Summary

PROMPT Wales is a large-scale maternity safety programme funded by the Welsh Risk Pool and supported by the PROMPT Maternity Foundation. PROMPT is an evidence-based, multi-professional training programme that incorporates practical simulation sessions and human factors training and is attended by all members of the maternity team annually. The PROMPT Wales programme was developed to reduce variation and standardise the quality of obstetric emergency training across Wales, with the overall aim of improving safe outcomes for mothers and babies. The programme is now in its third year.

Introduction

It is widely recognised that improvements in clinical care, multi-professional teamworking and human factors contribute to safer outcomes for mothers and babies.\(^1\)\(^2\) It is therefore no surprise that maternity units around the UK and abroad have been exploring their options for a robust, evidence-based training programme that incorporates all these factors and has been found to improve safety and outcomes. PROMPT (PRactical Obstetric Multi-Professional Training) is an evidence-based obstetric emergency training programme run by the PROMPT Maternity Foundation (PMF). PMF is a charitable organisation based in Bristol with more than 20 years’ experience in obstetric emergency training. Successful implementation of PROMPT has been associated with direct improvements in outcomes for mothers, birthing people and babies, including a 50% reduction in term babies born with a five-minute Apgar <7, a 50% reduction in neonatal hypoxic-ischaemic encephalopathy\(^3\) and a 100% reduction in permanent brachial plexus injuries after shoulder dystocia.\(^4\) Maternity units implementing PROMPT have also demonstrated improvements in organisational culture, including safety and teamwork.\(^5\) PROMPT is endorsed by the Royal College of Obstetrics & Gynaecology (RCOG), Obstetric Anaesthetists’ Association (OAA) and the Royal College of Midwives (RCM). PROMPT Wales is a maternity safety programme funded by the Welsh Risk Pool\(^6\) and supported by the PMF. PROMPT Wales aims to meet the needs of Welsh NHS organisations to make childbirth safer and improve outcomes for women and families. NHS Wales consists of seven health boards inclusive of 12 obstetric-led maternity units and 13 free-standing midwifery-led units. The annual birth rate in Wales is around 30,000, around 5% of all births in England and Wales. These demographics, along with support from Welsh Government, facilitated a national approach to the implementation of a new obstetric emergency training programme for Wales.
In 2016, the Chief Nursing Officer for Wales (letter, 8 December 2016) approached the Maternity Network Wales to consider the effectiveness of existing training to prepare maternity teams in the recognition and management of obstetric emergencies. A scoping exercise identified variation in approach among health boards, making it clear that a standardised, multi-professional training programme was required for NHS Wales. Having reviewed available training options and noting a strong take-up of PROMPT across the UK, the Maternity Network Wales approached the PROMPT Maternity Foundation. Following collaboration with key stakeholders, it was decided that PROMPT training should be rolled out in all obstetric-led maternity units in Wales and would be funded by the Welsh Risk Pool. PMF was commissioned to provide a bespoke Train the Trainer package for Wales, adapting it to align with NHS Wales initiatives, most notably OBS Cymru (the Obstetric Bleeding Strategy for Wales), a quality improvement programme aiming to reduce harm from postpartum haemorrhage, which was progressing at pace. In May and June 2018, two Train the Trainer events were held in Bridgend, Wales, attended by anaesthetists, midwives, obstetricians and support workers from all seven health boards. These 89 clinicians became the core faculty who went on to plan, implement and run PROMPT training in their own units. Nine university lecturers also attended, with the intention of introducing the PROMPT Wales principles into undergraduate midwifery education, to align with the PROMPT Wales courses students were to be encouraged to attend during year three.

By August 2018, the PROMPT Wales brand was introduced to health boards. Essential training resources including manikins and PROMPT course manuals were provided to the maternity units. An implementation team was in post consisting of an obstetrician, anaesthetist and midwife from PMF and a national lead midwife from NHS Wales. The team met with local faculties to benchmark and provide support for the planning and implementation of PROMPT Wales in their maternity units. Three health boards that were already running some elements of PROMPT training were supported to transition to the PROMPT Wales model, ensuring authentication and standardisation of the programme across Wales. The implementation team later expanded to include multi-professional clinicians from across NHS Wales organisations to support the programme during its first year. The PROMPT Wales strategy was launched at a national event in Cardiff on 23 October 2018, with keynote addresses from the chief nursing officer and chief medical officer for Wales. Given that successful implementation of PROMPT includes attendance by 100% of maternity staff annually if it is to have an impact on safer outcomes for mothers and babies, annual PROMPT Wales training was agreed and mandated for midwives, obstetricians and obstetric anaesthetists.
By January 2019, PROMPT Wales was running in all seven health boards. Practice development midwives, supported by the obstetric and anaesthetic PROMPT Wales leads, were instrumental in leading the roll out (or transition) in their respective maternity units. PROMPT Wales consists of a full-day training course, which includes lectures, workstations and obstetric emergency simulations. Scenarios take place in the clinical area, ensuring staff are familiar with their environment and the location of emergency equipment. There is a significant focus on human factors, and teamworking, communication and situational awareness are threaded throughout the training. MBRRACE-UK attributes lack of situational awareness with poor outcomes for mothers and babies, and formal training in human factors is a key recommendation in the 2015 ‘Each Baby Counts’ report. Throughout 2019, the implementation team provided support at 100 of the 107 courses held throughout NHS Wales. The team also supported the delivery of in-house faculty development training days and held a national Train the Trainer event to ensure enough clinicians were trained within each health board to provide multi-professional input on each PROMPT Wales course.

Measurement for learning and improvement

Outcome measures

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<th>Outcome measures</th>
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<tr>
<td>Five-minute APGAR score &lt;7</td>
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<tr>
<td>Hypoxic Ischaemic Encephalopathy</td>
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<tr>
<td>Unexpected NICU admission at term</td>
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<tr>
<td>Brachial Plexus Injury</td>
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<tr>
<td>PPH &gt;1500ml - 2500ml</td>
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<tr>
<td>PPH &gt;2500ml</td>
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<td>Maternity admissions to level 3 care</td>
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Retrospective clinical data has been collected from Welsh maternity units to establish over time whether improvements in maternal and neonatal
outcomes are evident. However, improvements in outcomes demonstrated by PROMPT can take several years to become evident due to the infrequency of some of the adverse outcomes. The development of new all Wales dataset coordinated by the Wales Maternity and Neonatal Network will facilitate the measurement of clinical outcomes for PROMPT Wales (see figure 1).

The Welsh Risk Pool are also interested in the impact on organisational culture and staff perception of teamworking and safety. This is being measured by PMF using a validated safety attitude questionnaire pre and post implementation of the project.

**Process measures**

Only through successful implementation of the PROMPT Wales Standards can Wales expect to achieve the improvement in outcomes experienced by other maternity units that have successfully implemented PROMPT training. The commitment of all health boards, local leadership teams and the local PROMPT Wales faculties is recognised in the achievements thus far. By March 2020, 2,714 maternity staff had attended PROMPT Wales training and midwifery, obstetric and anaesthetic attendance was at 94%, 90% and 86% respectively. The Welsh Risk Pool are evaluating the data, exploring the facilitators and barriers to attendance and aiming to identify areas for improvement.

**Litigation**

When implemented successfully, PROMPT has been associated with reduced litigation costs in hospitals in the UK\(^4\) and the USA\(^5\). If the expected improvements in clinical outcomes are achieved through PROMPT Wales, a subsequent reduction in NHS Wales litigation is anticipated, resulting in more available funding for patient care.

> Through the provision of unique central coordination, the Welsh Risk Pool was able to ensure rapid adoption of a consistent approach to multi-professional obstetric emergency training throughout NHS Wales

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Conclusion

Through the provision of unique central coordination, the Welsh Risk Pool was able to ensure rapid adoption of a consistent approach to multi-professional obstetric emergency training throughout NHS Wales. The Welsh Risk Pool remains instrumental in the sustainability of PROMPT Wales through the continuation of a national team that works closely with local PROMPT Wales faculties, building on the strong training foundations, so that high-quality training can be delivered year on year. By continuing to attend local courses, the team can ensure a high standard of authentic PROMPT training is maintained and provide quality assurance to the Welsh Risk Pool, local leadership teams and Welsh Government. PROMPT Wales has been recognised within the Welsh Government’s ‘Five Year Vision for the Future’. The vision itself underpins the principles of the PROMPT Wales training model stating: ‘High-performing multi-professional teams will deliver family-centred care within health boards, which display strong leadership within a culture of research and development, continuous learning, best practice and innovation.’

References


Dr Claire Feeley - Midwife/Researcher, Editor of The Practising Midwife

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Summary

As the ninth article in our normal birth series, we highlight the key evidence around birthing pool use: a tool for optimising labour and birth physiology. Drawing upon our collective clinical and research-based experience, we provide practice tips for intrapartum care in water.

Introduction

So far in this normal birth series, the articles have combined revisiting the basics of normal physiological labour and birth processes, alongside new research findings, insights and updates. International research tells us that most women value and expect to have a normal labour and birth with midwives who are knowledgeable and competent in facilitating physiological births. While the research also found that women understood that events may change, which may require ‘going with the flow’, their expectations of midwives capable of supporting normal labour and birth is a vital point to press. We know that increasing constraints on midwifery practice risks the key components that define midwifery practice as per the Lancet and International Confederation of Midwives (ICM), negatively impacting women’s capacity to labour and give birth naturally. Therefore, it is vital that midwives continue to revisit the basic anatomy and physiological process of childbearing as core midwifery skills and that researchers continue to advance that knowledge. Accordingly, in this article we advocate that water immersion during labour and waterbirth offers a valuable tool to optimise women and birthing people’s innate capacity to labour and birth, and midwives a unique opportunity to really ‘be with woman’.

Birthing pool use is an independent factor that improves birth experiences, some maternal outcomes with no risk to the neonate, other factors influence the degree of benefit that water immersion can offer

Water immersion: a low-tech, complex intervention

Water immersion appears to be a straightforward intervention that offers women the comfort of buoyancy,
space and freedom of movement. It is a low-tech intervention, and the key requirements include:

- A birthing pool big enough to enable full mobility.
- A birthing pool that is firm and stable to support women leaning/hanging against the sides.
- A water supply (clean and hot running water).
- Enough warm water filled to submerge the person’s bottom/abdomen.

However, when we unpack the evidence in favour of positive biological and psychological maternal outcomes (with no adverse effects on the neonate), we can see several things. First, the range of benefits across the birth continuum:

- Buoyancy enhances mobility, freedom of movement and positional changes that facilitate physiological labour and birth outcomes.6,6
- Pain perception: release of endogenous endorphins/analgesic properties,7 enhances ability to cope with labour.5
- Reduces epidural use6 (and therefore, subsequent risks associated with epidurals).8
- Labour augmentation/reduction in the duration of labour.9
- Increased number of spontaneous vaginal birth (particularly in midwifery-led settings).10
- Reduces transfer likelihood from home/freestanding birth centres.11
- No impact on perineal trauma/obstetric anal sphincter injury (OASI).6
- Improves satisfaction.6
- Enhanced feelings of safety, protection and privacy.5
- Facilitates (for some) a positive state of altered consciousness during labour.5
- Facilitates easier pushing (as reported by women).5
- Enables positive birth experiences with positive implications for postnatal mental-emotional health and wellbeing.5

Second, the level of benefit differs between care settings and models of care. For example, birthing pools are used most in midwifery-led settings (home/alongside midwifery unit (AMU)/ freestanding midwifery unit (FMU)) and birth pool use increases the rates of spontaneous vaginal birth at home or in a midwifery-led setting, but not necessarily in hospital.6 Third, the care culture as displayed by maternity professional behaviours can influence the access to and use of birthing pools.13 Therefore, with so many variables, water immersion can be viewed as a ‘complex intervention’14 defined as: ‘... in the number of interacting components; the number and difficulty of behaviours required by those delivering or receiving the intervention; the number of groups or organisational levels targeted by the intervention; the number and variability of outcomes; and the degree of flexibility or tailoring of the intervention permitted.’15 p.397

The warmth of the pool, maintaining ambient lighting and minimising distractions and stimulation will reduce the release of catecholamines and facilitate safe physiological placental birth in the pool

While we can see that birthing pool use is an independent factor that improves birth experiences, some maternal outcomes with no risk to the neonate, we also know that other factors influence the degree of benefit that water immersion can offer. Therefore, contextual information is required when assessing the maternal outcome data and applying it to clinical practice (see Figure 1). For example, the Birthplace study examined the relationship between birth setting and outcomes of 67,000 women. It found that comparable women (of low-risk status) were significantly less likely to use water immersion in an obstetric unit compared with women who birth in alternative settings.16 Only 13.3% of first-time mothers used water immersion in an obstetric unit versus 53.7% in a freestanding birth centre, and there was similar disparity among multiparous mothers.16 Additionally, Burns et al10 found marked differences in interventions and outcomes between midwifery-led settings in one large prospective observational water birth study (N=8,924 women).10 It found that women who used a birth pool in an AMU were more likely to be...
transferred to the obstetric unit and less likely to have a waterbirth when compared with similar women who laboured in water in the community (FMU/home). In fact, the interventions and outcomes for the women who immersed in water in the AMU setting were similar to those reported in the obstetric unit, highlighting the influence of care models and care settings, and reiterating birthing pools as a low tech but complex intervention.

**PRACTICE POINT 1**

Considering the strong evidence in favour of midwifery led place of birth and birth pool use, what initiatives are available in your area that facilitate these choices? Do share with us on Twitter @TPM_Journal

*Figure 1 Understanding context for water immersion as a complex intervention*

![Diagram showing the context for water immersion as a complex intervention](image)

**Women's voices**
Our recent work was a qualitative systematic review examining the views and experiences of women who had used water immersion during labour and/or birth. The seven studies we included provided rich insights into the value and biopsychosocial-spiritual benefits of water immersion. Our review, supported by numerous survey studies, highlighted the important contribution of water immersion to women’s experiences of childbirth. Physical benefits related to the buoyancy the water provided, enabling free and unrestricted movement, particularly profound for women who reported to be self-conscious about their weight. The warm water was reported to be analgesic, relieving labour pains, soothing and comforting. The properties of water, ‘cushioned the intensity’, enhancing women’s sense of control and ability to cope. Moreover, the physical separation that the pool afforded was also valued, where feelings of safety and protection were enhanced and likened to a ‘cocoon’ or ‘safe haven’. Many women reported blissful states of altered consciousness as the combined properties of the warm water and physical boundaries of the pool facilitated letting go into a liminal space of birth, for example: ‘Another world…it was like by the ocean, and then you come back to land and you are in another country…They call it ‘labourland’… It really was another world, and you think about the journey that you make from being pregnant to becoming a mother… An incredible journey.’ Rosa (Sprague, 2004).

Many women reported blissful states of altered consciousness as the combined properties of the warm water and physical boundaries of the pool facilitated letting go into a liminal space of birth.

Supporting labour in the pool
Concerns around supporting labour in water can result in midwives being expected to gain specific ‘competencies’ to facilitate water immersion.\textsuperscript{18} In our experience, this may indicate a broader cultural fear and suspicion of water immersion and is not necessary. Of course, it is beneficial for those who have not witnessed a water labour/birth to observe someone competent and confident,\textsuperscript{19} and is essential for midwives to feel supported in their practice. However, as the overall physiological processes of labour and birth do not alter in a pool, other than to enhance the neuroendocrinology,\textsuperscript{7} we advocate that midwives equipped with the knowledge and skills of physiological land births can apply this readily to a water situation. This includes ambient lighting, soft sounds, low voices and supportive one-to-one care. Moreover, there is no reason to alter the frequency of routine intrapartum observations for women in a birth pool from those labouring on land. It is sensible, however, that birth pool water is not greater than body temperature (370) because labour contractions generate heat and the fetus is hotter than his/her mother. For example, we know that epidural analgesia increases maternal core temperature, which can adversely affect mother and fetus, therefore two-to-four-hourly water temperature checks are advisable.\textsuperscript{20,21}

Clinical guidance can influence when women access a birthing pool. For example, some maternity units advocate that a woman’s cervix be at least 4cm diluted before she can enter a birth pool. However, there is no evidence to support this recommendation. Furthermore, cervical dilatation in itself, is a subjective, limited measurement and does not account for effacement, cervical application to the presenting part of the fetus, its position or descent in the women’s pelvis. A women’s cervix might be one to two centimetres dilated, but fully effaced, well applied to the presenting part and the uterine contractions good while, conversely, the cervix could be ≥5cm dilated, uneffaced and a woman is not in established labour. Women should be supported to use the pool as and when they prefer and should not be contingent on cervical dilatation. It is not unusual for contractions to slow down shortly after entering a birth pool. This is a transient physiological response to the relaxation of water immersion.\textsuperscript{7} The pelvic biomechanics involved with getting into and exiting the pool may also facilitate optimising fetal position by creating more space.\textsuperscript{22} Conversely, birthing pools can take 20-30 minutes to fill, and sometimes women labour too quickly to access, therefore it is helpful to start running the pool sooner rather than later.

**Key points for labour care**

- Pool has enough water to submerge the woman’s abdomen and bottom.
• Pool is big enough to enable a woman to flip over and adopt different positions with ease.
• Usual observations apply, plus two-to-four-hourly water temperature checks.
• Usual advice to maintain good hydration.
• Intermittent auscultation with a waterproof sonic aid avoids disturbing the mother.
• Vaginal examinations, if required, can be carried out in the pool.
• If concerned by labour dystocia, exiting the pool temporarily may help. The exiting/entering will support pelvic biomechanics, and mobilising to empty the bladder will support both pelvic biomechanics and fetal descent. Also just walking around for a while, or resting on her side on bed/floor cushions may also assist.

Supporting waterbirth

We advocate responding to the woman’s instinctive urge to push through gentle support and encouragement, rather than coached or Valsalva pushing. Those in water for the second stage follow the same patterns of land physiological births, whereby involuntary pushing (often) begins at the height of a contraction, gradually building towards greater expulsive pushing over time. Like on land, depending on maternal position, external signs (anal pouting, rhombus of Michaelis and/or the purple line) may be observed indicating the progression of fetal descent. Some midwives prefer to use a torch and mirror to observe progress, others find it unnecessary. While waterbirths should be hands off by the midwife, some women will reach down to touch the baby’s head, which should be unhindered. Depending on the woman’s position and preferences she may wish to ‘catch’ the baby, and this should be supported where possible. Of importance, once the fetal head is born, it remains under water. Should a woman raise her bottom out of the water at this point, the rest of the birth should be facilitated out of the water and must not be resubmerged to avoid any risk of water inhalation. Additionally, traction must not be applied to the cord to avoid cord avulsion (see practice point below).

Retrospective research expressed concern that waterbirth may predispose women to sustaining an extensive perineal tear to involve the anal sphincter (OASI). However, prospectively collected data analysis found no such association. When a midwife assists a woman to give birth in water, typically she adopts a hands off approach – a practice that is currently not recommended for women giving birth on land. The advent of the OASI ‘bundle’ has exerted a drive to encourage midwives to routinely adopt a hands-on approach to birth. However, the evidence supporting this intervention is less than robust and being challenged. Unfortunately, some maternity units have set the OASI bundle as a mandate, which may present a confidence and skills issue for midwives regarding water and land birth.
Cervical dilatation in itself, is a subjective, limited measurement and does not account for effacement, cervical application to the presenting part of the fetus, its position or descent in the women’s pelvis.

**PRACTICE POINT 2**

**One note of caution with waterbirth**

There have been reports of cord avulsion during waterbirth. Most of the babies were fine and did not require a blood transfusion or admission to neonatal intensive care unit (NICU). However, it is important not to exert traction on the umbilical cord as baby is brought to cuddle with mother. It is sufficient to just have baby’s head out of the water. Should a cord avulsion occur, clamp the cord immediately, assess baby’s condition, and act accordingly.

**Key points for waterbirth**

- Follow the woman’s instinctive pushing cues.
- Continue with usual observations and signs of progression.
- Adopt a hands-off approach.
- Support the woman to remain submerged during the birth, otherwise avoid re-submersion of baby’s head.
- Avoid traction on the cord as baby is lifted gently out of the water.

**Third-stage care**

Various hospital guidelines recommend leaving the pool for placental birth (whether active or physiologically managed), however, this is not necessary and may interfere with the high release of oxytocin that occurs following birth. This release of oxytocin facilitates the detachment and expulsion of the placenta. Therefore, interfering – for example, turning lights on, talking loudly, moving the mother out of the pool – may increase bleeding and/or haemorrhage. In addition, the warmth of the pool, maintaining ambient lighting and minimising distractions and stimulation will reduce the release of catecholamines and facilitate safe physiological placental birth in the pool. Furthermore, the vast neonatal benefits from delayed cord clamping, which means enabling the woman to remain in the
pool to birth her placenta followed by cord clamping, should not present a problem. It is easy to revert to active management in the event of concern. The purported risk of incurring a water embolism by birthing the placenta in water, is purely hypothetical and were it a problem, it would have manifest itself before now given the thousands of waterbirths that have happened across several countries.

**Estimating blood loss**

Visual blood loss estimates are only ever an educated guess during spontaneous or operative vaginal birth. Aids in the form of photographs of different blood volumes in a standard-size, plumbed-in birth pool with reference points to rose/red wine have been developed to guide midwives in their estimation. However, regarding waterbirth, anxiety lingers in this area even though the blood loss one sees is married to the women’s condition and factors such as the length of her labour and past history. Worry around possibly not identifying excessive blood loss in a timely manner may be making some midwives ask that women leave the pool for the third stage of labour, disrupting the crucial mother-baby skin-to-skin contact. estiMATE is an online tool developed to improve visual blood loss estimations during waterbirth, which showed promise in estimates and midwives’ confidence. A large-scale evaluation conducted during 2019 will soon be ready to submit for publication. This tool involves simulations using live models and involving a range of different blood volumes using expired blood filmed in real time will hopefully assist in resolving this worry and result in less third-stage disturbance in the absence of a problem.

Pain management is a key element of respectful and dignified maternity care, in which we advocate birthing pools should be as available as pharmacological options.

**PRACTICE POINT 3**

Most of the research regarding water immersion outcomes has involved healthy women and been undertaken in the obstetric unit setting. Further research has been upcoming or ongoing for those who may have a risk factor, for example, a previous caesarean section, or a BMI >30. Across the UK, many women deemed ‘out of guidelines’ have experienced successful waterbirths. While the physiology of birth does not change(!), our empirical knowledge of specific conditions during pregnancy and whether they affect water immersion outcomes, remain a work in progress. Another point that research has raised about women who use a birth pool is that the majority are white and high socio-economic. This raises the question: could and should we be doing more to inform all pregnant women about birth pool use, given our remit is to provide equitable care to all women?

**Key points for placental birth**

- Keep an ambient environment avoiding disturbing the mother-baby dyad.
- Support/encourage uninterrupted skin-to-skin contact and/or initiating breastfeeding.
- Observe for signs of placental detachment (cord lengthening, small acute blood loss, cramping), gently encourage woman to work with those cramps to expel the placenta.
- Observe for excessive blood loss in the pool and, if required, support the woman to exit the pool and revert to active management (if consented).

**Organisational practice points**

- Keep the birthing pool room free and available for those wishing to labour/birth in water wherever possible.
- Have a strict cleaning protocol in place, as per local infection control guidance.
- Organise regular multidisciplinary team (MDT) study days to raise awareness and knowledge of physiological labour and birth in water, and to troubleshoot concerns.
- Consider water immersion champions who can support inexperienced staff.
- Where possible, appropriate and with consent, encourage obstetricians and neonatologists to quietly observe a waterbirth.
- Invite women to speak about their waterbirths.
- Invite midwives to speak about the waterbirths they assist.
- Use online videos for educational purposes for those inexperienced with water labour/birth.
- Ensure all staff are competent with intermittent auscultation and usual labour care.
- Practice supporting women out of the pool, should it be required.

**Conclusion**

Water immersion during labour and waterbirth is a low-tech but complex intervention that optimises the normal physiological processes of labour and birth. We call for midwives and maternity professionals to familiarise themselves with labour and birth care in a birthing pool to ensure more women have access to its benefits. Pain management is a key element of respectful and dignified maternity care, in which we advocate birthing pools should be as available as pharmacological options. **TPM**

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Upcoming research

At Oxford Brookes University, we are working to advance the evidence base for labouring and giving birth in water. Claire led on the recently published systematic review of women’s experiences highlighted in this
introduction.5 This offers a rich insight to inform women and midwives in their discussion about this care option. A write-up of another systematic review is nearing completion on interventions and outcomes following water immersion for labour and waterbirth. It is a large review that includes more than 30 studies, comprising different designs undertaken by an international team led by Ethel. A scoping review of health professionals, organisational and policy barriers and facilitators for waterbirth is being led by Dr Megan Cooper, supported by Claire and Ethel. Ethel has run workshops and presented estiMATE at conferences. It is attracting significant interest in the UK and beyond from maternity personnel and it is planned to release it as a continuing professional development (CPD) tool this summer. Colleague Dr Jane Carpenter is completing a paper reporting on a secondary analysis of prospectively collected data to examine factors associated with normal birth (as defined by the Maternity Care Working Party) for women who labour in water. She is also co-supervising (with Dr Louise Hunter and Associate Professor Rachel Rowe from the National Perinatal Epidemiology Unit (NPEU)) a PhD undertaken by student Claire Litchfield investigating the outcomes and experiences of women with obesity who use water immersion in labour.

We thank our extended research group, OxMater, an international collaborative network, for contributing to our research programmes. For more information, see https://www.brookes.ac.uk/osnm/research/centre-for-nursing-health-and-social-care/oxmater/members/.

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**Dominant Discourses Affecting Asylum Seeking Women**

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**Summary**

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

**Introduction**

Misconceptions about asylum seekers generate negative attitudes within society, and the midwifery profession is no exception, as dominant negative political, media and social discourses can influence the
care provided to pregnant asylum-seeking women (ASW) and birthing people. ASW seek protection under UK law if they have encountered or are at risk of sexual abuse, war or any other threat to their life. The Refugee Council emphasised that ASW and refugees comprise 14% of maternal deaths in the UK, despite only accounting for 0.5% of the population.¹ This over-representation of ASW in maternal mortality statistics suggests that maternity care is not equitable, and that maternity settings need to do more to accommodate the needs of ASW and promote healthy pregnancy outcomes for this vulnerable group.

The Refugee Council emphasised that ASW and refugees comprise 14% of maternal deaths in the UK, despite only accounting for 0.5% of the population

**Dominant discourses**

Political discourse centres the government’s negative outlook on migration to the UK, which is reinforced by the net migration rate being reduced to 9% between 2019 and 2020.² Brexit has enabled the government to reduce migration rates with the support of the general public,³ a decision which was arguably influenced by the refugee crisis and societal disapproval of migration.⁴ This political development precipitates negative views and attitudes towards ASW among qualified and student midwives, and promotes a lack of empathy and understanding for ASW-specific needs that hinders the quality of care ASW receive. Asylum seekers’ diverse norms, values and cultures can be perceived as threatening due to the concern that British culture may become marginalised or viewed as inferior.⁵ These hypothetical threats contribute to the marginalisation of asylum seekers from the rest of society, and the government reinforces these views by prioritising the British economy over the basic needs and rights of asylum seekers, by imposing restrictions upon voting, employment and housing choices.⁶ Sensationalist media stories are known to alter societal attitudes.⁷ This sensationalism usually favours governmental rhetoric and supports policies for strict visa and immigration application processes designed to reduce migration rates. The media portrays asylum seekers as individuals that exploit the welfare state, thus maintaining society’s view that they abuse the benefits system when, in reality, asylum seekers are not entitled to mainstream benefits.⁸ The dominant influence of the media can also obstruct maternity care staff from questioning the harmful stereotypes associated with asylum seekers.

‘Moral panic’

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

**Changing education**

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

**Racism and cultural stigmatisation**

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

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

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

**Conclusion**

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

**References**


Summary

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

Can you explain your gender identities?

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

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

Why have you changed your name?

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

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

**What value do gender non-conforming students add to the profession?**

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

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

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

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

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

**What challenges have you faced?**

- [ ] Male
- [ ] Female
- [x] Non-binary

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

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

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

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

Any final bits of advice?

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

Ash: In practice, gender non-conforming students and midwives may need support in situations that demand ‘code switching’. Code switching is when speech and mannerisms change to put forward a different identity at a given moment in time.6,7 Two examples requiring code switching are discussing pink and blue clothing with parents for whom these colours are significant and declaring the sex of the baby at birth as an important moment for families. Cisgender colleagues can assist by leading these conversations and providing time for gender non-conforming colleagues to process when working in spaces of varying approaches to sex and gender. TSM
Recommended resources

Pronoun acrylic lapel pins:

Rise Up Midwife
https://www.riseupmidwife.com/
$11.50

Books:

Gender: A Graphic Guide


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

Portraying Pregnancy: from Holbein to Social Media

Film

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

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

Workshop

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

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Midwifery and Gender Discrimination in Ontario, Canada

Joanna Besana – Registered Independent Midwife, Ontario, Canada

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Summary

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

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

Gender discrimination

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

A huge win

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

References


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

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

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Summary

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

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

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

Introduction

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

**When is deinfibulation performed?**

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

**Who can conduct deinfibulation?**

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

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

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

**Box 1: Individualised reasonable adjustments**

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

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

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

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

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

6. Insert spencer wells forceps into the introitus and open gently. Use this to guide your anterior incision. The incision should end just beyond the urinary meatus, to allow for easy voiding. Use your fingers to feel
how high to separate the tissue.

7. Inspect the incision site for any bleeding. Very carefully inspect the revealed genital tissue to identify any partial or intact clitoral or labia minora tissue palpable within the scar tissue.

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

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

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

**Postoperative considerations**

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

Conclusion

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

TSM

References

Widening Access: Is There Space for Men in Midwifery?

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

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Summary

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

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

I have always wanted to be a healthcare professional, but the thought of being a midwife had never crossed my mind until I completed high school; when my favourite biology teacher and stepmother influenced me to start thinking about a career as a midwife. Immediately after my final exams, my teacher, who doubled as my school’s career guidance counsellor, spoke to me about my career plans and informed me about a new opportunity to study midwifery at Lira University in Uganda. The midwifery programme was open to women and men, and there was the prospect of obtaining a state scholarship to cover the cost of the programme if you achieved the stipulated grades. Prior to this, my stepmother, who is a practising nurse-midwife, had spoken to me about the same opportunity. She believed in my academic ability and was sure I would get the grades to secure a state scholarship for the midwifery programme – and she was right! Despite their encouragement, I was worried about how others would react to my decision to become a midwife. I also kept asking myself: ‘How could a man be a midwife?’ Initially, my friends and some of my family members struggled to comprehend why I chose midwifery. Some of them poked fun at the idea and insisted upon referring to me as a ‘mid-man’ or ‘mid-husband’. Nonetheless, I decided to give it a shot because it was a bachelor’s degree programme. Traditionally, trainee nurses and midwives in Uganda study at certificate or diploma level, so completing a bachelor’s degree would give me a competitive edge in the job market. However, in other countries where bachelor’s degrees are common midwifery qualifications, the prospect of a bachelor’s degree programme alone is unlikely to be enough to attract male applicants.
Unlike Sam, who was the first male to undertake and complete the BSc (Hons) in midwifery at Birmingham City University, I found it easy to fit in when I started my midwifery training because there were quite a few other men on the programme – almost one third of my class were male. My female colleagues were very friendly and welcoming and I was recognised and respected as their colleague, rather than being mistaken for a visitor or somebody’s husband. There is evidence of sexist discrimination towards male students, including lecturers telling students that men should not be midwives because they know nothing about childbearing or women. Although I have only met supportive midwives, midwifery professors and students, this is not the experience of every male student, and universities must have easy, accessible systems for reporting gender-based discrimination.

Most clients are happy for me to care for them, but occasionally my presence causes awkwardness. Many women and families refuse to refer to me as a trainee midwife and call me a ‘doctor’ instead, because using this misnomer is presumably more comfortable than accepting my identity as a male student midwife. Even though I am proud to be a student midwife, I do not correct people when they refer to me as a doctor, to prevent exacerbating their discomfort. Whereas these interactions do not have a negative impact upon me personally, they could be de-moralising for other male students. Therefore, universities and practice educators should prepare male students to navigate similar scenarios. Male students and midwives can be received with apprehension in maternity settings. I anticipate that I will be rejected by some women and female colleagues. Nonetheless, I respect women’s preference to be cared for by female midwives, because I have been taught that midwifery is all about empowering women to make their own decisions and respecting them. Furthermore, women and birthing people have the right to refuse care or treatment from any healthcare professional. Midwives and educators can normalise the concept of men being midwives by setting the expectation that women may be cared for by male students if this aligns with their personal preferences.

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

Conclusion

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

References


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

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Oli Silverwood-Cope – Registered Midwife, Gloucestershire NHS Foundation Trust

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Summary

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

Kay McWha, first-year Student Midwife

Former career: Head of English

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

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

Grace Mitchell, Registered Midwife

Former career: Singer

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

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

Oli Silverwood-Cope, Registered Midwife

Former career: Copywriter

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

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

Conclusion

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

Does Diversity Matter?

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

Published in The Student Midwife Volume 4 Issue 2 April 2021
Summary
Renée Rose challenges readers to consider the impact of a lack of diversity among trainee midwives upon student wellbeing, the midwifery workforce and healthcare outcomes.

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

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

Why does diversity matter?
When I decided to enter midwifery, I researched the role of the midwife and promptly realised that the images in books, journals, and websites did not look like me. This lack of representation led me to worry that I would not get a place at university or fit into a student midwife cohort. Non-diverse midwifery cohorts can further impair the self-esteem of students from marginalised populations by contributing to high attrition rates and precipitating an absence of diversity within the midwifery workforce, which is an undesirable outcome since recent studies agree that when patients and healthcare professionals share the
same ethnic background, communication is enhanced and health inequalities are decreased.¹ To enhance the self-esteem of aspiring midwives, they should be advised that their passion, knowledge, culture, life experiences and individuality are special qualities that they can bring to the role of the midwife. TSM

References


Maintaining Your Identity

Sophie Lee - Director and Designer of The Happy Planner Company

Published in The Student Midwife Volume 4 Issue 2 April 2021

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

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

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

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