Introducing the JuWeHen: The Birth of the New and Student Midwife Association in Germany

Nina Negi - Student midwife and regional JuWeHen representative

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Summary

The JuWeHen, the New and Student Midwife Association in Germany, was founded in January 2021. Although the former Federal Council of Future Midwives had been around since the 1980s, it had never had any long-standing structures or continuance, as all members moved on after graduating. To counter this, the delegates of the council approached the German Midwifery Association (DHV) in the summer of 2019, offering a long-term partnership which created a network for young and prospective midwives in Germany. This was to be the birth of the JuWeHen, the new youth association of the DHV.
A national model

In establishing the structures and design of the youth association, a country-wide model was created. Germany is organised into six regions, so it was decided that each region would have their own elected representatives. These first elections took place in May 2021, resulting in two representatives per region, as well as up to three deputy representatives. These representatives meet on a monthly basis to discuss current topics and updates in their regions, as well as planning countrywide activities. On a national level, six federal delegates were elected. These would represent the JuWeHen in the German Midwifery Association, as well as having voting rights in their main committee.

Who qualifies as a JuWeHe in Germany?

All student and prospective midwives, all new midwives in their first two years of work and all midwives younger than 32 years.
Vision

Although writing a mission statement is yet another work in progress, we dream of a future where a true midwifery model of care can be realised across the significant and consequential life phases of pregnancy, birth and postpartum. This would include:

- continuity of care(r)
- a one-on-one support model
- person-centred care
- evidence-based care
- shared decision making
- a true midwife-client partnership

In order to bring us closer to this vision, we have founded the JuWeHen, to connect, network, exchange and inspire each other, be stronger together and move collectively towards the realisation of our mutual dream.
Association aims

To date, the main aims of the youth association have been to build a networking structure, set up professional policy demands and engage in, as well as organise, political demonstrations and activities. This resulted in the #unersetzebar (translates to: irreplaceable, indispensable) campaign, with the aim to make midwifery work more visible.

By raising public awareness for the current working conditions of midwives and the current challenges of our birth culture, we are able to move collectively towards realising change. We raised the profile of midwifery with a nationwide photography campaign, online and offline, on International Women’s Day, as well as a demonstration on the International Day of Midwifery in front of the Berlin Ministry of Health, in co-operation with a Berlin organisation of health workers.

International intersections

Looking outwards, we created a working group to form a network to connect newly-qualified and student midwives from all over the world: the JuWeHen International Midwifery group. With this idea in mind, we founded online platforms to connect, through Facebook and Instagram. We recognise the importance of looking beyond one’s own country’s birthing culture and specific national health-care system’s policies to understand and learn from global diversity.

This sharing and comparing helps us appreciate many possibilities, ways and methods within pregnancy and childbirth. Best-practice models and birth models that “work” can find a broader platform. We envision a place to join forces and ideas surrounding the midwives of the future. The midwives we would like to become, and the kind of (global) birth culture we would like to create.

Check out our website (only in German language) at: https://www.hebammenverband.de/beruf-hebamme/junge-werdende-hebammen-im-dhv-juwehen/

We invite you to join us on our journey to channel the power of all the student and newly qualified midwifes out there! TSM
References

1. Bundesrat der Werdenden Hebammen in German.
2. DHV spelt out is Deutscher Hebammenverband.

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Examination of the Newborn: The Key Skills 1. The Eye

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Summary

Performing the newborn and infant physical examination (NIPE) is now recognised as part of the midwife’s sphere of practice. The majority of higher education institutions currently provide, or plan to include, NIPE training into their pre-registration curricula and many qualified midwives are embracing the NIPE role through undertaking continuous professional development modules. In the first of a five-part series, this article considers the importance of the eye examination in the screening process. The significance of history taking, knowledge of risk factors and the detection of the red reflex will be explored. The necessity for early detection of congenital cataracts, retinoblastoma and glaucoma, and the prerequisite referral pathways that the examination requires will also be highlighted.

Introduction

A detailed clinical examination is required as part of the national screening programme. Undertaken within 72 hours of birth, this examination encompasses screening for congenital cardiac defects, developmental dysplasia of the hip, congenital cataracts and cryptorchidism, as well as a robust, holistic examination.

Midwives are responsible for ensuring that they are, and remain, competent to carry out any aspect of their professional role, including universal care for all women and newborn infants. They are expected to carry out an appropriate number of examinations to maintain quality and retain the necessary skills. As such, it is widely recognised that midwives are the most appropriate healthcare professionals to conduct the NIPE on low-risk infants. Evidence has clearly demonstrated the clinical effectiveness of the midwife undertaking this examination, with increased parental satisfaction and the ability to provide continuity of care to women and their families.

Obtaining informed parental consent before the examination of the newborn is essential and not limited simply to permission seeking. Midwives should explain to parents that some physical conditions might become evident at a later stage, with screening taking place again through another comprehensive examination at six to eight weeks after birth.

Development of the eye

The development of the eye occurs between week three and week six of gestation, with the ocular structures and brain well organised by week six. For normal vision to occur, many complex structures within the eye must develop in relation to each other. The cornea and lens must both become transparent and properly aligned to allow a pathway for light to reach the retina (see Figure 1).

Figure 1 Anatomy of the eye
Development of the eye persists beyond birth, with myelination of the visual pathway not completed until two years of age. Any disruption to the process of this visual development may threaten the sight of the baby or infant.

Examination of the eye

The purpose of the NIPE newborn and infant eye screening examination is to detect any eye abnormality which may threaten the life or sight of the baby, with the primary purpose to identify congenital cataracts. Around two to three in every 10,000 babies are born with cataracts, and this is the most common treatable cause of blindness in the UK.

Risk factors

**Table 1 Risk factors for eye problems**

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<tr>
<th>Risk factor</th>
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<td>Prematurity</td>
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<td>Genetic syndromes associated with eye disorders, such as Trisomy 21</td>
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<tr>
<td>A first-degree relative with an ocular condition that was congenital or developed in early childhood, such as congenital or hereditary cataracts, aniridia, coloboma or retinoblastoma</td>
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In addition to the risk factors for eye problems shown in Table 1, there are also other factors that the midwife must be alert to, which she may have identified from her review of the history, such as low birthweight or low gestational age and ocular teratogens (see Table 2).

**Table 2 Ocular teratogens**
Prior to any physical examination, the midwife should ascertain the medical, family, antenatal, intrapartum and neonatal history, and also enquire about any parental concerns. In particular, any history of hereditary eye problems should be identified.

**Observation**

General observation of the newborn eyes would include any trauma, bruising, petechiae, birthmarks, oedema or discharge. Some will spontaneously resolve; others, such as port-wine nevi involving the eyelid, can be associated with Sturge-Weber syndrome and will require referral. The eyes should be observed for position, size and symmetry. The eyes should be positioned symmetrically in the front of the face. Widely spaced eyes (hypertelorism) or small eyes (microphthalmia) may be suggestive of a syndrome. Eyes that appear large are associated with congenital glaucoma. Presence of the normal features of the eye such as eyelids, eyelashes and eyebrows should be confirmed. Any drooping of the eyelid (ptosis) may indicate a weakened or absent eyelid muscle or a subtle clinical sign of disease elsewhere. Ptosis warrants an immediate referral, as it poses a significant threat to the normal development of the baby’s sight. Epicanthic folds are associated with Down’s syndrome but can also exist as a normal variant or associated with ethnic groups. Epicanthic folds alone should not be considered a diagnostic indicator for Down’s syndrome.

The open eye should be examined for the presence of the cornea, iris and sclera. The colour of the sclera should be noted: the sclera is bluish-white in the newborn, and any yellowing may indicate jaundice; an unusual blue colouring of the sclera is seen in a variant of osteogenesis imperfecta. The position and movement of the eyeball should be examined. Abnormal eye movements and any strabismus (squint) which appears to be fixed should be referred to an appropriate specialist.

**Inspection**

<table>
<thead>
<tr>
<th>Table 2 Ocular teratogens$^{12}$</th>
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<tr>
<td>Teratogen</td>
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<tr>
<td>Alcohol</td>
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<td>Opioids</td>
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<td>Cocaine</td>
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<td>Vitamin A</td>
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<td>Rubella</td>
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<td>CMV/HSV</td>
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<td>Syphilis</td>
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<td>Anticonvulsants</td>
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<td>Diabetes mellitus</td>
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The eye examination is completed using the ophthalmoscope, an instrument designed to examine the structure of the eye.

The room should be darkened so that the pupils will enlarge (mydriasis), with the baby settled and encouraged to open its eyes naturally. Consideration should be given to changing the baby from supine to upright, with auditory stimulus to encourage this. The eyelids may be gently parted, if necessary, however forcefully prising the eyelids open may cause the eyelids to evert and hinder accurate visualisation.\(^\text{13}\) In addition, through prising open eyelids, clinicians increase the risk of neonatal conjunctivitis due to the lack of immunity and absence of lymphoid tissue at birth.\(^\text{15}\) The midwife will then need to examine the eyes for the red reflex, which is the red glow in the pupil zone due to light scattered from the vascular choroid layer. The purpose of the red reflex test is to detect abnormalities of the retina, the lens and the cornea.\(^\text{16}\) The ophthalmoscope lens should be set to ‘0’ and the largest aperture selected. The ophthalmoscope should be positioned close to the operator’s eye, at arm’s length from the baby’s face.\(^\text{3}\)

**Normal red reflex**

The red reflex should appear in the baby’s pupil (see Figure 2), with both reflexes seen simultaneously. If the aperture does not allow visualisation of both reflexes at once, then altering your distance backwards until you can observe both red reflexes should be undertaken. Red reflexes should appear clear and equal in colour and intensity in each eye. If a clear red reflex is not seen in one or both eyes, they should be examined individually and compared.

**Figure 2 Normal and abnormal appearance of the eye**
Further examination required

A referral is warranted if the examination shows:

- A white pupillary reflex (leukocoria), which could indicate a retinoblastoma (see Figure 2)
- The presence of opacities in the reflex, which could indicate a cataract
- The absence of any reflex
- Inequality in colour, intensity or clarity of the reflection.

Screeners should be aware that the normal red reflex varies depending on the baby’s ethnicity, appearing less bright and magnolia in colour in Black, Asian or minority ethnic babies. In this instance, it is advisable to cross-examine the baby’s parents’ red reflex in order to determine the expected reflex colour.³

Retinoblastoma

Retinoblastoma is a life-threatening ocular condition, occurring in about one per 18,000 live births,¹⁷ with around 50–60 children newly diagnosed each year in the UK.¹⁸ There are two forms of retinoblastoma - an inheritable (often bilateral) and a non-inheritable form (usually unilateral). In the inheritable form, the dominant abnormal gene may either be inherited from a parent or occur for the first time at an early stage of eye development. Whilst children are likely to survive this cancer, many will suffer consequences from a delayed diagnosis, including the loss of one or both eyes, poor sight or blindness. Therefore, staff must be vigilant to the signs to achieve a prompt diagnosis.¹⁹
Congenital cataract

The UK incidence of congenital cataract rates ranges from two to three per 10,000 of the population by age one. A cataract is an opacification of the lens of the eye; often associated with systemic anomalies in children, causing 20% of childhood blindness worldwide and requires prompt surgery if sight is to be preserved. Midwives are recognised as having a significant role in helping to prevent profound amblyopia if early detection and management is exercised.

Congenital glaucoma

Congenital glaucoma affects only 0.05% of newborn babies, however has been blamed for 5% of childhood blindness worldwide. Glaucoma is fundamentally a problem of improper drainage of fluid in the eye as a result of incorrect or poor development before birth. The raised intraocular pressure is thought to damage the optic nerve resulting in vision loss but, if the pressure is well-controlled through surgical management, vision can be improved. The aetiology of congenital glaucoma is not fully understood, with most cases being sporadic (no family history), however about 10-40% are familial, with an autosomal recessive inheritance pattern. Additionally, congenital glaucoma appears most prevalent in ethnic groups with high rates of consanguineous marriages.

Referral

Following the examination, any abnormalities should be referred according to Public Health England’s pathways in Table 3. In addition to the referral pathways stated below, if the midwife is concerned in any way, it is advised that the examination is repeated by another experienced practitioner within the 72-hour guideline period.

Messages for midwives

The examination of the eye should not be considered in isolation, as it is only one aspect of the wider holistic examination of the newborn, with parents and their baby remaining at the centre of care. The importance of the midwife’s role cannot be overstated. Ensuring effective history taking related to hereditary eye problems, early recognition, ensuring precision of red reflex examination, good record-keeping and prompt referral along the correct pathways will ensure optimal treatment to prevent long-term negative sequelae for children. TPM

Table 3 The NHS newborn and infant physical examination programme (NIPE) referral pathway for examination of the eye
Five practice partner points

1. Further your knowledge by completing Unit 2 ‘Screening examination of the eyes’ of the NHS Newborn and Infant Physical Examination e-learning
2. Did you know that guidance regarding the distance in which the ophthalmoscope should be held from the newborn’s face has only recently changed? Examine the conflicting evidence and guidance with wider
3. Develop your clinical experience by following a newborn with a positive screening outcome through the referral process – can you shadow a consultant ophthalmologist for the day?
4. Make a note of your experience in identifying the red reflex presenting in babies of non-Caucasian How many variations of the reflex have you seen?
5. Reflect on your experience in identifying complex conditions associated with the Have you been able to successfully identify conditions such as glaucoma? How did it present?
References

Birthing in the Time of Pandemic: Reflections from Black and Asian Mothers

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In the United Kingdom, Black and Asian women suffer worse maternity outcomes compared with white women. Maternal health is one of the NHS Patient Safety Strategy priorities and at the National Institute for Health and Research’s Greater Manchester Translational Patient Safety Centre (NIHR GMPSTRC), we are planning research in this area.

To ensure that research reflects the key issues based on experiences and needs of women most at risk, we conducted a piece of patient and public involvement. This is a necessary precursor to any piece of research – i.e. letting the target of research help define the research itself. We worked in partnership with local community organisations that work closely with Black mothers: The Caribbean and African Health Network, and Awakening Minds and Diversity Matters North West who work closely with Asian mothers to find out from the women themselves what their recent maternity experiences had been.

The most common issue was perceived lack of communication between women and maternity staff.
In online discussions in the autumn of 2020, we spoke to ten women from a Black Caribbean and/or African community and to 12 women from the Asian community. Women spoke about the uniqueness of each pregnancy and many had positive experiences. But during their reflections, some common issues emerged. The following is a summary of these common reflections. Whilst it is important to recognise the impact that the COVID-19 pandemic had on women’s experiences, some of the issues raised were not related to the pandemic and we begin with these.

The most common issue was perceived lack of communication between women and maternity staff. Women felt that they were often ‘not listened to’. Inadequate pain relief was discussed by most mothers. Black mothers felt that stereotypes around the ‘strong Black woman’ influenced lack of adequate pain relief. Some Asian women talked about stereotypical assumptions that they were unable to speak or understand English when veiled. Women also spoke of decisions seemingly made without them about their care and some related this to language barriers. Others spoke of a lack of trust in maternity services, an issue highlighted in a previous edition of The Practising Midwife. Issues surrounding trust and communication are central to perceptions of patient safety for mothers to be and is well documented in the patient safety literature.

When we spoke to mothers about their increased safety risks or issues specifically related to ethnicity, it was clear that some of these may not be recognised by the mothers themselves or were not well communicated by maternity services. One example relates to Vitamin D deficiency. We asked women about this due to established links between ethnicity and Vitamin D deficiency. Many women said they weren’t aware of their increased risk of Vitamin D deficiency. They reflected that communication around vitamin D supplementation was vague with one woman saying she had simply been told that “because of your background, you need this”.

The largest factor for the women’s perceptions of safety however concerned the loss of touch.

In addition to these more general issues were those that COVID-19 had created. Opportunities for education were highlighted. Specifically, the lack of face-to-face ante-natal classes and opportunities to ask questions were mentioned. There was a sense of increased anxiety and vulnerability due to increased remote service provision and fewer contacts with maternity services overall. Some women’s ante- and post-natal care was conducted via telephone.

Video consultations seemed less common. The remote form of contact and the lack of desired face-to-face care were considered problematic. Issues concerning the lack of privacy for women when receiving care in their own homes was raised and questions around physical safety or abuse more difficult to raise and answer.

The largest factor for the women’s perceptions of safety however concerned the loss of touch. The removal of physical examination possibilities due to remote care undermined the women’s confidence in their care. Feeling safe when utilising health care encompasses psycho-social factors and a sense of safety concerning physical health (physical safety).

The focus on women’s physical health was seen as reduced during COVID-19, and the importance of touch also reduced and/or lost. Post-natal care in particular was highlighted as particularly problematic because it affected their perceptions of safety for their new-born babies.

Finally, COVID-19 also affected the opportunities and outcomes for the midwife/mother relationship.

Some mothers however, who were alone due to immigration status, did feel that they were able to have the type of relationship they wanted.
For many women, COVID-19 blocked the ability for Midwives to perform what has been described as the “being with” aspect of midwifery – encompassing the relationship, communication and understanding between the midwife and the pregnant woman. Comparisons to pre-COVID times were made by some women whereas for first time mothers, an ‘imagined loss’ occurred. The importance of this aspect of care was heightened during COVID-19 due to the limitations on birth partners. Some mothers however, who were alone due to immigration status, did feel that they were able to have the type of relationship they wanted.

The work reported here has led to new partnerships with clinical bodies locally to inform research priorities for the NIHR GMPSTRC, concerning Black and Asian mothers. Specifically, we are now working on evaluating a Vitamin D deficiency programme to facilitate high-uptake of Vitamin D to those most vulnerable.

References


Night Shifts: Tips to Help You Thrive Rather Than Just Survive!

Anon.

Summary

At the beginning of my degree, I remember feeling pretty daunted at the prospect of working night shifts. What should I eat? When should I sleep? What if I am too tired on shift? After three years I’ve started to get to grips with night shifts, although I don’t think it’s something you ever truly get used to! Here are some of my tips – I hope they help you feel more prepared when 3am hits!

1. Trial and error: Everyone has a different approach to night shifts – some like to stay up late the night before the first shift, others take a nap in the day. Some people eat sweet food, others eat savoury, and after the shift some people will sleep straight away whereas others will stay up for a few hours. To find out what works best for you, give different approaches a go and remember there’s no right or wrong.

2. Food: It is impossible to know what you will want to eat in the early hours, so I pack a variety. Sometimes I’ll want to eat loads, other times I have no appetite at all. I try to take food that is easy to digest, such as soup, and something yummy like cake! Peppermint tea can also be a saviour for the famous night-shift bloat. It’s best to eat a big meal before your shift to sustain you through the night, even if you don’t feel up to eating – there’s nothing worse than feeling hungry in the first few hours of a shift!

3. Sleep: Sleeping throughout the day is unnatural and can feel very disorientating. I replicate my bedtime routine and keep away from screens, swapping dinner for breakfast but keeping everything else the same. Earplugs, a black-out blind and an eye mask are helpful to trick your body into thinking it is night-time and some aromatherapy, such as lavender, can work wonders. To help
myself switch off I jot down any work thoughts on paper to empty my mind and try to read a few pages of a book as I wind down for bed. If I wake up in the early afternoon and can’t get back to sleep, I try to take it easy watching films, listening to a podcast or reading to save my energy for the shift. Following the final night shift some people take a short nap, others sleep for a while and some, like me, stay up until the early evening. It is very personal and depends on what your demands and needs are during the day. This is a trial-and-error situation and can change depending on what the next day has in store for you.

4. Hydration: It’s really important to keep hydrated with water/squash throughout your shift to prevent headaches, keep you awake and aid concentration. Cola, tea or coffee is fine to give you a caffeine boost but try to keep those drinks as a supplement to water rather than a replacement. Watch your fluid intake as you approach the last few hours of your shift. If you drink too much before you go to sleep you may find yourself waking up to go to the toilet throughout the morning, which can be very frustrating!

5. Plan ahead: As with day shifts, being organised is key – prepare your food, work bag, uniform and childcare ahead of time. If possible, I get all important tasks done the day before my shifts start so that only the most essential jobs are left for me to do between shifts. Sleeping and eating becomes my absolute priority during a row of nights.

6. Get outside: Make time for a walk between shifts if you are working a row of nights, and after the final one if you can – it’s so important to get some sun and fresh air. It can make a big difference both physically and emotionally.

7. Treat yourself: After a row of nights, have something to look forward to, however small. I find that it can give me a little boost on the final shift when I am feeling tired and ready for home.

8. Reach out for support: Make sure those closest to you are aware of your shift pattern so they can support you. If you are struggling with the effects of night shifts, or you have been allocated an unreasonable amount, consider having a conversation with the person who writes your shift rota. Once qualified, midwives can swap shifts and request a few shifts every month, but as students we don’t always have this luxury. Speak up and ask if you need to make some adjustments to your rota. Keep your personal tutor and practice supervisor in the loop too so they can support you with this. Night shifts are hard work – you don’t need to have do this solo.

9. Using your breaks: As a student, no matter how busy the shift is, you are entitled to your full break. Some like to have a short nap, others prefer to stay awake and relax. Use this time to rest and restore – take some headphones so you can listen to some music or watch TV. If you are really struggling to stay awake, ask your practice supervisor to take your break early, if the shift activity allows. Advocate for your own needs, we are only human.

10. Hitting the 3am “wall”: It is well known that around 3am you can hit a “wall”, dehydration and hunger can make this worse. If this does happen, make sure you have a drink and snack to hand and, if you are able to, take a short walk to wake up. I find it helpful to have a pack of face wipes and a toothbrush and toothpaste handy in my bag – it’s amazing how refreshing a quick wipe and brushing your teeth can feel.

11. Be gentle with yourself: Placement is hard work – not only are the hours long, you’re also constantly learning and soaking up new information all the time. Being a student can be a very physically and mentally demanding time. Give yourself credit and celebrate the small wins, even if it’s just making
it through to the morning.

12. Recovery: It’s very common to feel a bit sluggish for a few days following your final night shift. Take it easy and try to keep plans to a minimum on the day you finish your nights. I usually get tasks such as food shopping and washing done as they keep me awake but don’t require much mental or physical energy. Lower your expectations and take the pressure off yourself.

13. You can do it!: The adrenaline will get you through, and the more you do nights, the easier it gets. The night shift bloat and hangover feeling does pass, and you will adjust back to a normal sleeping pattern sooner than you think. We are more adaptable than we give ourselves credit for.

14. It isn’t all bad: Nothing beats the feeling as you drive home, knowing that you’ve seen and been a part of some amazing moments while everyone else was fast asleep. Lots of people prefer nights over day shifts, and it does feel pretty surreal supporting families at 4am while the sun comes up and everyone else is snoozing.

Have a look at our Wellbeing Zone for more! TSM

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**Inequalities in Perinatal Mental Health Outcomes**

![Image of Amba Louise Morrell]

Amba Louise Morrell - Student midwife, London

**Southbank University**

**Instagram:** @Londonstudentmidwife

**Summary**

Inequalities in perinatal mental health outcomes have been an ongoing issue in UK maternity services, with marginalised women and birthing people including those from ethnically diverse groups, lower socio-economic backgrounds and the LGBTQIA+ community being worst affected. Yet despite ongoing research into the reasons behind these inequalities, they continue to be poorly understood by midwives and birth workers. In order to enable early intervention and promote positive outcomes, it is imperative that all birth workers are continuously educated about the signs and symptoms of perinatal mental health disorders across all birthing populations, irrespective of their ethnic origin, socio-economic status or sexual or gender identities. This could save many women and families from life changing trauma and in some cases,
even save lives and optimise opportunities for better perinatal outcomes.

Introduction

The topic of disparities in perinatal mental health (PNMH) outcomes has been widely discussed for years, in fact, suicide is known to be one of the leading causes of maternal death during pregnancy and up to one year postpartum. Research has highlighted how PNMH disorders can have detrimental effects on women, babies and their wider families and that the women most prone to inequities in regard to PNMH are more likely to be from deprived areas and minority groups, which raises the following questions:

- Why do clients from marginalised groups appear to receive poorer care in relation to their perinatal mental health?
- Are all birth workers (midwives, maternity support workers, obstetricians and doulas) aware of the short-term and long-term impact perinatal mental ill health has on these groups?

Types of Perinatal Mental Illnesses

- Depression
- Anxiety
- Post-Traumatic Stress Disorder (PTSD)
- Obsessive Compulsive Disorder (OCD)
- Eating Disorders
- Postpartum Psychosis

The potential impact of perinatal mental illness

- Suicide or suicidal ideation
- Impaired mother-baby bonding
- Changes in physical well-being
- Impaired social engagement
- Self-harm
- Fear of subsequent pregnancy and childbirth
- Behavioural changes
- Negative effects on relationships
- Impaired short-term or long-term fetal/neonatal neurological development
- Future mental health disorders

Ethnic disparities

As the Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK (MBRRACE) report has identified women from Black, Asian and mixed ethnicity backgrounds are more likely than their white counterparts to die in childbirth and the first year after giving birth. This has been attributed to systematic racism, institutionalised medical bias, racial stereotyping and healthcare professionals ignoring the concerns voiced by people of colour; which has led to this client group expressing distrust towards healthcare providers. Further research has also found that non-white ethnicity
puts women at greater risk of being subjected to inequitable care in regards to their PNMH. This ingrained bias can result in women from Black, Asian and marginalised ethnic backgrounds not being listened to by maternity workers when asking for support.

The impact of low socioeconomic status

In the UK, Black, Asian and ethnic minority women are also more likely to have lower socioeconomic status, be from deprived areas and face barriers in regard to recognition, care and treatment for perinatal mental health disorders. Having a low socioeconomic status has been linked to poor mental health due to the stress caused by having a low income or relying on government benefits for financial stability. Worries about money and housing issues can be extremely taxing and such stress can be amplified by the arrival of a newborn, and cause or exacerbate previous mental-health issues such as depression or anxiety. It is not entirely clear why women from deprived areas have less support in regard to their PNMH, however, staff shortages, PNMH service suspension due to lack of funding or healthcare professionals’ lack of understanding about PNMH could be contributing factors. Women with lower socioeconomic status and PNMH disorders are also at increased risk of breastfeeding challenges, since 25% of people in highly-deprived areas are more likely to be prescribed psychotropic medications, which can potentially have adverse effects on breast-feeding, compared to those in less deprived areas.

LGBTQIA+ communities

Birthing people from LGBTQIA+ communities may also face the same barriers as maternity service users that are non-white or come from low socio-economic backgrounds. However, there is evidence that they also have to deal with barriers that are associated with their sexual and gender identity. Minority stress, which is described as additional stressors that members of marginalised groups face due to prejudice and discrimination, causes increased poor health amongst members of the LGBTQIA+ community, as they experience fear that they will be stigmatised, marginalised and discriminated against by maternity care providers. All midwifery educators and hospital Trusts should be providing staff education about how to work in an inclusive manner, and asserting that the use of correct gender pronouns is a necessity. It is also important that any reading material or online literature recommended to service users is inclusive and portrays both heteronormative and non-heteronormative different family structures.

The PNMH disorders that affect 1 in 5 women do not just impact these individuals in isolation, they also affect their children, family and friends. As such, urgent steps need to be taken to mitigate their impact. In light of the Government’s pledge to give NHS Maternity Services £96million, I feel that some of this funding needs to go towards educating all birth workers about the signs and symptoms of different PNMH disorders and their short and long-term effects. Funding is also needed to address the major staff shortages afflicting maternity services across the UK, as this would afford maternity staff more opportunities to recognise when women are struggling with their PNMH.

There are plans to increase the number of Mother and Baby Units (MBU) where women can access help for PNMH issues without being separated from their newborns. Funding needs to be continuously supplied to these MBUs to enable them to remain open and provide the care and support which clients need. Birth workers should always provide fair and equitable care and acknowledge that there are marginalised groups that are currently under-served. We must all work harder to make maternity care fair for all whilst being sensitive to individual needs; this means being aware of the different signs and symptoms of various PNMH disorders and thoroughly assessing each client’s mental-health status at every point of contact, rather than just asking the Whooley Questions as part of a tick-box exercise.

Finally, educating clients and their partners about the different symptoms of PNMH disorders empowers them to flag up any concerns early on, which will hopefully enable them to access help as soon as possible. In practise, this means making PNMH referrals promptly, rather than waiting until a woman is in crisis, involving women in the referral process and signposting them sources of support should they need


Recommended resources

- Red Flags for GPs in Perinatal Mental Health [https://www.rcgp.org.uk/clinical-and-research/resources/toolkits/~media/8BB0A8DBBF045BA9B32F4BB607773A69.ashx](https://www.rcgp.org.uk/clinical-and-research/resources/toolkits/~media/8BB0A8DBBF045BA9B32F4BB607773A69.ashx)
- Top Tips for Effective Communication in Perinatal Mental Health [https://www.rcgp.org.uk/clinical-and-research/resources/toolkits/~media/179F47DFDF25475A9D88EE0A7C41D8F6.ashx](https://www.rcgp.org.uk/clinical-and-research/resources/toolkits/~media/179F47DFDF25475A9D88EE0A7C41D8F6.ashx)
- Structural Racism and Health Inequities by Gilbert C Gee and Chandra L Floyd (2011) [https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4306458/](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4306458/)

Conclusion

Women and birthing people from Black, Asian and minority ethnic groups, low socio-economic backgrounds and LGBTQIA+ communities face a host of biases and barriers and sometimes even neglect when accessing healthcare. As healthcare professionals we must enforce change and make maternity care equitable and accessible for all. All healthcare professionals have a responsibility to their clients to provide individualised, judgement-free care at every point of contact whilst taking their concerns into consideration.

References


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**Returning to Practice: The Challenges of Becoming a Midwife Again**

Judith Smith – Healthcare Assistant, Norfolk & Norwich University Hospital

**National shortage**
Current government figures suggest that the NHS is short 2,000 midwives and more are leaving everyday. The need to train and recruit more midwives is clear. Yet little is done to encourage former midwives to return. A return to practice midwife can be retrained and re-registered far quicker than training a new midwife.

Why I left midwifery

I qualified as a midwife in 2001, having completed my midwifery degree at Kingston University and St George’s University of London. I started work as soon as my PIN was active and loved being a midwife, at least initially. About a year after I qualified the Head of Midwifery at the hospital I worked at changed, and the new head didn’t like me. For the next two years she made my work life increasing difficult and eventually the stress became too much and I quit. It has been 17 years since I last practiced but I decided two years ago that I wanted to return and began the process of re-registering. This turned out to be far more challenging than I had expected.

In order to re-register the NMC requires a midwife to either complete a return to practice course or undertake competency testing

Current situation

Midwives leave the profession everyday for a variety of reasons; to have children, because of stress, a desire to do something different or health issues. Some may never have a desire to return, others may wish to return but are put off by the process.

In order to re-register the NMC requires a midwife to either complete a return to practice course or undertake competency testing. The return to practice course has been the standard for years, but with few courses available this isn’t always an option. Currently only 11 courses are available with the bulk of the universities being in London, the Midlands and South West. This means that potential returning midwives who live outside of these areas often struggle to access a course, as they are unable to relocate or travel to the nearest site for family or health reasons.

From January 2020, the NMC began offering an alternative method to regain registration. Competency testing has been around since 2014 as a means of ensuring overseas nurses and midwives meet the required standard to practice in the UK. It requires the candidate to pass a 120 question theory test and a 10-station practical test, which covers all areas of practice. The NMC provides plenty of information on
what areas will be tested. However the practical test is only offered at three universities: Oxford Brookes, Northampton and Ulster – and testing costs £877. Health Education England will reimburse the costs once a candidate has secured a job using their registration. Although competency testing is a viable option to return to practice, in place of the traditional courses. Neither option is freely accessible and require a substantial investment of time and money, which may be a deal breaker for some midwives.

Neither competency testing or the return to practice course is freely accessible and both require a substantial investment of time and money, which may be a deal breaker for some midwives.

My journey to return to midwifery

As I live at least 100 miles from any of the current sites and am unable to relocate or travel for family reasons, I chose to undertake competency testing. I registered to start the process in February 2020, a fortuitous decision as once COVID-19 restrictions started, the NMC closed competency testing to new applicants.

I took and passed my theory test in August 2020 and applied for my practical test soon after. My original practical test date was November 2020, but I rearranged this as I had no childcare during lockdown to attend the test.

I rebooked for January 2021 and had to rearrange again as I was pinged by the NHS Test and Trace app three days before my test. I finally attended my practical test in March. The version of this test that I took only had six stations. The first five followed the journey of a woman through a hospital admission and the sixth station was a skills test.

I have rarely felt as nervous as I did during that assessment and I was ecstatic when I passed on my first attempt. I then applied for my registration to be reinstated and by the end of March I was a registered midwife again. The whole process felt fraught with challenges, some to do with the system and some to do with COVID-19 lockdown. Several times during this process I questioned if I should continue, but I’m very glad I did.

Next step

Due to the length of my break from midwifery I want to return as a Band 5 and complete a preceptorship programme again to ensure that I am a safe, capable and competent midwife.

The next challenge is finding a job, this has proved far more difficult than I had hoped it would be. I live within two miles of my local hospital, 20 miles from the next closest and within 40 miles of three more, all of which I would be happy to travel to.

I have applied to these five hospitals nearest to where I live each time they have a suitable position available, but so far have only been interviewed once. I was unsuccessful at this interview, mainly due to being completely unprepared for what I was going to be asked. Despite not receiving any feedback, which I did request, I have drawn my own conclusions on where I needed to improve and feel that when I am able to secure another interview I will be much better prepared.

Each time I apply, I’m going up against newly-qualified midwives that have recent clinical experience and up-to-date theoretical knowledge. I am doing as much reading as I can and have written a few pieces reflecting on changes in best practice over the years I have been away from midwifery but I am unable to work clinically and feel this is holding my application back. I have also made contact with the local hospitals to discuss opportunities within those Trusts. I’ve found the process of getting a job as a midwife far more challenging than I had initially expected it to be. But perseverance has been the key and I have now been offered a position as a midwife.
I would recommend undertaking a traditional Return to Practice course, over competency testing. The clinical experience that the course provides will be invaluable in job seeking.

**Conclusion**

Returning to practice is difficult, probably far more than it needs to be. More could be done to assist the return of midwives to the profession – it’s far quicker and cheaper than training a new midwife. I would recommend undertaking a traditional Return to Practice course, over competency testing. The clinical experience that the course provides will be invaluable in job seeking. Anyone wishing to return to the profession should be aware that it will not be easy and you will need to make substantial investments of time and money. However, I would absolutely go through it again and would encourage anyone to undertake the process if they wish to return. **TPM**

**References**


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**Safer Sleeping with Infants in Hospital**

Ali Brodrick - Consultant Midwife, Sheffield Teaching Hospitals NHS Trust

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Helen Baston - Consultant Midwife, Sheffield Teaching Hospitals NHS Trust

Published in The Practising Midwife Volume 24 Issue 10 November 2021
Introduction
The immediate postpartum period is an important time for both the mother and her baby. Facilitating and protecting mother-infant closeness is important in supporting the transition to motherhood and early neonatal adaptation.

Contact to communicate
The immediate postpartum period is a unique interactive time when a newborn starts to make sense of its new world and parents assimilate and adjust to their roles. Cross-culturally, parents use tactile contact as a means of communicating and responding to their infants. It is one of the most influential factors impacting human development and the growing body of evidence has led to changes in midwifery practice. The separation of mothers and babies, once seen as a normal part of midwifery care, has been replaced with guidelines that promote early skin-to-skin contact and maintaining mother-infant closeness at all times.

The benefits of close contact and the subsequent increase in oxytocin levels are well known. They include strengthening the mother’s or birthing person’s instinct to protect and care for their infant, and enhanced thermoregulation of the newborn. Skin-to-skin contact is also an important mediator for birth satisfaction, with skin-to-skin positively influencing women’s satisfaction with childbirth across all modes of birth.

The UNICEF Baby Friendly Initiative (BFI) has developed accreditation standards, which include ‘Support all mothers and babies to initiate a close relationship and feeding soon after birth’. We therefore create an expectation that it will happen, we place a value on its worth, and women want and expect to be able to see and hold their newborn. Thus maternity units are also questioning current practices in obstetric theatres, not just during caesarean birth, but keeping mothers and babies together when a mother requires obstetric theatre care post-birth, for instance with a third-degree repair.

Recognising cues
Keeping their baby close and in sight during the first hours and days will support parents to recognise feeding cues and enable them to respond to any signs that the baby is ready to feed or needs comfort. Being sensitive to an infant’s needs and being able to respond to them will aid the development of the baby’s trust and confidence. It is also important that this togetherness is continued in the early postnatal period; the value of skin-to-skin contact, face-to-face interaction and responding to cues are key factors in promoting emotional attachment.

Safer sleeping practices
To facilitate responsiveness, it is recommended that babies sleep in the same room as their parents for the first six months, preferably in their own clear cot. Many mothers choose to bring their baby into bed with them for feeding and comfort. Bed-sharing can inadvertently lead to co-sleeping and is not advised in narrow hospital beds, especially in the early postnatal period as women may be excessively tired and/or still under the influence of analgesia, affecting her ability to move, respond and stay awake. All parents should be informed of the principles of safer sleeping practices for preventing sudden infant death syndrome, accidental suffocation and neonatal falls, and how to create a safe sleep space for their baby.

TPM

References


Matricentric or Medically Responsible: An Exploration of Midwives’ Attitudes Towards Caring for Women and Birthing People Who Choose to Birth Outside of Guidelines

Becky Westbury - Community Midwife Team Leader, Bronglais Hospital, Hywel Dda University Health Board
Summary
Matricentric care centres around the birthing woman/person and acknowledges the systems and structures that may impact upon them and their experience. Choice is embedded into modern maternity care, with multiple human rights legislations supporting an individual’s rights to accept or decline care. In practice, birthing people have reported incidences of facing opposition or feeling unsupported in their choices, which has the potential to lead them to pursue other options exposing them to more risk. Midwives play an integral role in supporting birth choices and providing respectful maternity care, and as such it is crucial to identify factors affecting this.

Introduction
Birth outside of guidelines can be defined as choices that fall out of line with national clinical guidelines and policies. Women and birthing people value having opportunities to consider and plan for their birth, and support and choice from a midwife has been shown to be integral in this. Raymert et al also concluded that adequate information to make a choice was key, along with challenging the assumption that obstetric units are best for all women.

Matricentric care is focused on midwives fostering and protecting these essential human rights. A meta-ethnography, including five studies appraising midwives’ experiences of caring for those making unconventional birth choices, identified a spectrum of midwives’ views and the key role of the midwife in facilitating birth choices.

This study aimed to explore the attitudes and feelings of midwives who care for those who choose to birth outside of guidelines, focusing on perceived barriers, previous positive experiences and how comfortable midwives feel providing care.

Methods
Design
A 14-question online survey was designed using Qualtrics software to capture the thoughts and feelings of midwives regarding caring for those who birth outside of guidelines (TWBOG).

Recruitment
The survey link was shared solely via social media with relevant permissions.
Questionnaire

We collected both qualitative and quantitative data, with a variety of free text, multiple-choice and Likert scale questions. Open questions invited participants to share their feelings and comfort levels when caring for TWBOG, any barriers they perceive to be present, and their positive experiences. The time constraints of the MSc study precluded a pilot study.

Sample

Recruitment followed a non-probability convenience method, with participants volunteering to take part anonymously by following a link to the online survey. The survey invited participation from UK midwives. Data collection occurred over a period of 14 days in January 2020.

Data analysis

Quantitative data were analysed to determine the relationships between selected variables using Pearson’s Chi-Square tests. Quantitative tests were carried out by a statistics specialist at Swansea University using SPSS data analysis software.

Qualitative data from the free text answers were analysed using the Braun and Clarke method of thematic analysis, using NVivo12 for qualitative data analysis. The data were first read, then re-read and coded thematically by author A. Author B reviewed the codebook and nodes within NVivo to confirm themes.

Quantitative findings

In total, 707 midwives responded to the survey, equating to 1.9% of UK registered midwives. Midwives from all four countries responded; 62.07% of respondents were from England (n=437), 25% were from Wales (n=176), 6.96% were from Scotland (n=49), and 5.97% were from Northern Ireland (n=42).

Most roles within midwifery were well represented. Most respondents to the survey work within the NHS (92%, n=653). Independent midwives represented 3% (n=21), with the remainder of respondents working in education, the private sector, or not currently practising.

Respondents were questioned both about planning birth outside of guidelines and supporting TWBOG during labour. There was no significant difference overall between how respondents felt when planning birth and providing care in labour. Overall responses indicated that midwives agreed with feeling curious, uneasy and nervous, and disagreed with feeling afraid. That said, some midwives expressed extremely negative views. Community midwives felt more excited and less uneasy and nervous than hospital midwives. Perhaps this reflects the role of the community midwife in supporting women and birthing people to plan for labour and birth. When asked whether care provided is affected by the choice to birth outside of guidelines, 63.73% of respondents answered ‘no’ (n=448), 25.60% answered ‘maybe’ (n=180) and 10.67% answered ‘yes’ (n=75). Hospital midwives felt that the care they provided was more likely to be affected than community midwives. The responses of independent midwives reflected a more positive view of supporting TWBOG, with none of the independent respondents disagreeing with feeling excited, compared to 27.25% of NHS respondents.

Pearsons’ Chi-Square tests identified seven statistically significant relationships between variables:

1. Midwives who had been qualified for longer felt more comfortable caring for TWBOG. The highest levels of comfort for midwives qualified between 16 and 24 years.
2. Role affected level of comfort caring for TWBOG. The majority of community midwives reported some level of comfort. A greater number of hospital midwives showed some discomfort.
3. Midwives who felt supported by leaders felt more comfortable caring for TWBOG.
4. Midwives who felt less comfortable caring for TWBOG desired more training in this area.
5. Further training in caring for TWBOG was most desired by midwives who had been qualified for the least number of years.
6. Role affected whether midwives felt that if an individual declines any aspect of recommended care in labour, it may impact on the midwifery care that they would give her.
7. Midwives who wanted more training in caring for TWBOG felt more uneasy when reading birth plans of TWBOG.

Qualitative findings

We identified five key themes: ‘As long as’/fear of implications; challenging women and birthing people/negative relationships; coercion; organisational resources/time; person-centred care.

‘As long as’/fear of implications

The phrase ‘as long as’ was used by 162 respondents, indicating that clinical context and risk was important when considering TWBOG. Many referred to their professional registration/career, commenting they feared the professional implications of a negative outcome. Many midwives referred to repercussions, disciplinary action and lack of support. Some extreme views were expressed, with one midwife commenting that they ‘can usually persuade them to follow guidelines’.

Midwives felt confident in supporting women and birthing people only ‘as long as’ certain conditions were met, such as ‘a full and informed discussion prior to labour starting’ and ‘counselled properly and understands the risks fully, so that if a situation arose they are aware of what that could mean’. Some respondents also referred to the individual’s right to choose their care pathway:

‘More than happy if she has made a fully-informed decision. The risk is not ours to take’

This demonstrates a belief in women and birthing people’s right to exercise informed choice, but also suggests shifting accountability to the individual and an alignment with the language of medicalised practice.

Some midwives referred to the restrictive nature of guidelines, stating that they ‘prevent you from giving holistic care’ and that deviating from guidelines can be ‘really freeing’. Other respondents appeared more concerned with the implications for themselves rather than those under their care:
'I think as long as the senior staff offer a good support system for the midwife to support the woman’s choice it would allay my fears’

The repeated use of the phrase ‘as long as’ could be seen as a protective, caring statement in line with the midwife’s role, which is to promote informed decision-making.

Conversely, for some midwives, TWBOG provided them with the chance to exercise their professional autonomy:

‘I find it exciting and interests me when women challenge the guidance, I think many are right to do so and I love supporting choice’

This theme also highlights midwives’ discomfort when women do not access the support and birth guardianship offered.

Challenging women and birthing people/negative relationships

This theme (543 respondents) acknowledges difficulties that midwives might face when supporting people who may be challenging, obstructive or even combative in their relationships with care providers:

‘The women themselves often are defensive expecting negative communication’

However, some of the responses reflect the midwife’s authority and the institution of medicine, and the assumption that women and birthing people should defer to this authority:

‘The lack of respect from parents for evidence-based practice and safety for mother and unborn’

Furthermore, midwives appeared disturbed by situations where their knowledge, experience and professionalism are not accessed or respected by the birthing person.

‘Unable to provide the best or safest care I can because of choices’

This suggests that midwives maybe uncomfortable when the exercise of ‘informed choice’ is against recommendations. There may be degrees of deviation from guidelines, some of which are more tolerable than others. One respondent recognised that women often feel ‘passed from pillar to post’ and ‘radical’ when deciding to birth outside of guidelines, and can ‘take longer to let you build rapport or even communicate’. Some responses suggest the rigid adherence to guidelines and guideline-based practice works against midwives practising effectively and supporting informed choice and humanistic care.

That said, some responses reflected negative views of healthcare staff, which perhaps explains some of the barriers that midwives face:

‘Staffroom slandering, that ‘does she not love her baby?’ attitude. Doctors treat these women like naughty kids’

From this, we can infer a clash of cultures between a ‘truer’ midwifery ideology and the exercise of midwifery values, and a potentially deeply ingrained, inherited culture of patriarchal paternalism and reductionist medicalisation which fails to respect women and birthing people as experts in their own lives and bodily knowledge, and midwives as experts in providing person-centred care.

One midwife cites a ‘lack of trust’ and certainly this is unlikely to support a positive birthing environment or a positive workplace. Midwives also repeatedly cite issues with those in positions of greater power than their own:

‘External pressure from obstetric team, you’re then caught between two worlds and being stuck in the
middle is difficult'

What is most telling in this theme is how vulnerable midwives feel to judgement, censure and professional criticism.

‘Fear of being labelled as a reckless midwife’

Coercion

Fifty-nine respondents referred to coercion in their responses. Although midwives in this study cite the fact that decision-making often involves ‘compromise’, they also state that varying degrees of psychological force bring women and birthing people into line with guidelines:

‘Obstetric concern which can sometimes manifest as bullying or coercive, sometimes resistance comes from other family members’

The use of ‘coerce’ and ‘coercion’ appear in several of the responses to the questionnaire, often linked to the behaviours of obstetricians, but not always so:

‘Some of the senior midwives also will come and speak to the woman to talk her into compliance’

‘Consultants putting on pressure for women to ‘conform’, doctors telling women they are being selfish and their baby will die’

This links back to the previous discussion on authority, knowledge, power and trust, and speaks to a lack of trust in midwives from other colleagues.

One respondent displayed extreme views, stating ‘They won’t listen to my advice. I know better than [them]’. Other midwives appeared to recognise that coercion was unacceptable, however seemed unable to advocate this amongst their colleagues:

‘I feel like I have to lie and tell them that I have tried to persuade the woman to agree to their guidelines etc’.

Organisational resources/time

This theme was referred to only 44 times by respondents. However, common statements emerged strongly and frequently, which suggests systemic issues affect the ability of midwives to practise effectively and women to exercise their rights and agency:

‘System not set up to support either the woman or the midwife in this circumstance’

The limitations of ‘guidelines’, ‘institutional’ factors, ‘local policies’ and ‘birth centre eligibility criteria means not accepting women who would otherwise choose to birth there’ all affect how midwives support women and birthing people. This absolutist attitude derives from a perception of guidelines as ‘rules’ and the false idea that the guidelines are completely right for everybody.

‘Stand-alone birth centre guidelines are not clear enough, for example some issues say ‘individual assessment’ – what does this actually mean?’

Further responses referred to resource-based issues such as ‘management have closed home birth services due to lack of staff’, which clearly impacted upon choice. Other respondents, however, cited smaller issues as barriers to supporting TWBOG:

‘Failure to have time to get to know the woman’
‘Extra paperwork, risk assessments’

**Person-centred care**

The final theme identified was person-centred care, referred to 161 times by respondents. Many of the respondents find that there are benefits to supporting women as individuals, and align supporting choice with their core values and practices:

‘Choice is absolutely central to the care I give’

Midwives appeared to experience positive benefits to supporting women in this process of self-determinism and agency:

‘Feedback from women about feeling empowered, listened to, proud of themselves etc’

This is a feature of professional satisfaction for midwives and relates to the relationships they build with birthing people. However, there is also evidence in this theme that midwives may place a limit on their provision of person-centred care:

‘I support women’s informed choice but within the safe practice remit of my registration’

The sense of caution here aligns with earlier themes. Nevertheless, most midwives associated referred to supporting women to birth in autonomous ways and having positive experiences:

‘I feel it is important that women take charge of their own births, and often their choices will optimise their physiology and their spiritual experience of birth’

From this, it is possible to see that rather than being a professionally risky and maternally irresponsible issue, birthing outside guidelines is, in fact, a part of an empowered and powerful experience for both mother and midwife.

**Discussion**

There are some key issues that emerge from this study. The first is the evident fear of implications for midwives, meaning that they qualify their readiness and comfort in caring for TWBOG with conditions; ‘As long as’ the birthing person is informed, the midwife may feel safer. This raises questions about the meaning of ‘informed’ in this context. The responses within this theme infer consistently the idea that the authoritative knowledge lies with the professionals, which must be imparted for women and birthing people to make decisions. Midwives’ confidence might relate more to confidence in their accountability rather than their confidence in the individual making the decisions. Does this relate to the evolution of midwifery professionalism and increased medicalisation? Wright et al identify medico-legal issues as a source of professional stress for midwives. The idea that midwives’ care is conditional runs counter to the core principle of unconditional positive regard that should underpin all our activities. This is a critical point for institutions to consider, particularly as the role of the midwife should be and is matricentric, suggesting that the discourses and practices of midwives should be matrifocal. Yet the data suggest that midwives are greatly concerned with their own accountability.

Whilst some midwives find it liberating to facilitate informed choice, others are less than comfortable. This may reflect our cultural constructs of authority, power and control in birth. Madeley et al in their qualitative study of midwives caring for with complex needs choosing home birth, identified the ‘radical midwife’ and relate this to a tension between ‘traditional beliefs and practices, physiological processes, midwife knowledge’. Our study reflects this, drawing on tension between midwifery ways of knowing and being; the matricentric midwife, and professional ways of knowing; the medically responsible midwife. The dichotomy between guidelines as a representative of medical control and midwives’ role in promoting
autonomy relates to fears, which points to potential reasons why midwives might become less willing to support women and birthing people’s autonomous decision-making when it runs counter to the dominant will of the institution, as made manifest in the guidelines. The only real solution to this would be to change the nature of guidelines, and to instil in healthcare culture a new belief in the power of guidelines to inform practice, rather than defining or restricting it. This may then remove the pressure and coercion that has been identified in the qualitative themes.

Using threat to force a person to comply with recommended action is illegal. Deviance and conformity are socially derived constructs embedded in and shaped by social values of gender, behaviour and professional power. It is a concept that has emerged in other research and debate and speaks to the role of conformity within medical systems. In this case it is possible to see this made manifest in the microcosm of maternity care through the enacted power structures referred to in the data. Guidelines are not rules or laws, but a guide to support mutually respectful and individualised decision-making and care planning. They should be a pillar of person-centred care, something that the midwives in our study associated with their role and values. The study suggests that guidelines affect the autonomy and agency of both parties in the professional-person dyad and need a critical and radical rethinking.

Our study suggests that certain factors affect the comfort level and feelings of midwives. Length of time since qualification affected levels of comfort when caring for TWBOG, with those qualified for between 16 and 24 years feeling the most comfortable. This suggests that building midwives’ confidence in respecting and supporting choices might be needed in certain groups, particularly in those who have been qualified for fewer years. Bäck et al suggest that feelings of confidence and competence evolve over time, however Bedwell et al argue that it is the influence of colleagues that affects midwives’ confidence. Perhaps supporting informed choice in this regard comes with time and experience, but maybe more work with midwives with less experience would support them to develop more comfort with TWBOG.

Levels of comfort when supporting TWBOG may vary according to role. Most community midwives reported some level of comfort, whilst a greater number of hospital midwives showed some discomfort.

There was a statistically significant relationship between role and feeling that an individual declining care would impact upon care given. This may relate to a medicalised culture that persists in Western maternity care. Jenkinson et al discuss how a medicalised culture limits maternal autonomy, and enculturates women and birthing people into a limited maternal role holding them to account for their choices in restrictive ways.

Midwives wanting further training shows a potential desire to feel more prepared for caring for TWBOG. Bäck et al link competence to learning. Perhaps midwives need more training or learning opportunities to
understand women and birthing people’s perspectives and knowledge about birth or indeed to unpick the impact of medicalisation and current birthing systems on autonomy. It might also be that midwives need clearer training and guidance on respectful maternity care and human rights.

**Limitations**

The study was designed to gather information identified through literature review and professional interest, but the questionnaire was not validated or piloted before use.

**Conclusion**

Our research shows that professional and cultural issues, organisational factors and leadership and management/issues all impact on midwives’ ability to provide truly person-centred care. Yet it is vital that midwives can adhere to their philosophies of matricentrism as this supports them to create the conditions for positive birth experiences. Rather than viewing women and birthing people exercising choice and autonomy as ‘risky’, midwives view it as a sign of empowered mothers and empowered midwives. It is vital therefore that midwife leaders and managers, and midwives themselves, use this as a starting point to interrogate their own practice. Strong leadership is required from managers who also respect midwives and who push back against the systems that constrain them unnecessarily.

The power of this study lies in its ability to encourage us to interrogate midwives’ perspectives and the precarious position in which they find themselves, caught between the power of the system of medicine and the philosophy of midwifery. Guidelines should support autonomous decision-making and provide a framework to aid mutually respectful conversations between service provider and service user. A matricentric midwife is one who believes and practises person-centred care in which the birthing person’s power is celebrated, valued, respected and honoured. A medically responsible midwife combines matricentrism with care that empowers women and birthing people to feel fully informed and ensures that they are not alienated from or excluded from full access to all medical intervention and support should this be needed, regardless of their choices. It is time to rethink the ways that we view and use obstetric guidelines and consider reframing our practice to reflect humanised maternity care within a matricentrism and inclusive culture of respect for personal and professional autonomy. **TPM**

**Ethical approval**

Granted by Swansea University College of Human and Health Sciences Research and Ethics Committee [180919a].

**Caveat**

Alys is now Editor-in-Chief of The Practising Midwife. This article was submitted prior to her appointment and independently peer reviewed.

Thanks to Susie Moore, MSc Supervisor, and Ioan Humphreys for support with statistics.

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Exploring Food Guidance 2. Dairy in Pregnancy: Advice, Physiology and Evidence

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Published in The Practising Midwife Volume 24 Issue 10 November 2021

Summary

In the second article of our series looking at the guidance and evidence surrounding counselling pregnant and postnatal women around food and drink, we explore dairy: how concepts of dairy are changing, the nutritional components of dairy and their function in pregnancy, and alternatives for those who cannot or choose not to consume it.

Introduction

Dairy is the collective term for food products made from the mammary secretions of animals (generally cows) and includes such food items as milk, cream, butter and cheese. These items are typically associated with sources of fat, protein, calcium and vitamin D in the human diet, as well as less commonly known minerals such as iodine, magnesium, vitamin B12, zinc and riboflavin. Dairy products are not one homogenous food group. Cheese and yoghurt may confer health benefits due to their fermentation process, digestibility and lower lactose content. However, unlike coffee in our previous article, dairy products are not as universally consumed. Additionally, there are well-known recommendations to avoid certain dairy foods in pregnancy.

Furthermore, what constitutes dairy – and how the nutrients typically found in dairy make their way into our diets – is changing. Cow’s milk allergy in children in developed nations sits around 2–3% making it the most common food allergy amongst children. In addition, studies suggest that the ability to digest lactose beyond childhood is variable across populations and that upwards of 70% of the global population may be unable to digest dairy. Changing attitudes to dairy from environmental, health and ethical perspectives have also contributed to decreases in consumption of dairy products; the UK saw a decrease in dairy consumption of 16% between 2000 and 2018. This article will explore some of the nutritional components of dairy and their specific importance in both pregnancy and breastfeeding or chestfeeding. It will also examine some of the headlines, guidelines and underpinning evidence pertaining to dairy consumption for pregnant and/or breastfeeding women, including those who cannot or choose not to eat dairy.
Current advice

The current National Institute for Health and Care Excellence (NICE) antenatal guidance for care in uncomplicated pregnancies and the NICE maternal and child nutrition guidance make no mention of specific intakes of any nutrient in pregnancy, including dairy. The British Dietetic Association’s guidance for pregnancy is similarly non-prescriptive other than to mention that the iodine requirements of pregnancy may be met by eating dairy.\(^4\) The NHS stresses that dairy foods are good sources of calcium, but their guidance is more focused on the prevention of some of the inherent risks involved from pathogens in dairy.\(^5\) The only real guidance surrounding intake comes from government dietary reference values which have remained unchanged since 1991.\(^6\) These reference nutrient intakes indicate, despite our knowledge relating to increased calcium demands in pregnancy discussed herein, that dietary dairy intake between non-pregnant and pregnant populations should be the same (700 mg per day for adults between 19 and 50 years). There is, however, a recommendation that an extra 550 mg/day of calcium is added to intakes whilst breastfeeding.\(^6\)

Hazards relating to dairy consumption in pregnancy

The conversations midwives have with expectant parents about food safety (usually at their booking appointments) are familiar and often encompass dairy. The standard warning is that all consumed dairy items should be pasteurised.\(^7\) This generally entails avoiding soft white mould-ripened cheeses or blue cheeses (or cooking them thoroughly if they are to be consumed) whilst pregnant. The rationale is that the pasteurisation process (whereby liquids or foods are heat-treated to kill pathogenic bacteria) will destroy listeria monocytogenes which are associated with an increased risk of miscarriage and stillbirth. However, it is equally important to discuss with pregnant women that listeria can also be present in pasteurised milk cheeses, and as an environmental pathogen, can indeed contaminate any food after processing. The largest outbreak of listeriosis in England in recent years was, in fact, linked to frozen sweetcorn.\(^8\) The risk of contracting listeriosis, specifically from dairy, is therefore small.

Pregnancy and breastfeeding physiology

A healthy and balanced diet in pregnancy is, predictably, important in promoting normal fetal growth and development. Maternal diet may also be directly linked to the fetus’s susceptibility to chronic disease in later life,\(^9\) making antenatal diet even more crucial. In that context, an understanding of some of the nutrients that dairy provides to both mother and infant is key.
Calcium may be the most well-known of the nutritional components in dairy products as it is present in higher quantities than any other mineral. Calcium is essential in pregnancy as it is deposited in the fetus at greater rates than in any other period of life.\textsuperscript{10} It is particularly essential in the formation of fetal bone and this becomes more significant in the third trimester when up to 80% of fetal bone calcium is deposited.\textsuperscript{10}

The process also has a significant impact on the maternal skeleton as the process of ‘bone turnover’ (the breaking down of osteoclasts to release minerals into the blood followed by replacement with new bone) is increased in pregnancy. Studies indicate that maternal bone mineral density falls significantly as a result of this bone turnover, and lower dietary calcium intakes may exacerbate this, impacting future bone health.\textsuperscript{11}

Maternal calcium absorption increases in pregnancy from 20–30% to 60% to meet the increased demand,\textsuperscript{10} aided in part by the action of oestrogen. Successful absorption also depends on what the calcium is bound to in food, as well as other factors such as age, which can inhibit absorption as intestinal responsiveness reduces. Vitamin D additionally influences calcium absorption across the intestine and insufficient vitamin D levels are linked to decreased calcium absorption.\textsuperscript{10}

There are additionally increased demands for calcium when breastfeeding. Circa 250mg of calcium is secreted into breastmilk daily. Bone turnover also remains increased postnatally and bone mineral density is reduced. This is further exacerbated by the return of calcium absorption to near normal non-pregnant levels; these levels remain unchanged until menstruation returns under the action of increasing oestrogen, and this may not happen until breastfeeding has ceased.\textsuperscript{10} As such, postnatal dietary intakes of calcium (particularly whilst breastfeeding) should ideally be higher.

**Breastfeeding and lactase production**

Babies almost universally produce lactase and can digest the lactose in their mother’s breastmilk, but as they are weaned and mature, most young children switch off the gene that produces lactase. Only about 35% of the human population can digest lactose beyond the age of about seven or eight, notably those from northern European-derived populations. Therefore, the natural state of most humans is lactase non-persistence; this is often framed as a defect or ‘intolerance’ when this is the global norm. Some of the longest living populations are lactose non-persistent.\textsuperscript{12}
Meeting needs

Whilst dairy products are undeniably good sources of essential nutrients, there are other dietary sources of the nutrients that can be found in non-dairy foods to meet the needs of groups who cannot or choose not to eat dairy. Calcium can be found in everyday food items such as wholemeal bread, oranges, kale, tofu and broccoli.\(^\text{13}\) The explosion in popularity of plant-based diets and veganism over recent years has also ensured there is a wide variety of ‘alternative’ fortified dairy products that are widely available that have comparable calcium levels to that of traditional dairy (see Table 1). However, it is worth noting that this is only the case for those products that are fortified; organic plant milks often have added nutrients omitted.

<table>
<thead>
<tr>
<th>Dairy food (portion)</th>
<th>Calcium content (mg)</th>
<th>Dairy alternative (portion)</th>
<th>Calcium content (mg)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cheese - cheddar (30 g)</td>
<td>222</td>
<td>Calcium-fortified coconut cheese (30 g)</td>
<td>45–221</td>
</tr>
<tr>
<td>Yoghurt plain - whole (125 g)</td>
<td>193</td>
<td>Calcium-fortified soya yoghurt (125 g)</td>
<td>150</td>
</tr>
<tr>
<td>Semi-skimmed cow’s milk (100 ml)</td>
<td>120</td>
<td>Calcium-fortified plant milks – e.g. soya, oat (100 ml)</td>
<td>120–189</td>
</tr>
</tbody>
</table>

Iodine is another essential mineral found in dairy that, amongst other things, regulates thyroid hormone production. It is essential in pregnancy as deficiency has been linked to increased risks of miscarriage and low birthweight.\(^\text{14}\) Interestingly, iodine is not a natural component of dairy and is largely present as a result of cattle supplementation and/or iodine-containing disinfectants used to clean milking equipment.\(^\text{15}\) Whilst other dietary sources of iodine are available (such as bread and fortified plant milks), the amounts of iodine present in these can vary, and so those who avoid dairy can more reliably obtain their iodine via supplementation which we will discuss in a future article. A minimum recommendation of 150mcg of iodine per day is recommended.\(^\text{16}\)

The review concluded that randomised controlled trials were needed before an association could be conclusively drawn.

Impact on growth

A recent tabloid headline proclaimed, ‘Children on trendy vegan diets are 1.2 inches shorter on average, with smaller and weaker bones’.\(^\text{17}\) This is a familiar narrative – that those who do not have adequate dairy intakes may be risking their own or their children’s health, and often, growth is the focus.

Some research has indicated that low dairy intake in pregnancy and/or infancy may negatively impact the growth of the developing fetus and/or infant. A recent systematic review stated that 11 of 17 included studies drew positive associations between dairy consumption and reduced risk of small for gestational age (SGA) infants.\(^\text{18}\) However, the studies included were largely cohort or cross-sectional studies, sampling global populations where both intakes and lactase non-persistence rates are variable, and it is not clear whether it is the ‘package’ of dairy itself that is growth-promoting or one (or more) of dairy’s inherent
nutrients such as protein or fat that acts to promote growth. The review concluded that randomised controlled trials were needed before an association could be conclusively drawn.

Similarly, what the newspaper headline failed to mention in its interpretation of the results of a study into the growth of children was that the sampled vegan children were of a normal height and had better cardiometabolic health overall. Interestingly, the diets of all the sampled children were deficient; the omnivorous diets were higher in fat and sugar and lower in fibre, and the diets of the vegan children were inadequate in general (low in calcium as well as vitamin D and B12), so it is no surprise that this impacted growth for this group. The study seems only to confirm that diets need to be properly planned, whether dairy-free or not, to ensure children have a sufficient intake of necessary nutrients. Perhaps the dialogue is also in need of a shift away from a focus on poor growth towards the prevention of disease. The image of the bouncing baby as a paragon of health heralds from a pre-war era of food shortages and nutritional insufficiency where these concerns are now dwarfed by the growing public health issues of obesity and cardiovascular disease.

A critique of current UK policy

Despite these facts about dairy consumption, particularly those that relate to the global norm of lactase non-persistence, dietary discrimination is evident in the healthcare we provide to pregnant women and their infants. The government’s Healthy Start scheme is well known by midwives and provides support to low-income women and their families when they are pregnant or have children under the age of four. The vouchers supplied can be used to purchase milk, infant formula, fruit and vegetables however, inexplicably, they can only be exchanged for plain cow’s milk or first infant formula made from cow’s milk, thereby discriminating against those who are lactase non-persistent. The same is true within the Best Start Foods scheme in Scotland. This contributes to existing healthcare racism and inequality. Women from Black, Asian and Minority Ethnic (BAME) groups and their infants are more likely to be paid a lower income (and therefore benefit from the Healthy Start scheme) and be lactase non-persistent.

Conclusion

This article aimed to help you make sense of the guidelines, the headlines and a selection of research to enable you to have informed conversations with women to support them to make decisions about their dietary choices in relation to dairy and dairy alternatives should they wish to. Women may wish to know that whilst dairy products can be good sources of essential nutrients in pregnancy and breastfeeding, these nutrients can be easily found in other food products or alternative dairy sources. Furthermore,
avoidance of dairy is not conclusively linked to poor fetal or infant growth. Iodine may be most easily obtained from a pregnancy-specific multivitamin for those who do not consume dairy. Discussion with women may also incorporate guidance to increase intakes of calcium when breastfeeding and ensure an adequate source when pregnant alongside essential vitamin D supplementation to aid absorption. Midwives themselves should also be aware of the prevalence of lactase non-persistence, particularly amongst those from the global majority and the endemic dietary discrimination this group faces. The foods people eat are influenced by their culture, socialisation, economics and an awareness of sustainable environmental and ethical considerations. Therefore midwives need an understanding of these factors to support woman-centred conversations.

References

Waterbirth After Fourth-Degree Tear?

Emma Fisher - Birthing woman

Twitter @Emma_Fisher

Dianne Garland - Freelance midwife

Facebook @diannegarland

Cathy Williams - Doula

Twitter @chilledmamacath

Summary

With more people experiencing perineal trauma, it is timely to consider the information shared to
support their decision-making about their next birth. In this article, a woman, a midwife, and a doula reflect on the evidence, decisions and joint professional working leading to a waterbirth at home after a previous fourth-degree tear.

**Introduction**

When Emma was pregnant with her second baby, she found herself in a dilemma. The birth of her son had left her with a fourth-degree tear from forceps and birth trauma. Wanting to avoid all three, she felt she had two options: an elective caesarean or a home birth.

If she was going to have a vaginal birth, then she wanted to do everything to avoid a repeat experience. She felt a water birth would help her avoid instrumental birth, but the information she had received was negative. Emma reached out to local doula, Cathy.

‘The obstetrician said it was fine for me to labour in a pool, but she would actually advise against delivering in a pool as it can make the perineum ‘soggy’ and more likely to re-tear. She has put this in my notes and also said I need to have a senior midwife who should coach with pushing and offer perineal support during delivery (which would also be hard to do if I was in water). I mentioned this to my midwife at my last appointment and she also agreed that I should have a very hands-on midwife for the second stage! I’m worried that because this is written in my notes, I’m going to be prevented from even getting in a pool should I want to, or that I’m going to be told how to push when I actually might feel in the moment that I can just trust myself but am going to be in no state to say this. The above advice obviously goes against a lot of hypnobirthing advice, but at the same time, I really want to avoid tearing again, so also want to take on board their experience and advice.’

**Avoiding future tears**

Emma’s number one question was: ‘Is birth in water beneficial after a fourth-degree tear?’.

There was no clear answer to this question. Cathy shared with her the information about avoiding tears, the OASI Care Bundle – a collection of interventions aimed at reducing rates of obstetric anal sphincter injury (OASI) during childbirth – and articles offering a critique. There is some research to show that women with third- and fourth-degree tears with their first baby were more likely to have perineal injury
again, and were significantly more likely to opt for a caesarean birth for their second baby. However, the research doesn’t mention the type of birth these women had, whether they used water, nor what position they were in. There is no mention of ways to reduce the chance of tearing.

This study didn’t fill Emma with much hope, but an archived thread from the Association of Radical Midwives on third-degree tears and management of the next birth did.

Cathy put Emma in touch with freelance midwife Dianne Garland, who has 34 years of waterbirth experience and exposure in the UK and worldwide. She has also cared for mothers with a previous OASI tear.

Dianne has a set of standard questions which she asks anyone who contacts her with this type of previous birth:

- How well did the tear heal?
- Are there any long-term problems?
- What is the potential risk of a repeat OASI tear?

Dianne shared the following points with Emma:

- No one could ensure Emma does not experience another OASI tear.
- New studies showed: Women who gave birth in water were no more likely than women who used water for labour only to require perineal suturing or to experience OASI.
- Women choosing water immersion for labour or birth were no more likely to experience adverse birth outcomes than women receiving standard care and rated their birth experiences more highly.
- There was an association between waterbirth and reduced incidence of postpartum haemorrhage
and neonatal unit admission. There is limited evidence about Emma’s situation (which her obstetrician also stated).

- Using water will make the perineum more supple, not soggy; you cannot alter the internal cellular structure.
- Water acts as a positive pressure against the perineum.
- For delivery, some midwives like a mirror to visualise the perineum.
- Many birthing parents find all fours a good position in the pool.
- Use water for labour and birth if you feel confident in the water – listen to your body.
- Use instinctive pushing – not holding your breath and pushing.
- Allow your baby’s head to stretch the perineum at a gentle rate; singing is great.
- It is fine for you to cuddle your baby’s head – you will not stimulate the baby’s first breath – midwives should not try to ‘control’ the head as dry land care.

Speaking with Dianne gave Emma the confidence she needed to opt for a home waterbirth and to arrange this with her local midwives.

**A successful waterbirth**

Emma gave birth in a pool at home, listening to her body and trusting her instincts. She was only slightly concerned when she felt her baby moving down during a wave and then back up again, but her midwife and doula Cathy reassured her this was exactly what needed to happen to allow the perineum to gently stretch and not tear.

Emma described the second stage as a very intense pressure which she allowed to happen, rather than actively pushing, suggesting she experienced the fetal ejection reflex.

‘Being in the warm water allowed my perineum to soften and stretch, encouraging her head to be born slowly. I think the lack of gravity was my saving grace – had I been on land, with gravity pulling baby down, she might have been born a lot quicker and so increased my chance of tearing. I remember thinking even the ‘ring of fire’ wasn’t that bad, probably because I was in water!’

The midwife told Emma she might need to pant, but noted that Emma was doing so gently anyway, despite roaring her baby out during a surge.

Emma’s daughter was born with both hands by her face, yet Emma only had a small tear requiring two stitches.
Conclusion

What are our learning and reflection points?

- This is a great story of a home waterbirth during a pandemic, and of joint professional work between a midwife and doula.
- It is an example of challenging care: there is no evidence about water with previous fourth-degree tears – but lots of new research about waterbirth and OASI.
- There is a rationale for the use of water following a previous fourth-degree tear – all the points Dianne shared with Emma.
- Women’s and midwives’ stories are a source of evidence.
- Embrace the grey: acknowledge the lack of evidence or the constraints of the evidence. If you don’t know, then connect with others.

‘I wish waterbirth was more accessible to people. I had to push for it and jump through hoops, as [I was] going against guidelines’, yet it encourages instinctive behaviour and physiological birth.

Being in the water made me feel safe, like I was in a cocoon and I could really tap into my instincts. It is what helped make my birth such a magical, empowering experience.’ TPM

References