives can be received with apprehension in maternity settings. I anticipate that I will be rejected by some women and female colleagues. Nonetheless, I respect women’s preference to be cared for by female midwives, because I have been taught that midwifery is all about empowering women to make their own decisions and respecting them. Furthermore, women and birthing people have the right to refuse care or treatment from any healthcare professional. Midwives and educators can normalise the concept of men being midwives by setting the expectation that women may be cared for by male students if this aligns with their personal preferences.

Samuel Todd: ‘midwifery should be viewed as a genderless profession’
My mother and younger brother were probably the biggest influence upon my decision to become a midwife. During my mother’s pregnancy with my younger brother, she developed pre-eclampsia and at 32 weeks’ gestation, following a series of eclamptic seizures, my younger brother was born via emergency caesarean section. These events increased my awareness of the complications women can experience during pregnancy and prompted me to explore midwifery as a career. My ambition was fully supported by my mother, and although encouragement from family and friends increases male applicants’ likelihood of applying for midwifery training, I advise other men not to let societal views of what a midwife ‘should be’ affect their decision to explore midwifery. Midwifery should be viewed as a genderless profession, however, as Usaama mentioned earlier, it is imperative that midwives provide culturally safe care and recognise and respect that for some women, cultural safety means providing a female birth team. In 2020, 104 (0.3%) of the 38,855 registered midwives in the UK identified as male and the number of male midwifery registrants has progressively dwindled since 2017; this under-representation of men in the UK’s midwifery workforce is arguably a deterrent for prospective male applicants. There is also evidence that non-inclusive learning environments impair under-represented groups’ sense of belonging, attainment and retention at higher education institutions (HEIs). To encourage men to envision themselves as aspiring midwives and academics, HEIs should integrate men into their academies and prospectuses to make their institutions visibly inclusive. HEIs should also look at how midwifery programmes are promoted to increase the number of male applicants. Furthermore, common sources of information about midwifery careers such as the NHS Health Careers and Universities and Colleges Admissions Service (UCAS) websites could normalise the existence of male midwives by referring to them in their resources.
Despite the scarcity of UK-based male midwives, career prospects for male midwives are excellent. Since qualifying in 2012, I have worked in clinical and academic positions including being a rotational midwife, Band 7 Homebirth Team Leader, Band 7 Sign Up to Safety Maternity Lead and Assistant Lecturer. I have noticed a small increase in men pursuing midwifery within my region and hope that male midwives such as myself serve as role models and examples of what men wishing to pursue midwifery can achieve. Despite all these accomplishments, the most fulfilling element of my job is being able to support women and birthing people during childbirth. Having supported women in all birth settings, working within a homebirth team has transformed my practice and perspective the most - there is no greater achievement than being welcomed into a family’s home and supporting a woman in her choices to have a physiologically and psychologically safe birth. Anecdotally, many female student midwives pursue a career in midwifery due to their personal experiences of pregnancy and childbirth, however, research is required to understand whether witnessing childbirth or becoming a father influences men’s decision to consider midwifery as a career option.

Conclusion

Men can be deterred from entering midwifery for numerous reasons including a lack of support from friends and family, sexist discrimination from midwives, peers and educators and a lack of acceptance from birthing people and their families. But as Usaama, Sam and the 0.3% of successful male UK midwifery registrants demonstrate, some men are interested in entering the
midwifery profession, successfully complete midwifery training and have note-worthy careers. In the interests of widening men’s access to midwifery, organisations responsible for healthcare education should seek input from aspiring and registered male midwives to determine how they can be supported to access and complete midwifery training. Additionally, further research must be conducted into why the UK’s number of registered male midwives has declined in recent years as a way to promote diversity within the modern midwifery workforce. **TSM**

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**A Change Will Do You Good!: Exploring Pre-Midwifery Careers**

Kay McWha - First-year Student Midwife, Sheffield Hallam University
Grace Mitchell – Registered Midwife, Kingston NHS Foundation Trust
Oli Silverwood-Cope – Registered Midwife, Gloucestershire NHS Foundation Trust

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Summary
Some people have childhood aspirations to become midwives, while others become interested in midwifery as a second, third or even fourth career – it is never too late to train as a midwife. Previous career experiences can make your midwifery training application stand out and positively shape your practice as a qualified midwife. In this uplifting article, two registered midwives and a student midwife describe what led them to pursue midwifery after successful careers as a head of English, singer and copywriter, and explain how their previous occupations have prepared them to enter the midwifery profession.

Kay McWha, first-year Student Midwife

Former career: Head of English

Throughout my teaching career, I dedicated all my time to being the best I could be. I excelled as a result and my peers held me in high regard as an outstanding teacher. Despite this, I knew that I did not love teaching and wanted to explore other career options. I thought that my feelings about leaving teaching would subside when I secured a part-time leadership position as a head of English when I returned from maternity leave, as I was finally the leader of change – but it was not enough. I did genuinely love making a difference, but I just could not shake my fascination with anything pregnancy and birth related. I often found myself wistfully daydreaming about being a midwife and I would Google the entry requirements and the universities I could attend, becoming obsessed with finding someone else that had changed their career from teaching to midwifery. After having my son, I reflected on my life and what would make me and my family happy. I had lost friends and ex-boyfriends because of my commitment to my job and the fatigue associated with teaching – and I also felt considerably older after nine years of teaching! Teaching was not always kind to me, and I didn’t want
to live with the regret of not pursuing midwifery while I still could. And so, one week before the global COVID-19 pandemic crippled the world, I handed in my notice!

My time as a teacher has imbued me with multiple skills that I did not have before. At the heart of midwifery is the responsibility to act as a champion for women and birthing people throughout a period of profound change, so that they feel fully empowered. This is akin to teachers’ advocacy on the behalf of the children that they teach. Teachers are also resilient and prioritise putting students first, in the same way that midwives place women and birthing people at the centre of care provision. My former career as an educator has also prepared me for being a life-long learner. I am proud to have been a teacher, but I am even more proud that I was brave enough to change a situation that did not make me happy, and that will bring me true success!

Grace Mitchell, Registered Midwife

Former career: Singer

I come from a family FULL of singers and musicians: my grandfather was a trained pianist, while my grandmother was renowned for her beautiful singing voice. This musicality filtered down to my father who played the saxophone, and my siblings and I are all singers or involved in music in some way. Music was always going to be a part of my life journey – I have had some amazing experiences as a backing vocalist, from recording sessions for artists such as The Manic Street Preachers and Pixie Lott to performing live at Glastonbury with Stevie Wonder. A passion to care for people and more specifically, a desire to become a midwife, always existed somewhere in my heart. As a teenager I always felt that midwifery was my calling, however, I was comfortable with singing – I knew music and music knew me. I did not have to worry about the unknown or navigating something new if I remained within my comfort zone of music; moreover, I slightly feared healthcare, which was a totally alien environment to me. Despite my apprehension I entered the healthcare profession anyway! And after a wedding and three children, I completed a nursing degree and began practising as a gynaecology nurse, while performing as a backing vocalist/session singer whenever it was humanly possible. Nursing seemingly fed my passion to care for people, but I still felt drawn towards midwifery. Once again, apprehension re-surfaced and I was fearful about returning to education to re-train as a midwife – my nursing degree had placed a lot of pressure on my family because my children were quite young at the time. I missed the UCAS deadline for the postgraduate course yet somehow ended up with offers from two universities! Now that I am a registered midwife, I feel totally fulfilled. I practice primarily as a midwife, perform on the odd occasion, and undertake bank shifts as a nurse.
The main lesson I would share with others entering midwifery after another carer is: ‘What is meant to be for you, will be yours.’ I spent a lot of time worrying about things and thinking it was too late to pursue midwifery, but with perseverance, determination and a few seemingly unconventional skills, I have been able to develop into the midwife I am today. Singing and performing has given me many skills that have been very useful to me as a midwife. I am often asked how I maintain a calm exterior during obstetric emergencies – I attribute this to the times that I have forgotten lyrics or had a wardrobe malfunction but managed to keep a smile on my face. My communication skills have also been enhanced by my engagement with audiences during and after a show – my husband often comments on my ability to create a whole conversation in a short space of time and build a rapport with people I have just met at the best and worst of times. On occasion, I have had to speak up to demand what I deserved as a performer, which takes confidence and can be daunting.

I have used these experiences of speaking up for myself when advocating for women and birthing people. My experience as a performer has also given me the confidence to develop a podcast. The Brown Mama Brown Me podcast features discussions about important topics related to maternal mortality and morbidity for Black, Asian and non-white mothers in the UK.

Oli Silverwood-Cope, Registered Midwife

Former career: Copywriter

After my Social Anthropology degree in 1990, I lived in Brazil teaching English for four years. Learning Portuguese as a second language meant tuning in, listening hard and being open-minded and open-hearted, all of which are essential communication skills for midwifery. The nineties were pretty fun; I job-hopped from ‘Ideas Stimulator’ at Leo Burnett brand consultancy, designing brand development workshops, to shoot coordinator in the creative department of Getty Images. My remit was to identify and fulfil new needs for imagery, organise idea generation exercises and maximise efficiency of the shoot programme – basically lots of spreadsheets and admin, all of which provided solid experience for the essential non-clinical side of midwifery. More importantly, the endless liaising with a diverse range of people developed key personal skills for midwifery, like the ability to create an immediate rapport with anyone and everyone.

Next, I worked as a prominent architect’s assistant, a position with chic appeal but heavy on administrative duties: correspondence, diary management, organising travel, lectures and liaising with clients and international project teams. It honed my attention to detail and design and multi-tasking skills. I worked under pressure every day and learnt to be professional and diplomatic when dealing with big personalities.
and competing demands – all useful grounding for the role of the midwife. Whilst assisting in the architect's Press Office, I started subbing manuscripts and drafting press releases. When I left to have a baby, I set up my own freelance copywriting company and worked with clients on their brand language and tone of voice. The strategic thinking and creative process of copywriting kept my brain active and kept enough money trickling in throughout the ‘the baby decade’. Even though I enjoy writing and I got to share the stories of great charities and organisations whose values I respected, I still had a deep yearning to be in service to humanity, in a person-centred, caring role, something I could look back on and feel truly proud of. My midwife, friend and inspiration, Joy Clarke, encouraged me to undertake midwifery training and I realised it made perfect sense. Midwifery is an expression of love and political consciousness, combining wellbeing with human rights and feminism, and is part of our struggle for sovereignty over our own bodies - all in one profession. Becoming a midwife in my 40’s after numerous career changes and three children was the hardest, but also the best thing I have ever done. It is never too late to reinvent yourself, and the opportunities to continue to do this as a qualified midwife are endless.

**Conclusion**

Midwives come from a variety of backgrounds and many practitioners enter the profession after pursuing other careers. Aspiring midwives should be encouraged to view skills gained from pre-midwifery occupations as qualities that make their university applications stand out. This article demonstrates that previous career experiences, irrespective of what profession they are gained in, can prepare aspiring midwives for midwifery training and enhance their practice when they become registered midwives. **TSM**

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**Does Diversity Matter?**

Renée Rose - Second-year Student Midwife at University of Hertfordshire

Published in The Student Midwife Volume 4 Issue 2 April 2021
Summary

Renée Rose challenges readers to consider the impact of a lack of diversity among trainee midwives upon student wellbeing, the midwifery workforce and healthcare outcomes.

Call the midwife

What do you envision when you think about midwives? Do you instantly think about characters from popular TV programmes such as *Call the Midwife*, or the imagery that dominates social media and midwifery textbooks? In the same way that women and birthing people come from a wide variety of backgrounds, midwives can also represent diversity in terms of religion, ethnicity, sexuality, gender and neurodiversity. Diverse representation in the maternity workforce is essential, not only to inspire future midwives, but to promote provision of culturally sensitive care.

Challenging personal bias

As a prospective student midwife, I was invited to an interview for a place on an undergraduate midwifery programme. In the final stage of the interview I was shown a photograph of a woman whose body was adorned with piercings and intricate tattoos. I thought she looked beautiful. I realised the interviewers wanted me to discuss how I would care for clients that looked like the woman in the photograph, so I expressed my desire to work with birthing people and families from all walks of life and why it is important for midwives to remain non-judgemental and provide equitable care to every woman and birthing person. As registered and trainee midwives, we must challenge our personal biases by attending LGBTQIA+ competency and anti-racism training, and continuously reflecting upon our practice.

Why does diversity matter?

When I decided to enter midwifery, I researched the role of the midwife and promptly realised that the images in books, journals, and websites did not look like me. This lack of representation led me to worry that I would not get a place at university or fit into a student midwife cohort. Non-diverse midwifery cohorts can further impair the self-esteem of students from marginalised populations by contributing to high attrition rates and precipitating an absence of diversity within the midwifery workforce, which is an undesirable outcome since recent studies agree that when patients and healthcare professionals share the
same ethnic background, communication is enhanced and health inequalities are decreased. To enhance the self-esteem of aspiring midwives, they should be advised that their passion, knowledge, culture, life experiences and individuality are special qualities that they can bring to the role of the midwife. TSM

References


Maintaining Your Identity

Sophie Lee - Director and Designer of The Happy Planner Company

Published in The Student Midwife Volume 4 Issue 2 April 2021

Amid the many changing landscapes and circumstances of this year, don’t lose sight of your own personal identity. An important component of developing resilience in preparation for joining the clinical workforce is becoming confident in who you are, and understanding your strengths, beliefs and values.

A really good exercise to perform if you’re feeling like your self-esteem is running a bit low is to list all the different roles, titles and jobs you fulfil. You’ll be amazed at what you mean to so many different people. Write a list of the things you value about each of these roles: these could be particular beliefs, ideals, or interests. Make your list as broad as possible. As a busy student midwife with a lot on your plate, it’s easy to forget your values and the things that mean so much to you. These values form a huge part of your
identities, and your individual identity is inherently valuable to the midwifery profession. You add to the wonderful diversity of your environment, so being confident in your identity, and pushing through certain barriers inspires others to do the same! Knowing your values and being confident in your identity are tools that will help you to flourish during your studies and deliver empowered and compassionate care to those you assist.

Our values are also helpful at giving us some insight into why certain circumstances might trigger particular frustrations. Whether these annoyances arise at placement or university, your value system can direct you towards a solution. Perhaps you value something that challenges barriers against social justice – you can use this passion to be proactive in initiating change for yourself or someone else.

For more information on developing your self-confidence and resilience, check out my book, The Resilience Plan for Healthcare Students. TSM

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**Perceptions of Midwifery**

**Kate Stringer - Clinical Lead Midwife/ Lead Professional Midwifery Advocate- Surrey and Sussex**

This is a series presented by the NHS England Midwifery Ambassadors.

**Introduction**

The #PerceptionsOfMidwifery Programme is one England’s Chief Midwifery Officer, Professor Jacqueline Dunkley-Bent’s three key ambitions. There are currently approximately 150 Midwifery Ambassadors working in NHS Maternity services across England, working together to promote, support and raise the roar for our profession.

Led by Claire Mathews, North West Regional Chief Midwife, the aim of the Midwifery Ambassadors is threefold, firstly to engage with the future midwifery workforce by sharing the art and science of midwifery with children and young people so that potential future midwifery students from all backgrounds, ethnicity
and gender, may consider midwifery as a career of choice. Secondly to work with the current midwifery workforce to ensure they feel motivated, valued and proud of the work midwives do, thus improving morale and retaining midwives in the profession. Thirdly sharing the positive work midwives do and the good news stories with the media and the public so they may encourage and support both our current midwifery workforce, our future midwifery workforce and of course in turn supporting the women, babies and families we care for across the country.

Through this series we hope to show people the different paths to midwifery and the wide range of roles there are available, including the pathways to success. Midwifery can be a varied and diverse profession and we cover a myriad of roles, much more than caring for babies!

I am currently the Clinical Lead Midwife at Surrey and Sussex NHS Hospital Trust. I am part of the Maternity Improvement team and lead on service development, quality improvement and key policy initiatives. I am also the lead midwife for preceptorship programme. My previous roles have included Consultant midwife and clinical educator in India; labour ward lead midwife; labour ward coordinator and community/homebirth midwife. I trained as a midwife when I was 25 and had 2 children during my training! Prior to being a midwife I worked full time in restaurants, pubs and clubs.

Midwife Life – this day was a particularly busy day but it does showcase the variety involved in my role! I love my job and continue to feel privileged to witness birth and be with families in these life changing moments.

**February 2020**

5:30 am- Get up and get ready. Make large cup of coffee and leave for work. I live around an hour away from where I work and like to be in early to catch up with the night teams and I’m definitely more productive in the mornings.

7am- Head to the Labour ward office and check in on the labour ward. Quick chat with the labour ward co-ordinator (LWC) where we discuss a concerning CTG. We briefly review the history and CTG together on the central monitoring system and agree it needs action, the registrar is already in the room and the coordinator is heading there next.

It’s the start of the month so I review the Labour ward handover log. We are currently auditing handovers and multidisciplinary (MDT) ward rounds. These were identified in the Ockenden Report (2020) as an area of national focus. The initial review shows we are not capturing all the information we need which could be a concern; I plan to review the data in more depth with the Intrapartum Matron and remind staff the importance of the audit and data needed.

Next I head around to the wards to say hello- no concerns identified at the moment. As lead for the preceptorship midwives I try to check in regularly and during my visit to the antenatal ward I have a brief discussion with one of the team about a mother who is having an induction of labour but had a caesarean in her first birth. We review the local policy, briefly discuss things to watch out for and her priorities for care on the ward that day.

8:15- Brief catch up with my team- the Maternity Improvement Team (MIT). We run through our Newborn Life Support (NLS) teaching for the afternoon.

8:45 – Quickly see the Risk Lead Midwife about a serious post partum haemorrhage which occurred last week, we discuss the learning outcomes and some of the ongoing quality improvement work in this area.

9:30- Online lecture to Surrey University students. Discussed physiological breech birth including how to support midwives and families. Focus of the sessions was developing as a practitioner so we encouraged a future outlook, how as future midwives they could build support for ideas, find their tribe and build a case for change.
10:30- Lovely cup of tea with a tearful colleague who needed a virtual hug and wanted to discuss some personnel challenges.

10:45-11:45 Senior Midwives and Matrons operational meeting with the HoM and DoM. We each run through our current priorities and challenges. As a team we discussed the current Clinical Negligence Scheme for Trusts (CNST) demands and staffing concerns.

11:50- Bleep went off. There is a client waiting to meet me who wishes to discuss a maternal request caesarean section. We are already known to each other as she has come to the Breech Clinic- the baby is now cephalic but she still wishes to have a caesarean. I have already spoken to her at length the week before and she was going to spend the weekend researching her options and we agreed to have a more in depth discussion and make a plan today.

11:45- I see the couple in the Birth centre. Monika (seduo name) is feeling more confident about trying a vaginal birth now she has had longer to consider it. It is her first baby and she plans to have more children but is feeling very anxious about having a large baby and at 39+5 feels she needs a plan. I discuss the situation with the on call consultant. Monika’s baby has consistently measured above the 90% centile and locally this would mean we offer induction of labour from 39-40 weeks. I discuss this with Monika, we also offer a scan to aid decision making. Monika and partner are really happy with this plan and if the scan is normal and the AN ward can accommodate her, Monika will be induced today. She is aware of the risks and benefits of all options and I can see a weight is lifted from her.

1pm- Host an Instagram ‘live’ session. This is a new initiative being led by our team of professional midwifery advocates (PMA). We host weekly live Q and A session to connect with our local pregnant community. These sessions run for an hour and we have had great feedback from families and the local Maternity Voice Partnerships (MVP). I was hoping the Birth centre lead would join me as it’s much easier when we have two professionals but everyone is busy so it’s just me talking about how to prepare for birth. Around 60 people logged on live and the video has over 750 views by the end of the day! The MVP lead and a local doula both contact me after to offer to co-host in the future. Fabulous!

14:15- Dash to other side of the hospital for the NLS teaching. Stop at the trust canteen on the way for a sandwich and drink.

14:30- Assist the Practice Development Midwife (PDM) with the preceptorship day and NLS teaching. It was a great session with lots of engagement and reflections from the team. So nice to have some face to face training for a change.

16:45- Discussion with the HoM about a difficult case and some concerns raised by the coordinator. We agree to host an after action review (AAR) to discuss the issues and resolve any conflict. The HoM will arrange.

17:00 As I walk back to my office through the Birth Centre- the PDM grabs me and says she thinks someone who has just arrived might be having a breech baby. She already has an urge to push. We quickly move to the nearest room on the labour ward and alert the team. Fresh meconium is seen on the pad and a vaginal examination confirms the baby is Breech, the cervix is fully dilated and baby descending quickly. I reassure the family, it’s not what they were expecting but this baby is coming quickly and we will support them to birth as safely as possible. Plus, they are in luck! I am the breech midwife and my colleague the PDM has also had additional physiological breech training. The registrar on call is experienced and also supports with the Breech clinic so we all know each other well.

17:10- Labour progresses quickly but we identify a problem with the arms. We are using the physiological breech approaches and know we need to intervene for safety. We resolve the complication gently and the baby is born quickly after. We are prepared for initial resuscitation and the parents are expecting this. The Neonatal SHO is struggling to gain an adequate airway so we swop roles and the baby improves quickly after 2 sets of inflation breathes. The baby is passed back to the parents and congratulations all round.
We host a very quick team de-brief. Everyone is pleased, really good team work, with clear leadership and confident actions. We utilised the new Breech pro forma and algorithms provided to the team as part of the OpiBreech research project led by Dr. Shawn Walker. The consensus was overwhelmingly positive.

18:30- Still not finished! Safety Huddle on labour ward with the LWC, Consultant, HoM, Intrapartum Matron and Safeguarding lead. A very complex client is on the way in, she has a severe trauma and mental health disorder and has had minimal antenatal care. We need to ensure the team is briefed about the history and informed of the care plan overnight.

19:00- Head home. What a day!

Follow the #PerceptionsOfMidwifery #MidwiferyAmbassadors #LoveYourMidwife on Twitter.

Kate.stringer@nhs.net
@Stringer4Kate
#Midwifelife Blog

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**PMA Reflections on Adaptation to Continuity of Carer**

Clare Gilliland - Professional Midwifery Advocate for Royal United Hospitals Foundation Trust, Bath

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**Summary**

In the year following implementation of continuity of carer (CoC) caseloding teams in my trust, I
noticed some initial anxiety in the midwives for whom I provide support as professional midwifery advocate (PMA). Over time, however, midwives reflected that they simply needed to adapt their behaviours, having been institutionalised by years in an on-call model and faced with more flexible boundaries on their working hours. Adapting to a new way of working takes time and honest reflection to achieve a shift in mindset and a healthy respect for those boundaries, after which midwives report a better-than-ever work/life balance.

Fear of the past

In 2016, the National Maternity Review report, Better Births, hit our desktops, and with it a sense of panic grew in the workplace. That same year, I attended the Royal College of Midwives (RCM) Continuity Celebrated conference. As a supervisor of midwives, I was keen to hear the thoughts of the nation’s midwives on the recommendation within Better Births: that ‘every woman should have a midwife, who is part of a small team of four to six midwives, based in the community who knows the women and family, and can provide continuity throughout the pregnancy, birth and postnatally’. The voices I heard were overwhelmingly negative. In 2016, and in the years since, the concerns of midwives have centred on work/life balance. Those working in caseload midwifery previously told the rest of us how it had been, and indeed how it would be: endless on-calls, with diminishing numbers of midwives working due to exhaustion, leading to vacancies, which in turn lead to further on-calls. Their message was clear: it cannot be done in a way that benefits midwives. Nonetheless, in the latter part of 2019, the Royal United Hospital (RUH) set about implementing continuity of carer (CoC) in several parts of the trust. To date, we have 12 teams across the trust, six of which employ a traditional caseloading model. Now a professional midwifery advocate (PMA), I offer support and guidance to midwives and maternity service workers (MSWs) within our trust and was braced for a potential stream of midwives struggling under the weight of CoC.

A caseloading future continues to worry midwives who have not yet made the switch, but it has been noted that a capping of caseload numbers has meant we have not encountered the previous problems: burnout and stress

Providing PMA support

Midwives began requesting guidance as early as April 2019, a full eight months before the first caseloading team launched. By January 2020, I was approached regularly, formally and informally, by midwives wishing to discuss their fears about the change of working pattern and how it might affect them. Those contacts continue almost daily and come exclusively from midwives not yet working in CoC. Midwives working caseloading CoC models began contacting me for discussion and support about halfway through 2020. As I predicted, they were reporting feelings of anxiety, inability to relax on 24-hour ‘Availabilities’ and a lack of work/life balance. Most are working a set clinic day, plus two or three Availabilities per week. During these Availabilities, they conduct home postnatal visits to their mothers, work on admin in their own homes (the trust provides phones and laptops) and are available for labour care for their team’s women, in the acute unit, freestanding midwifery units and at homebirths. They are protected from being called to staff busy units, at the bottom of a list of others who should be called first. They are aware they might be required to plug gaps only at the highest level of escalation. I provided restorative discussion, signposting for mental health services and guidance on methods of self-soothing, calming behaviours and techniques. We also agreed to keep in touch and see what improvement could be gained over time.
Adapting to a new way of working

It was in these follow-up sessions that I noticed a pattern. Midwives typically needed three to four months to ‘settle in’ to their new way of working. It appeared that, institutionalised by years of working an on-call model, midwives initially approach their Availabilities as if they were on calls: that they could be called without warning to attend a unit in haste, due to emergency or heavy workload, anywhere in the trust. The RUH has maternity services over a large geographical area, across initially five (now three) birthing centres, which could represent a 90-minute drive from one end of the patch to the other. On calls are therefore stressful: midwives have no way of predicting need, due to the ad hoc nature of maternity services.

Availabilities, midwives have realised, are different. These midwives are ‘available’ for their own team’s women, and they know who these women are. They can look at the apps in their trust-provided phones and see the small number of women who are currently due or overdue: where they intend to birth, their partners’ names and the number and type of births they have already had. Far from being required to attend immediately, midwives operate a ‘90-minute rule’: reach these local mothers in up to 90 minutes. The women know this, so they call earlier than they might if phoning the obstetric unit, waiting for the traditional ‘three in 10’. If Available, midwives often have conversations with mothers through the day and are thus aware of who is ‘niggling’, who is awaiting induction, who has had a show.

Because of midwives’ knowledge of the caseload, and the 90-minute rule, the unknown and emergent elements of on-calls are absent. Midwives can go to lunch, to an exercise class, walk the dog – safe in the knowledge that they have awareness of the caseload’s current status. Of the eight CoC midwives who contacted me in late 2020 with concerns regarding their work/life balance, six have since reported back that their anxiety has dissipated, having learned not to treat an Availability as an on call, and report a better work/life balance than in their previous roles. Of the other two, one decided to leave midwifery altogether in a bid to remove overnight working from her life, but has remained in a health profession, and the other is nearing retirement but is still battling with an inability to relax while Available.

Conclusion

A caseloading future continues to worry midwives who have not yet made the switch, but it has been noted that a capping of caseload numbers has meant we have not encountered the previous problems: burnout and stress. It does, however, require discipline to keep to these numbers, and to put one’s phone away at 5pm if not Available: something those six midwives have gradually realised. It appears that caseloading can be fulfilling and without burnout, as long as each midwife learns a new approach to her working life and a respect for her own time and wellbeing. TPM

Reference