Exploring the Needs and Lived Experiences of Women Hospitalised During Pregnancy in the UK: A Qualitative Diary Study

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Published in The Practising Midwife Volume 24 Issue 11 December 2021

Summary

There is a global call to optimise antenatal care experiences. Hospitalisation during pregnancy may have a significant impact on the experience of care. Thus, the aim of this study was to explore the needs and lived experiences of those hospitalised during pregnancy. A thematic analysis rooted in interpretive phenomenology was undertaken on the content of five written diaries produced by pregnant participants whilst hospitalised. Three themes were identified from the data; (1) 'Uncertainty'; (2) 'Loss of control'; (3) 'Vulnerability'. Study findings could usefully be translated...
Introduction

A pivotal moment in the history of maternity services was the publication of the Peel report of 1971,¹ which recommended that all women should birth in hospital. Hospitalisation in this report was recommended for a minimum of three days and thus it was recounted that the overt medicalisation of pregnancy overtook domiciliary midwifery care.²

Reasons for hospitalisations during pregnancy are varied.³ Yet in many cases, it is reasonable to assume that hospitalisations during pregnancy will result in parents being separated from their children, and have a significant impact upon the lives of those experiencing it. Consequently, the aim of this study was to explore the needs and lived experiences of women and birthing people hospitalised during pregnancy in the United Kingdom (UK).

Methods

This study used interpretive phenomenology (IP), as described by Heidegger.⁴ Our sample was purposive. Recruitment began once ethical approval was granted. Those aged over 18 years who were able to write in English and currently hospitalised within a tertiary maternity unit for four days or more in the East Midlands area of the UK were invited to consent to participation. Participants were invited to write about their needs and experiences for the remaining duration of their hospitalisation. They were also asked to reflect upon whether their needs were being met.

Data collection

Our data consisted of participants’ diarised needs and experiences, recorded during the autumn of 2012. Brief demographic data was also collected upon recruitment. Diaries can offer participants greater scope to provide richer and more creative detail on the phenomenon of interest.⁵ Diary lengths varied between 421 and 11,676 words.
Data analysis

Data analysis was conducted by the lead author and focused on identifying shared needs and experiences through the process of colour blocking, where common phenomena were identified and then grouped into themes through an iterative process of refinement. Final themes were then triangulated with the wider research team.

Results

A total of five participants were included in this study, aged between 30 and 41 years (mean age: 34.8 years). The average length of hospitalisation for this participant group was 22.2 days. Baseline data collected at the recruitment stage is presented in Table 1.

Three themes were identified from the data; (1) ‘Uncertainty’; (2) ‘Loss of control’; (3) ‘Vulnerability’. In line with the quality reporting of IP, participant quotes are embedded into a prosed representation of the accounts being presented with interpretation. Pseudonyms are used to maintain confidentiality.

Theme one: ‘Uncertainty’

Within the diaries there was evidence of uncertainty, which in turn was seemingly accompanied by a need to understand the routine and culture of the antenatal ward in order to assume a compliant inpatient identity and role.

For Nieve, there was uncertainty associated with her ‘high-risk’ pregnancy in which she experienced persistent antepartum haemorrhages related to placenta praevia. These resulted in several ‘terrifying’ transfers to the labour ward for close monitoring of her baby’s welfare and a further degree of uncertainty in the accuracy of treatment. Similarly, Justina reflected on how due to ‘lots of admissions’ and staff being ‘flat out’, she had not ‘had a CTG performed.’ Justina went on to reflect how the cardiotocography (CTG) would have given her ‘that bit of reassurance’ that she ‘wasn’t getting any contractions or tightenings’ and that baby was ‘still OK’.

Along with uncertainty, some diary entries seemingly reflect both confusion and maternal ambivalence. For example, Amanda ‘met this lovely girl’ who ‘kept being told the same thing every day by the same doctor’ so she ‘asked the midwife is she could see a different doctor’ and the ‘midwife got really funny with her’ which Amanda ‘thought was really bad because all she wanted to know is what was going on with her and her baby!’

Theme two: ‘Loss of control’

In this theme, participants shared their need for autonomy, and to develop a sense of identity and belonging, and to regain control. For example, Nieve reflected her ‘joy’ when a midwife told her ‘about their ethnic menu’ as ‘no-one had mentioned the existence of this amazing menu before’. Here, seemingly as Nieve regained control over her food choices, she describes how she ‘went from being totally miserable and at the end of my tether this morning to a satisfied, relaxed and relatively cheerful new woman this afternoon.’ Similarly, Justina wrote of her ‘absolute delight’ when staff brought her alternative food from the canteen. The pleasures of this simple act opened up food choices for her and gave her a degree of ownership over her own nutrition.

Table 1 Participant baseline data
Have you ever noted how loud the crash of closing them is? Seemingly, if sleep deprivation persists, everything can become ‘too much’.

Empowerment and the regaining of control for participants seemingly came from supportive partners, and the positive attitudes of midwives. To ‘put a smile’ on Amanda’s face, the ‘ward sister’ got her a wheelchair so she could ‘go [off] the hospital grounds’, which made her ‘so happy’. Participants appreciated staff that went the extra mile regarding very basic inpatient requirements, and food again played a large part in regaining control. For Nieve, food was ‘so important’ as ‘there are no other possible pleasures. No glass of wine, no cigarettes, nothing indulgent’. Consequently, Nieve describes how she couldn’t ‘wait till all this is over’ so that she might ‘have a bottle of wine and a fag’. Such descriptions further reflect the need to regain control via one’s bodily intake.

Theme three: ‘Eye examination is completed using the ophthalmoscope, an instrument designed to examine the structure of the eye vulnerability’

The diary data featured in this third theme revealed a strong sense of vulnerability and the need for human connection. Some referred to the midwifery staff, one of whom had been ‘really good’ at ‘cheering’ Amanda ‘up’, and another had sorted out ‘all issues’ for Lucy. Justina reflected how ‘visitors/family are trying to be kind when they say, “there’s not much going on out there, you’re not missing much”’. However, she reflected how they were ‘wrong’ as she was ‘missing all of it’. Yet Justina had really appreciated being given flexible visiting hours for her family and being able to see them during the day. She commented that this made time pass more quickly and allowed her to keep in touch with ‘the outside world’. Evangeline wrote how she ‘needed some emotional support’ from her husband.

Yet this need for human connection with family was not always met due to restricted visiting hours. Justina also recounted a challenging visit from her children who ‘got really upset’ by the prospect of enduring a further period of separation. Nevertheless, inside the antenatal ward, there was joy in seeing a new face with whom participants could spend time. After such an encounter, Justina reflected she ‘felt glad because someone had actually been able to sit with me for over half an hour to chat about things.’

Anxiety and vulnerability remained evident throughout the diary data. Nieve and Lucy, in particular, expressed ‘panic’ and ‘worry’. Nieve catastrophised potential outcomes as being ‘horrific’. Lucy wrote about her maternal ambivalence to an unexpected change with her inpatient scan appointment, which meant that her family missed out on the experience, and also left her ‘panicking that something was wrong’. Such diary entries further highlighted participants’ vulnerability and their need for support from family and staff, which was not always met.

Key global recommendations on antenatal care for achieving a positive pregnancy experience were published four years after this data was collected.
Discussion

This study explored women’s needs and lived experiences of hospitalisation. Three themes were identified from the data; (1) ‘Uncertainty’; (2) ‘Loss of control’; (3) ‘Vulnerability’. In this context, the needs of participants in relation to autonomy, human connection and sleep were not always met. The lived experience of hospitalisation carries significant contemporary relevance given the COVID-19 pandemic and associated restrictions on visitors. Findings presented here may also be used in practice to support recommendations for extended visiting times for those admitted for a prolonged period of time.

Key global recommendations on antenatal care for achieving a positive pregnancy experience were published four years after this data was collected. Yet on a broader scale, the needs and experiences reported by this sample may still be relevant and remain unmet. For example, a recent study conducted in Australia identified how antenatal transfer is an extremely stressful experience for families. The fear of uncertainty presented more generally in theme one is also reflected in the more recent accounts of those hospitalised in one antenatal unit located in Jordan. Therefore, it is suggested that the provision of high-quality written and verbal information may improve the experience of such hospitalisations in future.

Similarly, the sense of a loss of control reported in theme two has likewise been described in later research conducted in both Jordan and New Zealand, where participants reported feeling like prisoners with no control over their food, bodies, time, or decisions. The need for, but yet inability to sleep, described by participants in theme two is also concerning given that maternal sleep has wide-ranging implications for maternal health and functioning. Yet others hospitalised more recently and elsewhere during the antenatal period also report this need for sleep being left unmet. Interventions designed to target sleep-disturbing factors may improve maternal health in such contexts.

The findings presented in theme three depict a focus on the need for social and emotional support and connection. Those hospitalised in both Jordan and South Africa during the antenatal period more recently have similarly expressed the need for social support and connection. Collectively, these findings suggest that whilst the need for support and connection may remain present, this need may also remain unmet for some. Future research could usefully identify how best to meet the individualised support needs of those hospitalised and explore how these may differ in relation to varied cultural, contextual and geographical areas. Likewise, the anxiety recounted and presented in theme three has also been reported by a cohort more recently hospitalised during the antenatal period in New Zealand. To reduce such anxieties during this time, the use of home-based telemonitoring could be considered for those with high-risk pregnancies, as it has been in the Netherlands.

Limitations

Whilst our sample lacks diversity, small purposeful sample groups are characteristic of phenomenological approaches which seek in-depth experiences from fewer participants. Whilst our findings offer theoretical insights into the experiences of women in 2012, they may be less relevant in a contemporary context. Nevertheless, they may be useful when comparing changes in the experiences of care following the implementation of newer recommendations with more recent comparable data.

Ethics

Ethical approval was obtained via the University Ethics Committee and NHS Trust Ethics Committee, as well as from Leicester Central Research Ethics Committee (Ref 12/EM/0405). This primary research was conducted for the award of MSc Health at the University of Northampton, funded by Learning Beyond Registration – Health Education East Midlands.’
Conclusion

This cohort of childbearing women hospitalised in the UK during 2012 experienced ‘Uncertainty’, ‘Loss of control’ and ‘Vulnerability’, where their needs in relation to autonomy, human connection and sleep were not always met. Considering that more recent evidence collected in other geographical areas has identified similar concerns, such findings may suggest a paucity of progress in improving women’s experience of care in this context. Thus collectively, these findings could usefully be translated into improvements for those hospitalised during the antenatal period through extended visiting times, wider food choices, high-quality written and verbal information, responsive antenatal monitoring and reduced sleep disturbances toward a more positive pregnancy experience for all. **TPM**

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Perinatal Positivity - new film to help Health professionals talk about perinatal mental health

Emma Lazenby - Director of ForMed Films CIC

Midwives are uniquely placed to support parents and parents-to-be at one of the happiest, and, most stressful times of their lives. But what do you do when you find both the mother or father in tears? Or a mother has disclosed that she ‘just doesn’t feel right’ and cannot cope? How can we prepare families to be be aware of their mental health during this time, and when needed help them to be ready to find support early on?

I’m a film-maker and founder of ForMed Films CIC, we create animated films about health and medical issues. In 2010 I won a BAFTA for my film celebrating midwifery and childbirth. ‘Mother of Many’ is based on the work of my own mother, a midwife for 30 years in West Yorkshire. While interviewing people for that film I heard a lot about the loss of identity and difficulties people had when starting a family. This set the seed of an idea for a new project, Perinatal Positivity, an animated film to help families-to-be mentally prepare for having a child.
In 2014 I met Rachel Liebling (Consultant Obstetrician at St Michael’s Hospital, Bristol). Rachel’s been involved in trying to improve services for pregnant women with mental health problems for many years and we wondered if we could work together?

In 2016, we found a small pot of funding to set up workshops. With the help of local charity Bluebell Care we gathered people with experience of perinatal mental health issues and discussed what had helped find positive ways forward. This resulted in the Perinatal Positivity manifesto designed and printed by participants (available to download and print on our website).

In 2017 we started our search for funding for a film and gathered partners. Specialist Midwife, Louise Nunn and Consultant Obstetrician, Louise Page joined the team, bringing thier expertise and funding from the Perinatal Mental Health Partnership in Innovative Education. Health Visitor Barbara Jayson joined as an executive producer, locating a considerable sum from the Burdett Trustor Nursing. The Foundation for Mother and Child Health and The Mother and baby Trust also contributed. Bluebell Care founder, Ruth Jackson, and trustee Sasha Barber (Mental health and bereavement lead at New Horizons - M+B unit) gave their support and advice.

This meant that as well as funding to make the film, we had a brilliant team of health professionals with in-depth knowledge who regularly come into contact with new parents, to advise on the film.

I’m always keen to use real voices and experiences in my films. Animating films means that we can use audio interviews whilst protecting people’s anonymity. Nine people agreed to be interviewed and six of these were used in the final film.

As well as touching on what it might feel like to have mental health problems as a new or expectant parent, we wanted to make a positive film with ideas for self-care. When interviewed, people were open and honest about their experiences and many spoke about particular things that had helped them. We were able to include these in the film alongside information about professional support.
According to NHS England, 43–61% of adults (aged 18–65) do not have adequate literacy and/or numeracy skills to understand health information. ForMed Films aim is make health information more accessible, because our films are engaging to watch and shared are designed to speak to any level of literacy. We plan to translate Perinatal Positivity into other languages commonly spoken in the UK to extend its reach.

Our aim is that the film is seen by all parents-to-be, and we hope it will be a useful resource for health professionals. This is a free resource. You can show Perinatal Positivity to parents on a phone or tablets, or text/email them the website address (www.perinatalpositivity.org). You can also ask your Trust/organisation to embed it on their website as well as sharing it with colleagues in training and staff meetings.

At the time of writing (08/10/18), Tommy’s, the Institute of Health Visiting have joined support for the projec using the film. As well as the NCT, a number of NHS Trusts, one New Zealand health team and one in Canada have embedded the film on their websites. It has been watched by around 6,000 people already (only one month after the films launch).

www.perinatalpositivity.org

The Perinatal Positivity Team:

- Director – Emma Lazenby,
- Producer – Rachel Tomlinson
- Executive producers:
  - Dr Rachel Liebling (Consultant in fetal medicine and obstetrics, St Michaels hospital, Bristol)
  - Louise Nunn (Perinatal mental health specialist midwife)
• Dr Louise Page (Consultant obstetrician and Gynaecologist, Chelsea and Westminster hospital)
• Barbara Jayson (Health Visitor; Clinical Nurse Specialist at St Georges NHS Foundation Trust; Founder/co Chair of charity ‘The Foundation for Mother & Child Health’).

Film advisors:

• Ruth Jackson (Founder and CEO Bluebell Care Trust)
• Sasha Barber (Mental Health and Bereavement lead, North Bristol Trust)

The film is Funded and supported by:

The Burdett Trust for Nursing

The Foundation for Mother and Child Health

Bluebell Care

The Mother and Baby Trust

Perinatal Mental Health Partnership in Innovation Education

Tommy’s

The Institute of Health Visiting
Treasure Hunting: Establishing a Midwife-led Fetal Growth Assessment (MFGA) Clinic to Identify the High-risk Fetus in the Low-risk Pregnancy

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Published in The Practising Midwife Volume 21 Issue 6 June 2018

Summary

Finding and appropriately managing fetal growth restriction and small for gestational age babies is often a challenge for midwives, especially those in midwifery-led teams. Access to fetal growth scanning facilities often necessitates the introduction of the low-risk mother to the high risk care pathway. In BHSCT Maternity Service, we wanted to avoid this introduction where it was not required, while also ensuring that the high-risk fetus in the low-risk mother was identified, by supporting our midwives with the provision of a midwife-led fetal growth clinic.
Introduction

According to Gardosi et al (2014), fetal growth restriction (FGR) – after including all known variables such as smoking, obesity, ethnic origin and social deprivation – is the single largest population-attributable risk for stillbirth.

With this evidence in mind, we have focused our attention on the monitoring of fetal growth and detection and management of suspected FGR/small for gestational age (SGA) in the low-risk population of pregnant women. Surveillance of fetal growth in the third trimester of pregnancy, using regular fundal height measurement, ultrasound (USS) biometry or a combination of both methods, continues to be the mainstay for the assessment of fetal wellbeing (Morse et al 2009). In instances where:

- First fundal height measure is < the 10th centile on the customised growth chart
- Static growth: no increase in sequential measurements
- Slow growth: curve crossing centiles in a downward direction it is recommended that available protocols prompt the referral of women for USS to determine the estimated fetal weight (Gardosi et al 2013).

According to Gardosi et al (2014), fetal growth restriction (FGR) is the single largest population-attributable risk for stillbirth.

Objectives
In the past, arranging a third trimester USS to assess growth, has been a challenge for community midwifery teams, as the high-risk hospital-based antenatal clinics were always at full capacity, and referring women to consultant-led services often meant that they remained within that high-risk care pathway. The waiting times for women referred to these clinics were often long and their experience was not always satisfactory as a consequence. In addition, consultant obstetric colleagues raised concerns in relation to the additional workload, in what were already busy clinics.

The BHSCT MFGA clinic was set up in February 2017 to provide a direct referral route for midwives to arrange a USS for low-risk women attending a midwife-led care (MLC) pathway, where there was a suspicion of FGR/SGA following a fundal height measurement. This clinic would assist midwives to identify FGR/SGA babies and ensure that they were adequately monitored, and also reassure those who did not require any further intervention to remain on a low-risk midwifery-led care pathway.

**Materials and methods**

The overall performance of growth screening, in terms of the proportion of FGR/SGA babies who are detected antenatally, depends on adequate resources for third trimester USS, which are often difficult to access for low-risk women on an MLC pathway.

The establishment of the MFGA clinic was implemented by the Head of Midwifery in order to address one of the biggest perinatal problems in the UK: identification of the high-risk fetus (the fetus that is failing to reach its growth potential) within the low-risk mother. Women referred into the MFGA clinic by midwives, are scheduled to have a USS appointment within the
recommended 72-hour period.

This requires the identification of suitably trained midwifery staff and their availability to undertake any potential referrals. As the BHSCT maternity service has the benefit of two fetal surveillance midwives, it became important to ensure that they were available to perform USS for those babies who were of concern.

The midwifery improvement team was formed and, as a result, the MFGA clinic was subsequently established as a direct referral service for low-risk women. Following a review of their activity and in agreement with consultant obstetric colleagues for whom they also provided support, a total of 21 appointment slots over three afternoons weekly, were identified as being made available for midwifery teams to use.

A recent survey of the midwives’ experience in referring into this clinic revealed that midwifery teams valued the ease of the referral system and that 94 per cent of respondents reported an ability to arrange a USS appointment within the recommended 72 hours of referral.

Results

Over a 10-month period, the clinic received 287 referrals for USS (See Chart 1), of which 284 were given appointments for an USS (three were inappropriate referrals). The monthly attendances and outcomes of the 284 USS performed at the MFGA clinic, can be seen in Chart 2.

![Image](chart1.png)

Of those mothers who attended the MFGA clinic and had an USS performed, 41 (14 per cent) were referred into consultant-led care (CLC) with suspected FGR/SGA, over the 10-month period. Birthweight centiles are illustrated in Chart 3. Midwifery-led teams, when surveyed, reported satisfaction with the MFGA clinics noting: “I think it is working very well to date. I am confident in the process and I feel that I can phone at any time for help or advice.” They felt that it was an “Excellent service and reassuring to have a back up when frequently doing review clinics in the MLU.”

The maternity improvement team requires further development of the MFGA clinic data and correlate these to the birth outcomes in this population.
Conclusions

- 41 women were identified as requiring serial USS for suspected FGR/SGA following referral to the MFGA clinic, with 29 per cent
  of babies born (n=12) having a birth weight <10th centile (Chart 3).

- Of those 12 babies born with a birth weight <10th centile, 67 per cent had a birth weight <5th centile (n=8), which includes one
  case of FGR/SGA identified as requiring birth at 38 weeks (birth weight centile at birth of 1.3).

- Where FGR/SGA was excluded on referral to MFGA clinic and women were returned to MLC, 91 per cent (n=218) babies were
  born with a birth weight >10th centile.

- Establishing this clinic has resulted in increased satisfaction rates for midwives, mothers and obstetricians.

- The maternity improvement team requires further development of the MFGA clinic data to include statistics on smoking status
  and carbon monoxide levels at time of USS, and correlate these to the birth outcomes in this population. TPM

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   3: e003942.


A recent safeguarding update at work inspired me to write this blog about Adverse Childhood Experiences (ACE’s) and the importance of a multi professional ‘ACE informed approach’ to care. The ACE Study was one of the largest investigations into childhood maltreatment and its later effects on health and well-being (Felitti et al., 1998).

The study highlighted links between adverse childhood experiences and severe health and wellbeing outcomes across the life continuum. Similar studies have been replicated across the world and drawn comparable conclusions (Bellis et al., 2014 & Bellis et al., 2016).

What are Adverse Childhood Experiences (ACE’s)?

The following infographics explain ACE’s.
ACE's cause alterations to brain stress physiology or toxic stress and predisposes individuals to an increased risk towards health harming behaviours. This in turn may lead to chronic and multiple adverse illness such as cancer, diabetes, heart disease and mental health disorders, including depression, anxiety, and post traumatic stress disorder (PTSD). Multiple ACE's may accelerate ageing and lead to premature death, approximately 20 years sooner for those with 6 or more ACE’s.
Considerations for practitioners

The prevalence of ACE’s as shown in the infographics above are widespread, and are not exclusive to poorer socio-economic groups. ACE’s are passed via intergenerational transmission in family settings leading to vicious cycles of inequality and health inequities. Trust demographics showing higher than national averages of poverty and deprivation have more significant challenges. This video explains this effect.
Midwifery input

ACE’s and their consequences can be prevented

It goes without saying that women with multiple severe ACE’s are likely to need specialist support during their pregnancy. They may already have input from children’s social care or a mental health team. However many will not reach thresholds for intervention but require understanding and sensitive supportive care.

There are many ‘midwifery ways of being’ that can help to support women with confirmed or suspected ACE’s to experience a positive and safe childbirth journey. This list is by no means exhaustive but offers suggestions for practice:

- **Act now**: Don’t wait for a disclosure of childhood maltreatment or abuse. Recognise the signs and do your best to provide support that is caring and non judgemental. Women might present to care as “difficult” clients, disengaging, fearful, rude or aggressive. Remember ACE’s disrupt numerous developmental processes, including those that should lead to an individual’s ability to regulate emotion, attend to bodily cues, and navigate trusting relationships (Sperlich et al., 2017). Women may struggle to believe that a midwifery relationship may be fruitful. It is up to you to demonstrate that services can help.

- **Connect**: Change social norms. Instead of asking “What’s wrong with you?” ask “What has happened to you?”

- **Provide a holding environment or sanctuary space**: A parent provides a supportive space for a child to feel safe and secure in developing and exploring their emotions (Sperlich et al., 2017). In your capacity to be ‘with woman’, you can provide a space for protection, encouragement, and support. Make references to what and why you are doing this and use the opportunity to discuss human needs.

- **Educate**: Women with high levels of maltreatment and adversity may lack good models for maternal role development with regard to sensitive, reflective, and protective mothering (Sperlich et al., 2017). Describe how a baby’s brain develops, discuss responsive parenting, provide easy tools for example, the benefits of skin to skin to facilitate closeness and bonding. Babies whose mothers have PTSD and depression are more at risk for bonding impairments.

- **Use mentorship skills**: You are her guide through childbirth, help her to grow and achieve her birth. Take opportunities to enhance parenting knowledge and assess capacity. Take time to understand her goals, collect evidence of her progress and tell her how well she is doing.

- **Employ advanced knowledge**: Understand that the woman who goes outside regularly for ‘some air’ does so because substance misuse and smoking are broadly understood to be self-medicating behaviour that is an effort to treat symptoms of toxic stress (Sperlich et al., 2017). It is important to remain non judgemental and woman centred. Instead use the opportunity to tell her you understand her needs.

- **Listen**: Find out what she’s having difficulty with, what are her stressors? Is it parenting a difficult teenager? Is she concerned about how she’ll cope with three children under five? Signpost to services, improve access.
to services – you are a font of local knowledge. Children’s centres often offer access to affordable high quality childcare and parenting support groups. They provide children with education and life skills whilst also giving parents opportunity for sanctuary or time to complete other social and health improving tasks. Look for ways which may support a break to the adversity cycle or provide trauma specific interventions.

- **Resilience through empowerment**: Having a strong relationship with a trusted adult throughout childhood has been found to reduce the long-term negative impacts of childhood adversity (Ford et al., 2015). Empower women in mothering abilities, put information in her hands, ensure she has a safe space to share her thoughts and feelings, encourage her to seek positive peer networks.

- **Pain management**: Drevin et al. (2015) suggest ACE’s are associated with higher pain intensities and larger pain distributions in late pregnancy, which are risk factors for transition to chronic pain postpartum. Understand that symptoms of pain may be grounded in experience of trauma. Be sympathetic to her needs, ensure pain is well managed and referred for additional assessment where appropriate.

- **Don’t be defeatist**: The pressures and impact of ACE’s on an already stressed NHS service have the potential to cause frustration. Remember ACE’s don’t define a person they are an opportunity for intervention – for you to make a difference to the lives of others.

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**Safeguarding**

Within a safeguarding capacity midwives must practice a child-centric model of care. It is important to evidence concerns factually within documentation and report elevated concerns about safety and parenting capacity to safeguarding teams for structured assessment. If you suspect a child is at risk of harm or in danger you must act and make a referral to children’s social care or the police.

**Use professional curiosity**: this is a capacity and communication skill to explore and understand what is happening within a family rather than making assumptions or accepting things at face value. Consider the family holistically, ask questions and keep an open mind, critically evaluate any information you receive and always document anything which stands out or intuitively doesn’t ‘feel’ right. Your comment within a safeguarding log may
be the final piece of the puzzle (MSCB and MSAB, 2018).

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**Public health and responsibility; ACE informed initiatives?**

Over the last few years there appears to be a movement towards a societal acceptance that punishing adults or children for negative behaviours is not conducive to transforming lives.

I have recently seen innovative reports on social media:

- ‘meditation for pupils instead of detention’
- ‘volunteer run shops opened to support the community in trading skills or repair of broken household items’
- ‘the barber who gives up a day a month to groom the homeless in preparation for job hunting’

Indeed enhanced local community, individual generosity, understanding and support are the pillars to intervening and preventing the cycle of adversity which ACE’s may cause.

Positive concepts and individual contribution to help change social norms are vital and social media can be used to facilitate this. These act’s have a potential to help improve individual social and personal belief systems, resources and physical capacities.

The Centres for Disease and Control Prevention (CDC, 2017) suggest a 5 strategy approach to preventing ACEs;

- Strengthening economic support for families
- Changing social norms; support parents and positive parenting
- Quality childcare and education in early life
- Enhancing parenting skills to promote healthy child development
- Intervening to lessen harms and prevent future risks

The success of an ACE informed approach not only depends on community collaboration but also a multidisciplinary responsibility between health, schools and the police.

In the spirit of this month’s theme. Give a little... your efforts and sensitivity can help to make a difference to people. We all have a responsibility to improve the future of our communities.

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**Routine Enquiry?**

As yet routine enquiry about ACE’s in maternity care is not mandatory, however the REACH Study (Routine Enquiry about Adversity in Childhood) (Larkin, 2016) has demonstrated:
Most clinicians were not aware of the impact of adversity on later life outcomes before the training.

Professionals, when adequately trained and supported, are confident in holding difficult conversations around ACEs, and feel the approach is valuable and can deliver improved outcomes.

Routine enquiry does not appear to increase demand on services, but instead allow individuals already accessing support to have their needs more effectively met.

A further recent American study by Flanagan et al. (2018) suggests ACEs screening as part of standard prenatal care is feasible and generally acceptable to patients. Women's health clinicians are willing to screen patients for ACEs when appropriately trained and adequate behavioural health referral resources are available.

Next steps

Providing ACE informed care as part of midwifery practice has the potential to prevent adverse outcomes, helps break intergenerational cycles of maltreatment and mental health disorders, and change the mother's and child's life-span trajectories into a positive direction (Seng and Taylor, 2015).

It is likely given the breadth of research on this subject and the compelling case for routine enquiry that we can expect a national roll out by the Department of Health.

Public Health England (2016) have suggested further research is needed. Including, feasibility and good practice to enquiry with children, enquiry into challenges and solutions of implementing routine enquiry within a multi agency partnership and further research to identify evidence based strategies which could help to prevent ACE's and mitigate their impact.

Watch this space...

For more information please go to: Blackburn and Darwin Council Website

Logo and Video produced for Blackburn and Darwin Council available at www.aces.me.uk or free download from Vimeo

Infographics produced by Centre for Public Health

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Survey of UK and Nigerian midwifery students on their view of respectful midwifery care

Inno Omar Principal of Usmanu Danfodiyo University Sokoto, Nigeria
Asha John Senior Midwifery Lecturer at University of Wolverhampton
Respect and dignity of child-bearing women, throughout their childbearing period and at the time of birth is the hallmark of respectful midwifery care. In every country and community around the world, pregnancy and childbirth are hugely important events in the lives of women and families. They are also a time of great vulnerability. The relationship with the maternity care system and with the caregivers during this time is incredibly important. The concept of “safe motherhood” is usually restricted to physical safety, but safe motherhood is more than just the prevention of death and disability. It is respect for women’s basic human rights: respect for women’s autonomy, dignity, feelings, choices and preferences, including companionship during maternity care (The White Ribbon Alliance [WRA] 2011).

**Objective**

The aim of this short survey was to research the student midwives’ experiences of respectful midwifery care in the UK and Nigeria. This study was part of a tutor-to-tutor twinning project with the organisations Women for Health, Save the Children and the Royal College of Midwives. The aim was to gather the midwifery students’ perspectives and experience of respectful midwifery care in their countries and to compare and contrast similarities and differences in their views, especially as they are countries that are very different in their midwifery provision and culture.

**Design**

Qualitative data were collected from student midwives in both countries, via a short questionnaire designed by the tutors.
Participants

Participants represented senior student midwives in both countries. The Nigerian tutor chose some students from community placements and some from hospital placements, whereas students in the UK get the opportunity to work in both the hospital and the community, so seven senior students were randomly selected.

Key conclusions

The student midwives identified a series of key elements that were surprisingly similar in the two countries, despite the disparity in the clinical settings. These included the notion that the definition of respectful maternity care, woman-centred care and respectful care can be improved for women. The following themes were derived from the findings of the questionnaire.

A definition of respectful midwifery care

The Nigerian student midwives defined respectful midwifery care as universal or competent care provided by the midwives to pregnant women with due respect and concern.

On the other hand, the UK students went into greater detail as to what constitutes respectful midwifery care. For them it involved listening to the woman’s wishes and doing their best as a midwife to facilitate those choices in a kind and compassionate manner; giving care during pregnancy, the intrapartum and postnatal periods, with compassion and empathy, providing care that they themselves would like to receive, again with dignity, honesty, equality, sincerity and compassion. They felt that it also meant taking into consideration what their employer, as well as the recipient of the care, expects.
Both sets of students wanted to encompass the universally accepted definition of respectful maternity care as sympathetic, kind, compassionate and non-judgemental (WRA 2011).

Examples of disrespectful maternity care

The Nigerian students were forthcoming in their answers and noted that shouting at or beating clients during pregnancy, antenatal appointments or during labour constitutes disrespect. This is in line with international literature and a recognised global problem. It is widely known that pregnant women accessing midwifery care in many countries receive ill treatment that may be a form of ‘subtle disrespect of their autonomy and dignity to outright abuse: physical assault, verbal insults, discrimination, abandonment, or detention in facilities for failure to pay’ (Bowser and Hill 2010: 9).

The UK students discussed subtle forms of disrespect, such as midwives not providing enough information to the women so that they are unable to make an informed decision about their care; not engaging with the birth partners; not taking heed of the birth plan; and providing care that is not evidence based. However, one student noted that she has never encountered disrespectful care, which is an encouraging thought.

Encouraging respectful midwifery care

Overwhelmingly the Nigerian students felt that improving the hospital facilities and the birth environment would change midwives’ attitudes towards the women in their care. They also discussed introducing regular supervision to ensure that care is delivered in a respectful manner. However, it is not clear who would be providing the supervision or whether this would affect the dynamics between a woman and her midwife.

Similarly the UK students discussed changing the birth environment, staffing levels and empowering both the women and the midwives to change the culture of maternity care. One student focused on staff shortages putting strain on those providing care; she felt that working under pressure and stress can make staff come across as unwelcoming, if they are not able to give enough time to their women, resulting in a lack of one-to-one care. A lack of resources can also restrict what type of care a midwife can provide.

Implications for practice

It was encouraging to read that students from both Nigeria and UK are discussing and deliberating the care they provide. They appear to be uncomfortable with instances of disrespectful maternity care they encounter, but they also have ideas for changing the culture in their respective countries. It is such concern from future midwives that will bring this hidden problem to the forefront. A lack of awareness about women’s human rights among health professionals working in maternity
care is tackled in new guidance published in the UK recently (Nicola Merrifield 2016) and again in an article by Denny (2018), where she urges policy-makers and practitioners to make respectful care the norm for all women. Hopefully we will move towards the vision of respectful midwifery care described by one UK student:

‘Warm and welcoming are the eyes and smiles of the midwife.

She listens to my expectations and reassures me, in my womb is life.

She tells me what I should do to get ready for my child.

She makes me feel special and respects what I disclose to her.

I feel empowered and prepared for the birth.

Now it's time for my baby to come and to become a mum.

The midwife once again smiles and encourages me to go on,

The warmth of the room, the dim lights and peaceful atmosphere

I feel the ecstasy - my baby is near.

She keeps me going, telling me what to do, listening to my baby’s heartbeat

Reassuring and being there for me, makes me feels safe and secure.

Bringing my baby into this world safe and sound

However can I repay her and show her my appreciation?

A special place in my heart she has found.’

May all the midwives of this world earn a special place in their women’s hearts by providing respectful midwifery care; this is our hope for the future.
References


By Angela McBennett
A note to start....

It seems that in the ‘blink of an eye’, 27 years have flown by as I retire from general midwifery. My memories of midwifery will always be forever in my heart. Pregnancy and birth is a unique time in a family’s life and, as a midwife, we witness times of great love, joy, resolve, and endurance by women and families. The close trusting relationships midwives form with families can help women to disclose sensitive and emotional issues within the family. My experience in midwifery has given me a greater understanding of other people, including their cultural and religious beliefs.

The wonder of birth will never leave me

As a mother of two children I was delighted to finally have my dream come true, in commencing midwifery training in October 1990. It was the first Diploma Pre-Registration Midwifery course for Birmingham and it became obvious, fairly early on, that this would be a challenging but exciting entry into midwifery. Understandably some of the midwives were wary of what to expect of our group and a few were sceptical. We felt it was imperative to prove our passion for midwifery and our willingness to learn from those around us. We were a small group of 18 students and became very close to one another, to offer support and comradeship. We were lucky that many of us learnt from enthusiastic and empathetic mentors who helped us to develop into professional and competent midwives.

I feel very privileged that I began my training in a small maternity unit in another area in Birmingham, before it was closed and the care was transferred to a larger tertiary maternity hospital where I continued the remainder of my midwifery career. Later on, we often reminded ourselves of the marvellous postnatal care that was provided within the small unit and how each newborn baby would be carefully transported across the gardens, swaddled within a large silver cross pram from delivery suite to the cozy postnatal ward.

The wonder of birth will never leave me, and I recall the most amazing feeling of witnessing my first births as a student midwife. I have been so lucky to be able to form long-term close friendships with many of my colleagues. Throughout my midwifery career I have always tried to remember that feeling of vulnerability as a student, and have empathy for the students I worked with.

Becoming a midwife

As a newly qualified midwife in 1993, I was keen to gain as much experience as possible in various areas of midwifery, before moving on to my passion for normality and addressing inequalities in health. It was an exciting time of change in midwifery with the Department of Health (DH) report Changing childbirth (DH 1993), highlighting the benefits of choice, control and continuity of carer. Health professionals and women were gradually embracing some of the benefits that water can provide for labour and birth. The birth rate was much smaller at that time with about 5,500 births per year at the hospital where I was based, compared to almost 9,000 a year now. Maternity services had an enormous challenge in meeting the needs of a changing and growing population, with limited resources.

Caseload midwifery

After a few years working within the hospital environment, I moved out into the community and it was wonderful to work once again with my previous mentor and a fabulous team who were committed to providing continuity of care for women and their families, and were striving to provide caseload midwifery. We worked closely together with the women, babies and families to try and maintain continuity and individualised care. Many of the women verbalised how they valued the continuity and feeling of being cared for by the team. I learnt so much from the team and women during those couple of
years and will always be thankful for having experienced working in this way; of providing continuity of care throughout pregnancy, birth and the postnatal period. When I reflect back on that time, it was not always possible to provide continuity of carer; however continuity of care was achievable within a small like-minded team.

Bellevue project

It was very difficult to settle back into traditional community midwifery once the project was stopped. I was keen to try and provide more individualised care, particularly for women who were marginalised and tended to experience poorer health outcomes for themselves and their babies. Shortly afterwards I commenced a pilot project within a primary health care team based in an area that included areas of social and financial deprivation.

This was called the Bellevue Project (Perinatal Institute [PI] 2003) within the Birmingham area. It gave me the opportunity to develop and provide continuity of care to suit the needs of the local population, while working very closely with the primary health care team at the practice; and also local services such as a sexual health clinic and a citizen’s advice bureau. It was fabulous to be able to share this experience with an enthusiastic student midwife in her third year of training. We had many in-depth conversations and shared ideas of innovative education for families.

Continuity was achieved for women with both high- and low-risk pregnancies, and the results were: improved qualitative
experiences for the families; mental wellbeing; reduced caesarean section rates; increased breastfeeding rates; and improved uptake and participation in health education programmes for all parents from a variety of backgrounds. The primary health care team also expressed greater satisfaction with the maternity care and enhanced communication. Sadly the funds were not available to continue with this service for the Bellevue families. On a positive note, some of the results were used within the aims for early antenatal booking, breastfeeding and continuity adopted by other areas in the UK.

**Purpose-built alongside birth centre**

As one door closed, another opened and a new venture began, involving the provision of a brand new birth centre service in Birmingham, where I was delighted to be part of the team. This service provides evidence-based and individualised care that follows a philosophy of women- and baby-centred care within a natural, relaxing environment that is sensitive to the holistic needs of the families. We were so lucky to work with an enthusiastic and knowledgeable consultant midwife, who had great empathy for women and babies. We learnt so much about normal midwifery during the years of the evolution of the birth centre. Water birth became more and more popular. Holistic assessment of women attending the birth centre enabled me to observe how deep relaxation and hypnobirthing influenced women during labour and birth. It was wonderful to be able to offer aromatherapy to enable women to have greater choice and help with relaxation, pain relief, energy, nausea and positive childbirth memories. I recall a mother describing her feeling of pure joy whenever she smelt lavender, as it reminded her of the birth of her baby.

It was during these years that I became a Supervisor of Midwives, and I gained more knowledge from colleagues about the challenges of different working areas. It was inspirational seeing individual midwives grow in strength and knowledge as they overcame emotional and difficult times; and embraced being advocates for women and babies.

**Designated home birth service**

For several years I attended a local home birth group led by mothers. The home birth service at that time was fragmented, due to community midwives sometimes being asked to cover staffing shortages within the hospital. Listening to parents’ concerns regarding the uncertainty of having a midwife available for a home birth at night was very disconcerting; this was fed back to our maternity service via Supervision. Our service was keen to meet parents’ needs for a robust home birth service and a number of strategies and bids were put forward for funding. Our consultant midwife was successful, after many attempts of applying for funding. This coincided with the *Place of birth in England research programme* findings (Hollowell 2011), which provided evidence that home birth was not only as safe for women and babies as obstetric units or birth centres, but also reduced the rate of intervention for mothers in second or subsequent low-risk pregnancies.
In 2014 I was delighted to join the new dedicated home birth team and witness the amazing care that women, babies and families received within the home. During this time I was able to complete hypnobirthing training, which I felt finally rounded off my midwifery journey. My final year was spent working within a warm and friendly community midwifery team and also helping to provide NIPE checks within the baby clinic. I valued the greater insight into newborn babies that I had gained over my last eight years, enhancing the holistic care I provided for babies and parents.

**Retirement from NHS midwifery**

Due to health challenges, I decided to retire from contracted midwifery, which was a difficult decision for me. On the bright side, I have more time with my family, who have been by my side throughout my midwifery journey.

However, I knew that I was not ready to give up being involved with parents and babies. Many parents have commented on the helpfulness of deep relaxation and hypnobirthing during their pregnancies, particularly women, who have faced a number of difficulties: they have stated how it helped them to have a peaceful pregnancy, birth and ongoing emotional wellbeing as a new parent. Now I’m looking forward to focusing on this area and sharing my midwifery experience with student midwives.

**And now…..**

As I look back at my midwifery career I cannot believe how fortunate I’ve been to share the most amazing experiences with wonderful families and compassionate and inspiring colleagues. Although there have been some great advances in maternity care, it is evident that midwifery is still striving for increased continuity of care, addressing health inequalities and meeting the needs of the constant changes within society. I believe it is important to tackle health inequalities before the baby is born to strive towards meeting the recommendations of Every child matters (HM Treasury 2003)). I have been privileged to have commenced midwifery at a time of great opportunity, autonomy and more time with women and babies. Midwives, assistants and doctors are working hard towards meeting the Better births (National Maternity Review 2016) recommendations of consistent high quality and safe maternity care around the country.

I look back with great fondness and also move forward towards this exciting new personal phase in my life.
References


UNICEF UK
BABY FRIENDLY INITIATIVE
30TH ANNUAL CONFERENCE
By Rachel Evans, 3rd Year student midwife, Swansea University

As a self confessed breastfeeding geek, the [UNICEF UK Baby Friendly Initiative Conference](https://www.unicef.org.uk/baby-friendly) is one of my dream gatherings. I was fortunate enough to receive a grant from the Swansea University Student Midwifery Society enabling me to attend the 2017 conference. It was great to spend two days with others passionate about infant feeding, and to catch up with some of the amazing women who inspired me to become a midwife.

There was a great deal to learn, both from the speakers and from other attendees who had produced poster presentations. Mindful of the opportunity to feed back to the midwifery society, I focused on information of particular use or interest to student midwives in practice.

**So, here’s what I learnt!**

**Resources**

Some [UNICEF information leaflets](https://www.unicef.org.uk/resources) are now available in Arabic, Bengali, Polish, Romanian and Urdu, which will be a great help to midwives and students working with these populations. UNICEF is on the lookout for people with language skills to help them expand the available languages.

[UK Drugs in Lactation Advice Service (UKDILAS)](https://www.ukdilas.nhs.uk) is an NHS service run by specialist pharmacists who can be contacted for advice. Throughout a number of years providing breastfeeding support, I have often come across women who have been unnecessarily advised to wean from breastfeeding (or ‘pump and dump’) because they need medication. In fact, there are very few medications that are incompatible with breastfeeding. It is so important to have professionals working in this area who are knowledgeable about the subject, but also understand the importance of the breastfeeding relationship to mother and baby. It is good to know that this NHS resource is available to provide accurate and helpful information.

**Neonatal care**

Dr Nicholas Pembleton of Newcastle NHS Trust spoke about the infant microbiome and the cutting-edge research taking place in this area. Focusing particularly on necrotising enterocolitis (NEC), he emphasised that this disease causes more deaths than all childhood leukaemias. Exclusive feeding of mother’s milk reduces the incidence 10-fold and therefore
provision of it should be the focus of neonatal care, rather than an ‘extra’ or something to help mothers with when they feel better.

Dr Neil Patel, a consultant neonatologist from Glasgow, emphasised the importance of family integrated care (FiCare) and the positive effect it has been shown to have on length of stay and breastfeeding, as well as families’ wellbeing. I have been fortunate enough to see FiCare and the difference it can make in action at our local unit.

**Hypoglycaemia**

Having been trained in the use of handheld glucometers, it was somewhat disconcerting to hear Dr Jane Hawdon of the Royal Free Hospital state that these can be inaccurate by up to 0.5mm/dL: a hugely significant figure, when we are talking about values around 2.0mm. She also discussed the importance of looking at clinical signs as well as the numbers, as we attempt to keep babies with their mothers and reduce the 12 per cent of neonatal admissions resulting from hypoglycaemia, while not missing those babies who really do need support. She referred to the *Framework for practice* from the British Association of Perinatal Medicine (BAPM), which makes interesting reading on this subject (BAPM 2017).

**Lactation after loss – a student midwife project**

Judith Kennedy and Anna Matthews – student midwives who had undertaken an elective placement at the Hearts Milk Bank – presented a poster on their literature review about lactation after loss. They found that more research is needed but could conclude that donating her milk may offer benefits to a bereaved woman who chooses this option. Good relationships with health professionals are paramount when such things are discussed, and another area where continuity is so important.

**Responsive feeding**

Finally, Emma Pickett (Chair of the Association of Breastfeeding Mothers) spoke about her viral blog piece entitled *The dangerous game of the infant feeding interval obsession*. This is an article I feel every breastfeeding mother should read, explaining simply but effectively the importance of responsive feeding and the needs that are met by breastfeeding, and emphasising that breastfeeding is not a milk-delivery system. Many of us have, during breastfeeding training, listed all the tastes and sips of food and drink we have had in a day, but have we considered how many times our partner hugged us, or a friend smiled, or someone spoke to us warmly? For a baby, all these emotional needs are also met at the breast.
Reflecting on implications for practice

I felt that, for midwives, Emma Pickett’s article presents a lovely piece to pass on to breastfeeding mothers, but it also reminds us to consider the focus of our antenatal breastfeeding education; yes we need to highlight all the beneficial content of human milk, but breastfeeding is about so much more than milk. A different way of looking at it can lead us to creative thinking in supporting those mothers who are unable to breastfeed, to enjoy some of the benefits of a breastfeeding relationship.

The practical resources from UNICEF and UKDILAS will be invaluable to students and midwives alike. Anyone who has previously attempted breastfeeding support via translation services will be glad of UNICEF’s resources in translation and looking forward to expansion of the range. A wider awareness of UKDILAS will go towards ensuring that mothers who need medication get the best advice.

Finally, the focus of the neonatologists on the importance of human milk reminds us that even in complex circumstances, we still need to be mindful of the importance of breast milk and breastfeeding. In the event that a mother has had a difficult or traumatic birth and her baby is unwell, it might sometimes feel kinder to leave her to sleep, or to offer to talk about expressing another time. In fact we are doing her and her baby a disservice, and early help and support will not only give her baby optimal nutrition, but also get their future breastfeeding relationship off to the best possible start.

A terrific event

There were many more interesting talks and chances to network, and perhaps one or two missed opportunities. For example, Duncan Williamson of the World Wide Fund for Nature (WWF) spoke about sustainable food and diets for the future. When questioned by delegates about the role of human milk in a sustainable infant diet, and the impact of the formula industry, however, he was unable to address these points. The WWF feel that this is an area it cannot address alone and needs a partner organisation to address the issue of sustainable infant feeding; so perhaps this is a subject that will be explored in the future.

Overall, the UK Baby Friendly Initiative Conference 2017 was a stimulating, thought-provoking event and offered great opportunities to meet others passionate about infant feeding. Roll on 2018!

References

Hyperemesis Gravidarum or severe nausea and vomiting of pregnancy impacts on women’s physical, social, psychological and consequently fetal wellbeing and often necessitates regular hospital admissions and consultant led care (McCarthy et al., 2011; Fletcher et al., 2015).

‘Sense of Coherence’ relates to how people cope with stressful life events; those who interpret life as manageable, comprehensible and meaningful can thrive in the face of difficulty (Antonovsky, 1996).

This blog offers a salutogenic perspective in the management and care of women with Hyperemesis Gravidarum, exploring ways to alleviate the stressors it causes and how to support women’s internal and external resources to advance health and wellbeing.

Cartoon’s from the Hyperemesis Gravidarum e-Zine by Leonie Dawson have been used to raise awareness about the impacts
of this condition on the women we care for (some of them contain well placed expletives!). Links to Leonie’s website and a PDF of the e-Zine can be downloaded free of charge at the end of this blog. Signposting women to online support groups and evidence based research is reported to increase understanding and manageability.

The condition

Severe and intractable Hyperemesis Gravidarum occurs in approximately 0.5–2% of pregnancies, defined as vomiting three or more times a day, with weight loss of over 5% of booking weight and ketonurea (Snell, Haughey, Buck, & Marecki, 1998). Hyperemesis Gravidarum is reported to be linked with an increased risk of adverse pregnancy outcomes such as preterm birth, small for gestational age and in worst case scenarios miscarriage and stillbirth (Robson & Waugh, 2013).

Ambiguity remains with regard to the cause which researchers suggest to be a complex interplay between biological, psychological, and sociocultural influences interestingly mirroring the factors that contribute to ‘Sense of Coherence’ and therefore supporting the idea that women suffering from Hyperemesis Gravidarum require a model of care which considers all aspects. Contemplating life as a continuum of health, feelings of control are crucial to wellbeing and similarly loss of
control, disempowerment and anxiety can lead to long-term chronic stress, which affects the immune system and can directly contribute to disease (Salleh, 2008). Meighan & Wood’s (2005).

**The experience**

Research illustrates that women suffering with Hyperemesis Gravidarum describe the effects of the condition to be so debilitating that they felt they had very little concern about anything else including the growing fetus. They and other researchers (O’Brien & Naber, 1992) demonstrate the impact to affect all of a woman’s ability to perform usual routine, this includes professional roles at work, caring for children, maintaining the household, family and social relationships.

Descriptions regarding the turmoil and stressors experienced by women include:

- Despair and anger at unpredictable nausea and vomiting,
- Exhaustion
- Fear, feelings of wanting the pregnancy to end,
- Feelings of embarrassment about vomiting in public, social isolation (Meighan & Wood, 2005)
- Feelings of judgement and stigma due to the unhelpful attitudes of staff (Power, Thomson, & Waterman, 2010)

**A stressful life event and general resistance resources**

In consideration of these complex factors, in assessing women’s stressors midwives could take advantage of evidence based principals to develop care with a salutogenic structure by supporting the growth of women’s protective factors, described by Antonovsky as general resistance resources.

These resources are seen as inextricably linked to each human being and could be endogenous exhibited as either physical or non-material characteristics which contribute towards a person’s capacity to cope. Indeed they also present in a person’s intimate and distant environment and can be used when a person is motivated to do so. ‘Sense of Coherence’ develops as an aptitude in understanding how to use and re-use these resources for their intended purpose (Eriksson, 2016).
Midwifery Input

In the first instance, providing Hyperemesis Gravidarum is not too severe and oral fluids can be tolerated, community treatment is within the scope of the midwives role which should centre on diagnosis, excluding other pathology, blood tests, vitamin supplementation and oral antiemetic treatment (Slager, 2000). An initial focus on diet and lifestyle choices may help to alleviate symptoms. Midwives can offer individualised nutrition advice; avoidance of foods known to irritate, smaller and more frequent meals based on carbohydrates rather than fats and ensuring adequate oral fluid intake as part of ongoing management (Robson & Waugh, 2013).

Remaining in the comforts of her own home is considered preferable although it may also be prudent to consider that external environmental stressors; housework, employment and children may be adding to any loss of control experienced.

In order to assist women in their cognitive understanding about the condition, information can be provided in a way that is clear and easy to comprehend. Likewise explaining that the underlying cause is unknown may in turn help to reduce feelings of personal guilt regarding impact of the condition on the fetus (O’Brien, Relyea, & Lidstone, 1997).
Handover of care to staff should be sensitive, providing full information to ensure a smooth process and mitigate any professional culture-issues around attitudes to women with Hyperemesis Gravidarum.

**The duality of medical management**

Discussion around pharmacological management options to control HG need to be sensitive, increases in anxiety and emotional distress relating to the use of medication and its potential teratogenic effects are common; studies show Ondansetron in particular may not be safe during pregnancy and doctors have a duty to inform women before prescribing it adding to feelings of disempowerment where women either suffer the condition or potentially harm their baby (Siminerio, Bodnar, Venkataramanan, & Caritis, 2016).

In addition, informing women that medical treatment offered is merely palliative and that only termination of pregnancy or delivery of the baby can resolve their suffering is not reassuring.

![Image of a note listing things that helped](image-url)
A balancing act – protecting women’s motivations to cope

Midwives distinctive obligation to balance the natural and medical perspectives of pregnancy by promoting the woman’s instinctive capacity to be a mother is important. With a focus on meaningfulness midwives can facilitate listening time, helping women to verbalise and take ownership of feelings which may help her to be motivated towards coping (Sinclair & Stockdale, 2011).

In the pursuit of manageability, women may also wish to explore options of alternative therapies such as acupressure and ginger however there is an absence of robust evidence for their use as an effective treatment therefore midwifery recommendation should be avoided (Matthews, Dowswell, Haas, Doyle, & O’Mathúna, 2011). Careful management of this situation is required to ensure women’s exploration of possibilities are not impacted, this demonstrates her seeking out meaning and being motivated to cope.

Midwives could suggest the use of tactile massage which has been shown to promote relaxation and provides an opportunity to regain access to her body (Agren & Berg, 2006).

Choice as a coping mechanism

Choice is a long established and integral part to providing quality maternity care (RCM, 2014) and can also be offered by the midwife as a way to promote meaning in a situation where women feel disempowered.

By engaging women to participate in care, choose and commit to a purpose, it is anticipated that it has meaning, what then follows is identifying the best way of fulfilling that purpose using her own resources.

For example considering how to manage dynamics such as family visits to the hospital ward, it may be helpful for the midwife to suggest options from which the woman can make her own choice rather than feel like she must accept visitors throughout the entire four hours visiting per day. Suggesting a more conservative schedule will help to reduce sensory stimuli which are known to exaggerate symptoms (O’Brien, Relyea, & Lidstone, 1997) and protect her space giving her more time for self-care and rest.

A refocus on the purpose of the decision and supportive explanations to relatives may help to empower her to regain control of her decision making abilities. Due to a loss of ‘Sense of Coherence’ women with Hyperemesis Gravidarum may have an impaired or altered view of their external resources, the midwife having an understanding of family dynamics can provide a connective bridge between the women and her partner or close family who may not understand the condition, its severity and impact (Soltani and Taylor, 2008). In doing so equipping those closest to her to consider what resources are available, these might be around employment issues, childcare or finances.

Equally, Caruso et al (1990) suggests family environmental stress may sometimes reflect aetiology of Hyperemesis Gravidarum, recognising ethical aspects around respect, diversity, individual choice and culturally sensitive care are fundamental in this case (The Revised Code, 2015).

Continuity of Carer

Berg’s (2005) concept of ‘dignity-protective action’ which takes place in a midwife’s caring relationship with a woman who has a high risk pregnancy and includes empathy, trust, ongoing dialogue, enduring presence, and shared responsibility,
indeed this all-encompassing support may help women to identify the midwife as a protective factor; one of their coping resources.

Advocacy for women is important, in practice it has been observed that an explanation about the recommended medical management of a woman’s Hyperemesis Gravidarum was given at a time which suited the medical review team but not the woman. This led to a lack of understanding about why palliative antiemetic’s and IV rehydration were required and added to the woman’s confusion exacerbating feelings of loss of control. In this case providing extra time and support in a more suitable moment was much appreciated by the woman and continued to build the trust in the midwife as a resource to further develop her ‘Sense of Coherence’.

**Thoughts about system barriers**

Evidence and guidelines recommend midwifery led antenatal care for low risk women (NICE, 2016; RCM, 2014). Current obstetric care however, focuses on risk and outcomes which in the case of Hyperemesis Gravidarum may be too medically orientated to meet all of women’s complex needs (Perez-Botella, Downe, Meier Magistretti, Lindstrom, & Berg, 2015) and research suggests the organisation of multidisciplinary services are far from woman centred, which continues to add to the challenge (Cumberledge, 2016).

Navigating a medicalised system of antenatal care shifts emphasis to pathology rather than the normality of pregnancy. In practice doctor’s ward rounds and clinics often take precedence over midwifery care and in order to prevent multiple appointments midwifery care is forgone.

Conversely, it could be argued that in managing the care of women with high risk conditions midwives are quick to refer responsibility to doctors relieving themselves of the challenges in maintaining normality and professional boundaries (Downe, 2010).

The implications of this are highlighted in the recent Kirkup Report (2015) which has suggested that the absence of quality multidisciplinary collaboration was a factor in maternal and infant mortality and morbidity. Given the grave consequences of flaws to our maternity system, a rationale for a model of care which incorporates a salutogenic approach concurrent with professional multidisciplinary working to achieve best outcomes is advocated.

Browne et al (2014) found that midwives working in continuity models understood the benefits of a salutogenic approach to their practice but that barriers such as length of appointments and limited availability/access to antenatal classes were highlighted.

In practice, similar difficulties have been observed with managers preoccupied with bed numbers, length of stay and ability to discharge rather than focus on the holistic aspects of Hyperemesis Gravidarum which may prevent readmission.

**Conclusions**

Successful treatment of Hyperemesis Gravidarum needs to extend beyond managing symptoms with rehydration and pharmacological management and look towards a holistic offering which centres on personalised care that seeks to determine a cause or multiple causes.

The current organisation of services, fragmented multidisciplinary care and complexities of managing high risk pregnancy in
today’s society cannot be underestimated (Ferguson, Davis, Browne, & Taylor, 2014).

Jakeway (2001) identified that the care of women with Hyperemesis Gravidarum could not be managed only through medical treatment and readily accepted that ‘close midwifery care’ was a crucial requirement to maintaining a positive attitude and the ability to achieve optimal results.

Therefore salutogenic interventions that aim to strengthen women’s ‘Sense of Coherence’ enabling her to complete pregnancy may enhance her birth experience satisfaction and lead her to have the resources necessary to make the transition to motherhood.

References
There can be no doubt that we should be implementing relationship-based continuity of carer for most women and their babies. The evidence has been mounting over years and is compelling: there are few developments that offer so much benefit, with fewer risks (See http://www.gtc.ox.ac.uk/images/stories/academic/skp_report.pdf).

It is difficult to understand why this evidence is still seen as contentious, and why even - or perhaps especially - professionals can say that they do not ‘believe in’ continuity of carer.

**Relationship-based continuity of carer should be the default for women**

Given the evidence and the policy mandate in Better Births England and Best Start Scotland, we should be heading for
continuity of carer as the default structure of care for most women.

Perhaps it is because (despite good information being available about what works) relationship-based continuity of carer has often been set up badly – or misunderstood – that resistance is felt. It is certainly a fundamental change that needs carefully-considered implementation and operation.

Following the Facebook LIVE session run by myself and Michala Marling on the All4maternity FB Page (12th December 2017), it became clear that information on how working in this way might be supported to create sustainable approaches for midwives, is still needed.

It is important to note that what works for women will often be best for midwives, too. We should be creating woman-centred midwife-friendly services. Not every midwife will want or will need to work in continuity-of-carer schemes, one-to-one midwifery, neighbourhood midwifery, caseload midwifery or team midwifery. Midwives may also choose to change their style of practice according to their personal circumstances. But we should be scaling up relationship-based continuity of carer eventually, serving all women in this way, in a stepwise manner, over the next five years.

It is important to realise that without continuity of carer, safety and quality of care are badly compromised. The current fragmented services that most women pass through in maternity create many unnecessary risks.

What makes relationship-based continuity of carer work?

So how do we make this approach to practice work for midwives and for women, making it sustainable? It is critical that policy makers, change agents, leaders of services and midwives understand and reflect that it is the development of relationships over time that is associated with the benefits of this approach. There can be many ways of setting up and running relationship-based continuity, as long as there is fidelity to this principal. Each and every woman, her baby and family, should be cared for by a named midwife who co-ordinates her care and provides most of her care, working with a small number of ‘buddy’ midwives. The aim is for women to get to know and trust a midwife – and a small number of other midwives, over time – so that each has the opportunity to get to know and trust the other. This is a reciprocal relationship in which both benefit. It can be achieved through what I will call group practices that are situated in the community for women with all levels of care, from the most complex to straightforward. Always the woman is followed by her midwife/midwives wherever her care is situated. It can also be achieved through group practices working in the hospital, perhaps with women
who have highly complex medical needs, or through group practices that attend home births. The ideal number in a group practice is six-eight. Numbers of births for each midwife vary between 35-40 per year, depending on complexity and geography.

On call – or availability, autonomy and enabling support, rather than control

The system of on-call or availability should be established by the group practice, which will be expected to ensure their ‘caseload’ - or ‘patch’ - is covered effectively. It should not require 24/7 on call or very long stretches of care. Having women contact midwives directly with mobile phones that can be switched between the team members works best for the service, for women and for the midwives.

The group practice requires autonomy to maintain the numbers in their team, to organise their own workload, to maintain standards through meetings, reflection and audit of care and outcomes. Management of these group practices should be enabling and not controlling. Annualised hours are essential.

Support may be needed to develop time management skills and flexible approaches as well as effective and authentic team working. If relationships in such small groups break down, it can have an extremely damaging effect. Facilitated meetings may help in this authentic rather than pseudo team-work, and can be one of the joys of working in such a way, sharing and enacting philosophies of care together with like-minded midwives.

While the satisfaction of developing relationships with women is one of the factors that protects against burnout while giving relationship-based continuity, if there are adverse outcomes, this can be devastating for the professionals involved, and there should be an immediate pathway of support for midwives in this situation.

Many successful group practices have been destroyed by calling on midwives to help in shifts on top of their caseloads. Midwives in group practices may choose to contribute to core services at times, and this will help integration of the group practices with core services, but this should not be expected.

Avoiding the us and them divide

One of the problems identified repeatedly is the development of us-and-them mentalities when there are two or more systems of care in place. This is a leadership challenge for all and requires approaches that ensure there is integration of all, respectful relationships with clear pathways for referral.

The avoidance of myths, rumours and misunderstandings requires compassionate and strong leadership. The highest ethical
standards are required, to follow and investigate rumours, and to avoid misperceptions.

**Students’ and newly qualified midwives’ needs**

For the next generation of midwives, being able to work in relationship-based continuity of carer practices offers a very rich way of learning, and better supervision and support than being in acute wards and departments. Opportunities need to be presented for at least some newly qualified midwives to make this their first rotation. All students should have the opportunity to follow women through in each year of their midwifery education.

**Ensuring sustainability and that midwives have a choice**

Fundamentally, the establishment of sustainable relationship-based continuity requires careful implementation, and commitment to maintaining the model. To close such developments is unethical and unwise, and commissioners should be advised to avoid this.

To be able to practise in this way offers many benefits to midwives, and every service ought to ensure that midwives, as well as women, can choose their style of care and have the opportunity to work in this way. Care mediated through human relationships, given by skilled, knowledgeable compassionate midwives, is the best gift we could give to the next generation. For their sake, let’s do it.
Navigating Spaces: Fetal Navigation Techniques

Alix Fernando - Campaign Founder and Director at Make Birth Easier Campaign UK

Published in The Practising Midwife Volume 20 Issue 11 December 2017

Summary

“I turned my OP baby and regulated my own contractions in an hour, directly avoiding induction and possibly other interventions. This was my second labour, which from this point on flowed smoothly to a physiological birth in just a few hours. My first baby had also started labour in a less than ideal position. She was still not engaged and contractions weren’t progressing. I then did something that immediately sent my stagnant labour into active flow.

How did I change the course of two labours? I used fetal navigation techniques (FNT). If I can use FNTs myself with such impressive results, imagine what trained midwives could achieve using them every day. If midwives had routine training in FNTs, women could have a better chance of easier, shorter, uncomplicated, intervention-free, drug-free, physiological birth and faster postnatal recovery.”

How many times have you attended labours or cared for women where labour wasn’t going well and you wished you could do something more to make birth easier? Even when labour starts with the baby head-down and left occipito-anterior (LOA), it can be long and arduous, and develop complications, ending in one or several interventions. What if there is a way to reduce or avoid intervention by making more labours progress well? If you could do something to transform an initially difficult labour into a shorter, straightforward, more comfortable labour ending in unassisted vaginal birth, would you as a midwife want to learn more?

Not all medical intervention is essential

Medical intervention happens for so many reasons, of course: some is unavoidable and absolutely necessary. In other cases, could it be that the baby is simply not well aligned with the pelvis? If the head is asynclitic (a tilt towards baby’s shoulder, not the normal tilt of a LOA baby entering the pelvis before rotation to OA at mid pelvis), or flexion is poor, the smallest diameter of the head is not presenting through the pelvis: square peg, round hole, so to speak. Logically this could cause delays, as would a baby caught on the pelvic brim, or a baby restricted by strong pelvic floor muscles.

...could it be that the baby is simply not well aligned with the pelvis?

Modern poor posture could be a major contributing factor. The human body wasn’t designed for modern behaviours such as slouching on the sofa or at a desk (compressing the sacrum), driving, carrying a child on one hip, carrying a bag on one shoulder, or crossing your legs. These repeated unnatural body positions - or even a sudden stop in an accident or sport - create imbalances in the uterine ligaments and muscles, pulling the uterus out of its natural shape, and potentially causing misalignment of the pelvis or sacrum. In addition, the pelvic floor muscles can be too tight or asymmetrical, restricting the baby’s passage. All this reduces space in the pelvis and affects fetal position, attitude and rotation (Andrews 2010).
There are several techniques to choose from, depending on the symptoms of malposition, the baby’s known position or pain levels.

**Fetal navigation techniques**

There is a range of non-invasive, specific techniques known as ‘Spinning Babies’, combining body balancing, fetal positioning and flexion (Tully 2017). Spinning Babies extends the concepts of optimal fetal positioning (Sutton and Scott 1996). Some who have heard of the techniques associate them only with turning breech babies during pregnancy and, whilst there are specific techniques for breech, many of the techniques can be used for cephalic presentation, OP or OA and many can be used during labour as well as pregnancy. I like to call them fetal navigation techniques (FNTs).

**Fetal navigation techniques could prove useful to alleviate the following issues:**

- contractions with no progress
- very slow progress
- contractions which are erratic, slow down or stop completely
- baby is known to be high or malpositioned
- baby is known to be malpresented
- mother experiences excessive pain, particularly back or hip pain
- baby appears ‘stuck’, seemingly ‘too big’ for the mother’s pelvis
- swelling on the side of the cervix (baby’s head pushing on the side of the cervix instead of pressing down evenly)

**Fetal navigation techniques could improve these labours prior to incidence of the following:**

- drugs are given to restart or augment the labour
- mother becomes exhausted or fetal distress is detected
- assisted/instrumental birth resulting in injury to the neonate or severe perineal trauma to the mother
- the mother undergoes caesarean section (CS) instead of the vaginal birth she had hoped for
- negative birth experience leaves mum traumatised

FNTs, many developed by chiropractors (Tully 2017), gently release tight uterine ligaments and muscles, and bring balance back to the uterus. This helps align the smallest part of baby’s head with the pelvis and gives the baby space to make the subtle movements it needs to navigate through the pelvis and make birth easier and shorter (Andrews 2010).

During labour, midwives can assist mothers into specific positions (to alleviate difficulties/reduce pain or even avoid difficulties altogether) and can even enlist partners so the couple can practise these short and simple techniques together (a combination also helpful for oxytocin release). There are several techniques to choose from, depending on the symptoms of malposition, the baby’s known position or pain levels.

The following four techniques have the widest range of applications during labour:

- ‘Abdominal lift and tuck’ takes just a minute to teach an upright mum to do by herself or with her partner. Use through 10 contractions in a row.
• ‘Rebozo sifting’ requires assistance between contractions and involves the use of a rebozo/scarf around the mother’s belly (or buttocks) while she leans forward.
• ‘Forward leaning inversion’ is held through one contraction. Repeat two-three times.
• ‘Side lying release’ may be the most important as it has so many uses, particularly if labour is long or contractions slow down or stop. This requires attentive assistance holding through three contractions on each side.

Benefits of FNTs

More women could be given the opportunity to experience the uncomplicated physiological birth they want if midwives were using FNTs as standard in mainstream, routine antenatal and intrapartum care. The repercussions could be profound, eliminating the need for a significant percentage of medical interventions and analgesics, with positive physical and mental health implications for women, babies and their families. From a business perspective, this could save a huge amount of money for our severely underfunded NHS. In terms of occupational health, staff shortages leave midwives stretched to their limits and under tremendous pressure (Plotkin 2017).

By routinely using FNTs, the NHS could help to reduce the time each woman is in labour, which could give midwives more precious time with each birthing mother.

The cost of birth without FNTs

Imagine if using FNTs could reduce the current 25-30 per cent CS rate (in many UK trusts) (National Institute for Health and Care Excellence [NICE] 2011) to 10-15 per cent as recommended by the World Health Organization (WHO) (Gibbons et al 2010). How would this affect costs to the NHS? According to NICE figures (2011) and the birthplace study (Schroeder et al 2011), unplanned CS is almost four times the cost of an uncomplicated vaginal birth at home. In addition to the direct financial cost of this major abdominal surgery, there’s a long list of inherent risks to mother, baby and future pregnancies. Women are also at higher risk of postnatal depression (PND) and post-traumatic stress disorder (PTSD) following medical interventions (Fisher et al 1997). Maternal and neonatal aftercare and subsequent pregnancy costs must be astonishing (NICE 2011).

If I can immediately change the course of two labours personally by using FNTs, and be directly involved with several other labours where the use of FNTs had an immediate impact, avoiding CS and potentially assisted birth – then surely, it is possible, in the hands of midwives using these techniques routinely, that intervention rates could be significantly reduced. These techniques have been in use for years and there is plenty of anecdotal evidence (Andrews 2010; Tully 2017; Fernando 2017).

Research recommendation

Therein lies the issue: anecdotal evidence is not enough. Clinical evidence is needed, yet even so it’s difficult to prove that the techniques are directly responsible for a straightforward labour - or a change in labour - on an individual basis. A potential direction for research may be training all the midwives in a midwife-led unit or maternity department with FNTs for use during labour, and comparing overall before-and-after statistics for the department over several months. Key indicators would include: planned CS/unplanned CS/induction/epidural/analgesic/length of labour. Further analysis of postnatal
complication rates and perinatal mental health treatment could highlight additional areas where FNTs may have a positive influence.

**Features of upright birth**

There is already a wealth of evidence supporting upright birth, which benefits from gravity and an increase in the available space within the pelvis by 28-30 per cent (Gupta et al 2012). This gives more space for rotation and descent (Andrews 2010) and being upright, empowering as it is, often facilitates mothers’ instinctive movements – hip rotations, walking, forward-leaning, kneeling, squatting – changing the dimensions of the pelvic inlet and outlet as the baby travels through the pelvis. With upright birth positions there’s a reduction in duration of labour and episiotomies and a significant reduction in assisted births. Reduction in episiotomies is offset by an increase in second-degree tears (Gupta et al 2012), although tearing arguably causes less perineal trauma than episiotomy (Carroli and Mignini 2009). Blood loss over 500ml is more frequent, although no increase in blood transfusions has been indicated (Searle 2010). The risk of abnormal fetal heart rate patterns is lower in upright positions compared with supine positions, which compress the mother’s aorta, affecting baby’s oxygen supply (Kinsella et al 1992). The Royal College of Midwives (RCM) recommends upright birth based on the overwhelming evidence (Munro and Jokinen 2012). It is this kind of evidence base which is needed to support FNTs – extending the benefits of upright positions.

With upright birth positions there’s a reduction in duration of labour and episiotomies and a significant reduction in assisted births.

Randomised clinical trials are the route to midwives using FNTs as standard in routine care. This is the goal of @MakeBirthEasier and it could mean the difference to many women, between a cascade of interventions and a shorter, uncomplicated vaginal birth with faster postnatal recovery. FNTs could mean the difference between negative birth experiences (for mothers, for babies and for midwives) and positive ones: improved outcomes – in the hands of midwives – every day.

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**Conclusion**

So, if a few simple manual techniques requiring only training (as part of the standard midwifery syllabus for student midwives and as a continuing professional development module for existing midwives) could promote birth with no formal equipment, no drugs and no reported unwanted side effects, this could save thousands of birthing women from pain and trauma, save babies from distress, reduce stress on midwives and significantly reduce costs to the NHS. Hands up who would like to make birth easier? Clinical trials need to be an urgent priority. **TPM**

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