Summary

In part two of this series exploring the role of International Board Certified Lactation Consultants (IBCLCs), Laura Henry and Lucy Ruddle examine the vital skill of providing unbiased information to support informed infant feeding choices.

Choices matter

Choices are influenced on a multitude of levels. We all have personal beliefs, norms and values that direct our actions. These beliefs are shaped by our family and friends, as well as wider societal, cultural and organisational factors. Irrespective of the
choice, parents may feel guilt, judgement and fear about their decisions. Family and social influences have a particular impact; many people emulate the feeding choices they are exposed to most.\(^1\)\(^2\) Lifestyle factors are another influence on decision making.\(^3\)\(^4\)

**Facilitating decisions**

The IBCLCs role is to empower families to meet their individual feeding goals through the facilitation of informed decision. As specialist practitioners, IBCLCs can provide more focused information on infant feeding than midwives, who provide a far broader service. This can allow dedicated consultation time for more in-depth exploration of individual factors and the holistic picture behind the decision to feed human milk.

**Consistency and continuity**

Structured and paced support from professionals and peers focused on developing the skills and knowledge of parents increases the duration of chest/breastfeeding.\(^5\)\(^6\) Research demonstrates continuity of carer and consistency of information provided leads to more confident decision making;\(^7\) specifically providing homogenous support to parents throughout the multidisciplinary team to prevent confusion and misdirection.\(^7\) The success of IBCLC support can give insight into how other healthcare professionals (HCPs) can support informed infant feeding choices.

**Conclusion**

A flexible, paced approach is required when sharing infant feeding information. It is important HCPs and IBCLCs hold a space individual needs of families, ensuring that unbiased facts are communicated clearly.\(^4\) the multidisciplinary team when educating families about infant feeding choices. **TSM**

---

**References**

Navigating Social Media: Professionalism In The 21st Century

Carolyn Zitha [she/her] - Third-year student midwife, University of Salford

Published in The Student Midwife Volume 5 Issue 1 Jan 2022

Summary

Many student midwives find themselves confused in aligning their social media presence with their newfound role as healthcare professionals. Inclusivity and freedom of identity are current hot topics: is it acceptable that some students are expected to hide their true selves to comply with an outdated perception of professionalism? For example, does someone’s choice of clothing affect their ability to be seen as “professional”? Should universities be criticising or even disciplining students over outfits worn on social media? This article explores the difficulties student midwives face as they try to balance professionalism with being true to their own identities and how they represent themselves on social media.

Defining professionalism

The Nursing and Midwifery Council (NMC) advises student midwives to uphold professionalism at all times,¹ yet opinions differ on the definition of “professionalism”.² This difference can cause conflict for student midwives as they establish
themselves as healthcare professionals, leaving them confused and unable to express themselves freely. As a predominately female workforce, many midwifery students find themselves affected by gender bias within a healthcare system that is built on patriarchal hierarchies. The use of social media adds to this issue; anecdotes abound of students and healthcare professionals being reprimanded for the content they post, criticism over their choice of clothing and suggestions that they are acting in a provocative manner.

**The scale of the issue**

“Rather than disciplining or criticising a person’s outfit, it is time to look more constructively at how a person demonstrates professional behaviour on social media.”

Midwives have worked, and continue to work, tirelessly to prioritise the rights of the women and birthing people in their care. How can perinatal services be truly inclusive and free from discrimination when student midwives, the majority of whom are female, still find themselves on the receiving end of gender bias? A bias that tells them how they are permitted to dress outside a professional setting.

In her book Why Women are Blamed for Everything, Dr Jessica Taylor discusses how inert sexism has led to female victims of sexual assault being blamed for their perpetrator’s crimes because of their sexual history or the way they have chosen to dress. Earlier this year, there was a public outcry against victim blaming after the tragic murders of Sarah Everard and Sabina Nessa.

Public opinion is moving away from the notion that women need to take steps to keep themselves safe, to one where men are made responsible for their actions. The time has come for these outdated ideas and opinions to be eradicated. Everybody has the right to express themselves freely, including which outfits they wear when posting photographs of themselves on social media accounts.

A person is capable of professionalism at work regardless of how they dress outside of the workplace. If we offer individualised care without bias or discrimination, then we need to accept everybody’s right to choose – including our own.
An antiquated approach

Many students struggle with establishing their identity when transitioning to higher education. Gender bias and discrimination were found to be factors in the emotional burnout experienced by some female medical students. This is compounded in student midwives who are susceptible to stress and often lack self-empathy. Self-esteem is important for healthcare students, leading to better overall care for service-users.

When people are self-confident, other people's confidence in their ability to provide quality care increases. Shaming healthcare students over their clothing can only serve to lower confidence. With the growth of the #metoo movement, and a greater social awareness of the dangers surrounding formulating opinions and assumptions based upon clothing, healthcare professions and universities must re-evaluate the link between a person's choice of clothing and their perceived professionalism.

An alternative approach

Rather than disciplining or criticising a person's outfit, it is time to look more constructively at how a person demonstrates professional behaviour on social media. Such constructive steps could include only sharing factual information from reliable sources, and promoting principles of anti-racism, inclusivity and kindness.

Useful advice could extend to addressing concerns about the dangers of social media such as being traced. Students could be advised to avoid using their full names on-line and to switch on high-level privacy settings. This education could be taught alongside the NMC's guidance on social media usage.

Rather than disciplining or criticising a person's outfit, it is time to look more constructively at how a person demonstrates professional behaviour on social media.

Confusion and fear
A massive 95% of UK adults use a social media platform. The NMC offers some guidance concerning the inappropriate use of social media, including protecting patient confidentiality and cyber bullying. However, little information is offered concerning how social media can be used responsibly, or even be of benefit. The unprofessional use of social media is a common reason for universities to take disciplinary action against healthcare students.

However, many students have little awareness of their universities’ rules regarding social media. Mabey et al interviewed physiotherapy students and found over half did not realise their university had a policy on the use of social media. Such confusion can lead to students fearing using social media. Such fear could be detrimental to the midwifery profession as social media is becoming a platform for many modern-day midwifery services.

Not all negative
Social media offer a previously unheard population the chance to influence and instigate change. It is important that those voices are heard and that influential institutions take the opportunity to listen and act. Recently, a university issued an apology over Twitter after a medical student was criticised for her choice of dress during a practical exam. No doubt this apology was influenced by the fact that the original tweet was shared over 3,000 times.\textsuperscript{11}

Furthermore, online forums offers improved access to perinatal care. The Facemums platform, for example, is an incredibly successful Facebook forum allowing midwives to communicate with maternity service-users to provide support and advice. This online support has been particularly valuable during the COVID-19 pandemic.\textsuperscript{12}

With researchers recommending further expansion of these platforms,\textsuperscript{13} the development of robust social media guidelines are required for healthcare professionals to feel confident and supported in using them.

\textit{Moving forwards}
A recent study found medical students wanted to use social media professionally but were unclear on how to achieve this,\textsuperscript{14} supporting the recommendation that professional guidelines should be refined and updated to meet the needs of a more social media-driven society. Midwives and students need to understand the expectations of their professional body.

Educational and healthcare institutions have a duty to guide their students and employees in the effective and confident use of social media, ensuring these policies are updated to include robust information about how students should conduct themselves in person and online. However, these expectations need to reflect modern society.

More research needs to be carried out into how service-users perceive professionalism, as well as the views and opinions of healthcare students. \textbf{TSM}

\begin{table}[h]
\begin{tabular}{ll}
\hline
\textbf{References} & \\
4. & Taylor J. Why Women are Blamed for Everything: Exploring Victim Blaming of Women Subjected to Violence and Trauma. Constable; 2021. \\
\hline
\end{tabular}
\end{table}


11. Duncan C. Newcastle University apologises to medical student ‘who was told her skirt was too short’. The Independent; 2021 https://www.independent.co.uk/news/uk/home-news/newcastle-university-student-skirt-sexism-b1918026.html


The Third Stage Of Labour: Part 1. The Physiology

Ciara Kirwan - Assistant Professor of Midwifery, University College Dublin, Republic of Ireland

Twitter: @MidwifeCiara

Published in The Student Midwife Volume 5 Issue 1 Jan 2022

**Summary**

An understanding of the physiology of the third stage of labour is essential for midwives. A poorly-managed third stage accounts for the largest proportion of maternal deaths worldwide. In understanding the physiology, midwives can promote safe practice and informed choice. This article is the first in a two-part series surrounding the third stage. In this instalment, Ciara Kirwan discusses the physiology of placental separation, descent, expulsion and the control of bleeding.

**Defining the third stage**
The third stage of labour is defined as the period from the birth of the baby until the expulsion of the placenta and membranes and control of bleeding. Although the stages of labour are traditionally defined as separate from one another, it should be viewed as one continuous process. The uterine muscles that contracted and retracted to facilitate the birth of baby in the second stage of labour continue to do so in the third stage of labour to facilitate birth of the placenta. The process of placental separation begins with the contraction that facilitates the birth of the baby. Once the placenta has separated, it descends into the birth canal and is expelled. Numerous physiological processes work together to achieve control of bleeding.

**Hormones of the third stage**

The hormones that orchestrated the first and second stage of labour continue to play a role in the third stage of labour. The main hormone is oxytocin, which is released from the maternal posterior pituitary gland and causes contraction of the uterus. Synthetic oxytocin is often administered during the third stage of labour to increase the contractility of the uterus and prevent postpartum haemorrhage. The release of endogenous oxytocin is promoted when the woman or birthing person is in a calm, safe, supportive environment.
is also released during skin-to-skin contact\textsuperscript{2} and during breastfeeding.\textsuperscript{3}

When the human body is exposed to stress, the sympathetic nervous system becomes activated.\textsuperscript{5} This is also known as the “fight or flight” response. Catecholamines are released, and these inhibit the release of oxytocin. Midwives have an important role in supporting the physiology of labour by ensuring that the birth environment is conducive to the release of endogenous oxytocin and suppression of catecholamines.\textsuperscript{6}

\textbf{Figure 1: Anatomy of placental attachment site prior to third stage of labour}

\begin{center}
\includegraphics[width=\textwidth]{placental_attachment.png}
\end{center}

\textbf{Separation and descent of the placenta}

During the second stage of labour, the uterus contracts and retracts, causing the uterus to reduce in size and thicken as the baby descends. By the time the baby is born, the size of the placental attachment site has significantly diminished,\textsuperscript{2} due to the reduction of the size of the uterus. This reduction in the size of the placental attachment site results in compression of the placenta.\textsuperscript{6} As a result of this compression, maternal blood that was in the intervillous spaces of the placenta is forced back into the decidua.\textsuperscript{3} The placenta no longer has a stable base of attachment and it begins to separate from the uterine wall.\textsuperscript{3}
The type of placental separation depends on the position of attachment in the uterus. When placental attachment is to the wall of the uterus, it usually separates at the lower pole first, progressing gradually upwards towards the upper pole. Placentas attached in the fundus of the uterus tend to separate from the poles first, followed by the centre area of attachment. The formation of a retroplacental clot is no longer considered to contribute to the process of placental separation. At the same time, the contraction and retraction of uterine muscles results in compression of maternal blood vessels that supply the decidua. The uterine muscle fibres surrounding these blood vessels act as a clamp, ceasing blood flow from the intervillous spaces in the placenta, back into the maternal system. Maternal blood is now trapped in the blood vessels of the decidua.

The pressure in these blood vessels increases and they eventually burst. The blood that was in these vessels seeps between the placenta and the decidua as placental separation occurs and it is expelled from the body vaginally. A gush of blood is observed by the midwife.

**Descent of the placenta**

Following placental separation, the uterus contracts strongly forcing the detached placenta into the lower half of the uterus and then into the vagina. As the placenta descends, the membranes are stripped away from the uterine walls. The cord may be seen to lengthen and the woman or birthing person may report feeling pressure from the weight of the placenta entering the vagina.

**Control of bleeding**
What remains at the placental site of attachment is effectively an open wound. During pregnancy, as much as 800mls of blood pulses through the maternal vessels into the placental bed every minute. It is therefore important that the physiological mechanisms in place to cease blood flow work quickly to prevent haemorrhage. Contraction and retraction of the muscle fibres in the myometrium continue to exert pressure on the blood vessels that burst during separation. These muscle fibres that weave around the torn blood vessels act as a “living ligature” to stop blood flow.2,3

Strong contraction and retraction of the muscles of the uterus continues after the placenta descends into the lower uterine segment. The uterus can now get smaller and thicker until its walls are in apposition.3 This means that the walls of the uterus compress against each other, applying firm pressure to the placental attachment site.3 This is another physiological mechanism that assists with cessation of bleeding. As the walls of the uterus come together, the fundus rises to the level of the umbilicus, on top of the separated placenta4, and it is firmly contracted. This is one of three signs of placental separation and descent (see Box 1).

Box 1: Signs of placental separation and descent

1. A gush of blood emerges from the vagina
2. The umbilical cord is seen to lengthen
3. The uterus rises to the level of the umbilicus and is firmly contracted

An additional mechanism for control of bleeding originates in the maternal coagulation system. Pregnancy is a hypercoagulable state,10 meaning the body produces more coagulation factors, making the blood more viscous. During
labour, the coagulation system is activated to intensify clot formation. After placental separation, a fibrin mesh forms quickly over the placental site to assist in bleeding cessation. This fibrin mesh eventually becomes a blood clot.

The uterus should be left undisturbed during the third stage of labour, so not to interfere with these complex physiological mechanisms. The midwife should only perform a palpation of the uterus when there is a clear indication to do so, to assess uterine tone for example, in the case of postpartum haemorrhage.

Birth of the placenta

The weight of the placenta in the lower uterine segment stimulates placental expulsion. If the third stage is being managed without intervention, the placenta is born by maternal effort. Gravity, which results from upright positioning, assists this process. Where the placenta presents fetal side first, this is known as the ‘Schultze’ mechanism. Figure 2 shows the fetal side of the placenta. Note the blue colour and shiny appearance. Where the placenta presents sideways, the maternal side will present first and this is known as the ‘Matthews Duncan’ mechanism. See Figure 3 for a photograph of the maternal side of the placenta. Note the red colour and presence of cotyledons that differentiate it from the fetal side of the placenta.

Figure 2: Fetal side of the placenta

Figure 3: Maternal side of the placenta
As the placenta is born, the membranes continue to strip away from the walls of the uterus. The third stage is complete when the placenta and membranes are expelled and bleeding from the placental attachment site is controlled. This entire physiological process should be complete within 60 minutes of the birth of the baby. Where synthetic oxytocin is administered, the duration of the third stage is expected to be less than 30 minutes.

**Conclusion**

The third stage of labour is orchestrated by oxytocin and it results from a number of physiological processes acting together. Detailed knowledge of the physiology of the third stage is essential for midwives to ensure they can support the third stage of labour and recognise deviations from the norm. 

**References**


Harnessing experience

I was six months postpartum before I realised there was no reason to be ashamed of my birth experiences. The leaflets I was given after my crash caesarean were all about where my baby was and what might be wrong with him. There was nothing about how I might feel or how flashbacks and panic attacks would invade my brain. I had only ever heard of postnatal depression or baby blues. I had never heard of post-traumatic stress disorder (PTSD) caused by childbirth experiences.

The support I found in the Birth Trauma Association (BTA) was invaluable; it was a safe space to talk about all the unwieldy emotions I was feeling.

Birth trauma

Birth trauma is defined as emotional, physical or mental distress caused by a birth experience, leading to symptoms such as flashbacks, intrusive thoughts, trigger avoidance, negative cognition and memory loss. It is estimated that 4% of births in the UK per year are affected by birth trauma, but a recent national survey revealed 62% of respondents “did not know anyone suffering from birth trauma”. This indicates that PTSD from childbirth is not disclosed in social situations, or it is viewed as a taboo subject. As a result of this lack of exposure, many people find locating support difficult.

Community

The support I found in the Birth Trauma Association (BTA) was invaluable; it was a safe space to talk about all the unwieldy emotions I was feeling and gave me the opportunity to support and reassure others who felt the same. Soon after, I was invited to become the Community Lead. When the pandemic loomed, membership of the group increased exponentially as fragile parents felt isolated. I investigated ways to ensure present and active support, working within government restrictions.

Demonstrating leadership

I launched a tri-monthly peer support group on Zoom, advertising via social media and parenting groups. I created this space for people to share their burdens and find solace in the stories of others, even whilst separated by distance, lockdowns and COVID-19. Facilitating group discussions could be challenging at times, sometimes triggering my own trauma. However, I knew that this safe space provided others with the strength and support that was not available in my time of need.

Moving forward

Leadership in action often involves the support of others. Find people you share a common ground with and work towards improving practice as a group will ensure you feel supported on the path ahead. TSM
Zelle facilitates the Birth Trauma Association’s Zoom support group, further details can be located in the Facebook group “TheBTA”.

References

Summary

The choices we have and decisions we make throughout life are personal and vary depending on need and context. When making decisions, do we always read the terms and conditions before clicking “I agree”? Think about some of the big decisions we make – would we choose differently if we had read the small print? In other words, if we had been able to make an informed choice? The concept of informed choice for childbearing women, people and their families’ is complex and far-reaching. Kat Skeates and Laura Henry examine informed decision-making and the impact COVID-19 has had on birth choices.

Facilitating informed choice

Personalised, safe and compassionate care is at the heart of maternity care policies and guidance. Facilitating informed choice and decision-making, as a basic and vital human right under the European Convention on Human Rights, is fundamental to midwifery practice. Legally-valid informed choice requires the provision of evidence-based information including risks, benefits and potential outcomes with consideration of the personal perspectives, preferences and needs of the people in our care.

Despite the legal clarity, informed choice in practice presents complex moral and ethical dilemmas for families and professionals. Whilst midwives and other birth workers aim to support informed choice to those in their care, researchers argue that informed choice is “at best illusory”.

A delicate balance

The concept of “informed choice” is dynamic, influenced by a multitude of factors, including:

- individual beliefs, values and actions, shaped by their lived experiences
- ideals of their family and friends
- relationship with healthcare providers
- wider society and culture
- organisational factors such as healthcare policies and services.
Frequently, for midwives and those providing care to childbearing people, decision-making is closely linked to risk assessment.⁷

Every contact with a midwife involves assessing the health and wellbeing of those in their care, including assessing personal needs, safety and preferences. Multiple contextual factors can influence the information health professionals share, including:

- knowledge of latest research, guidelines and policies
- local culture and practices
- fear of litigation
- complex health needs of those in our care
- service provision and environments
- resources (time, staffing, information and service resource)
- relationships and models of care
- personal bias
- structural and institutional racism.
Levy’s grounded theory in research describes how midwives tend to ‘protectively steer’ families to make decisions that they feel are the safest, aligned to their own perspectives, local guidelines and practices.\(^8\)

However, strengthening rights-based, personalised care requires midwives and maternity-care staff to take a different approach, one that centres individuals, considering their values, needs and preferences as the priority. This is essential throughout all phases of childbearing, birth and early parenthood.

It can be particularly challenging to facilitate informed decision-making during active labour and birth, as it may be more difficult for birthing people to process new information.

As such, preparing for labour and birth in pregnancy is important. Exploring and documenting birth preferences, considering all eventualities, during unhurried antenatal birth conversations can act as ‘advanced directives’, enabling birthing people to share their values and needs for labour and birth to retain control over their experiences.\(^9\)

Despite this, it remains the duty of midwives and birth-workers to gain informed consent for all care provision offered, regardless of prior direction, as personal preferences are transient and continually shift.

Birth choices became constrained during the COVID-19 pandemic as a result of imposed restrictions and guidelines to reduce unnecessary close contact between individuals, especially in healthcare settings.
Choice constrained: the impact of COVID-19

Specific restrictions in maternity settings included pregnant people attending antenatal appointments and scans alone, as well as installing limits on birth partners and visitors. Although these new policies were somewhat accepted at the beginning of the pandemic to maintain safety in response to the rapid development of COVID-19, restrictions continue to linger in many areas despite most other restrictions across the UK being lifted.\textsuperscript{10,11}

Perhaps the most contentious restriction was the limited access of birth partners to labouring people, despite WHO stating the attendance of a companion of choice should be supported regardless of suspected or confirmed COVID-19 infection.\textsuperscript{12,13} Birth companions are described as a “lifesaving intervention” (see figure 1), the exclusion of which is “unethical”, undermining basic human rights.\textsuperscript{14}

During the pandemic, many hospitals required the birthing person be in “active labour” before a companion could attend. In obstetric settings, vaginal examination is often used to determine active labour over other physiological signs, but active labour diagnosis can be inconsistently defined.\textsuperscript{15}

Pregnant people may feel pressured to consent to a vaginal examination in order to have their chosen companion by their side, whereas they may have otherwise declined it. Birthing people may also feel pressured to make decisions without the advice or reassurance of their birth partner, fearing partners may miss the birth entirely. This can lead to those receiving care having to adjust to the needs of the system rather than the system adjusting to their individual needs. Rapidly changing guidelines and practices without underpinning evidence of effectiveness and safety could unnecessarily limit choices without improving outcomes.\textsuperscript{13}

Figure 1: The benefits of Birth Companionship
Power imbalances and finding solutions
Midwives can feel powerless, trapped between their desire to advocate for birthing people and the guidelines and policies they feel duty-bound to follow. Equally, birthing people can feel powerless in a system where healthcare providers encourage decisions reflecting policies written for populations rather than exploring individualised needs. Obstacles must be addressed to instigate change for better outcomes.

a. Words Matter

One way to address these challenges is through effective education surrounding the language we use. When a person declines an aspect of a care pathway, they are often labelled as “refusing”, indicating compliance was expected and leading to possible coercion.

Midwives must be mindful of the language used in both written and verbal communication, ensuring the use of appropriate translation services and tools as required. Document what discussions were had and their outcomes; care is “accepted” or “declined” rather than “agreed” or “refused” and “consent was given” rather than “consent gained”.

There are a range of tools available to support person-centred decision-making and support planning (Box 1, Box 2). The concept of shared decision-making (SDM) initially offers a useful framework.
It moves away from paternalistic hierarchy and puts midwives and birthing people on equal footing when it comes to decision-making. However, birthing women and people should be at the centre of decision-making, with midwives and birth workers offering options and information, and supporting birthing people to make their choices considering individual wants, needs, beliefs and other personal factors.

Midwives can help birthing people interpret and understand various care options, relevant evidence and information, using the tools to inform person-centred conversations. Benefits of person-centred decision-making include increased understanding between birthing people and healthcare providers, promoting mutual trust and respect, and allows care to be individualised.

Box 1: Three-step model for Person-Centred Decision-Making
b. Relational Midwifery Care

By building a relationship of trust, midwives can better facilitate individualised and informed decision-making and respect a person’s right to accept or decline care. As guided by Montgomery case law, understanding what is important to each person and family is a key aspect of supporting them with appropriate and relevant information to make decisions centred on their individual circumstances and values. Positive relationships with person-centred decision-making leads to more positive feelings towards their birth experience.

16 As guided by Montgomery case law, 19 understanding what is important to each person and family is a key aspect of supporting them with appropriate and relevant information to make decisions centred on their individual circumstances and values. Positive relationships with person-centred decision-making leads to more positive feelings towards their birth experience. 9,20

c. Personalised Care in Practice

Personalised care and supporting planning (PCSP) enables safe care and as such is a priority across local maternity systems in the UK. PCSP is determined by five technical criteria, as outlined in the universal personalised care model:

1. People are central in developing and agreeing their PCSP, including deciding who is involved in the process.
2. People have proactive, personalised conversations that focus on what matters to them, paying attention to their needs and wider health and wellbeing.
3. People agree the health and wellbeing outcomes they want to achieve in partnership with relevant professionals.
4. Each person has a shareable PCSP that records what matters to them, their outcomes and how they will be achieved.
5. People are able to formally and informally review their PCSP.

Box 2: The BRAIN Tool:

References


Addressing Personal Bias In Relation To Weight Bias: Part 2

Nicola Salmon [she/her] - Fat-positive fertility coach

Instagram: @fatpositivefertility

Published in The Student Midwife Volume 5 Issue 1 Jan 2022

Summary

In part two of this series, Nicola Salmon explores how to recognise bias and the practical steps healthcare practitioners can take to eradicate it through recognition, challenging, noticing and leadership.

Unconscious bias
Recognising bias exists is the first step towards addressing it. We all hold this bias to some degree, regardless of the size of our own bodies, demonstrated in how we talk about our own bodies and how we treat other people’s bodies. Harvard University’s Implicit Association Test\(^1\) can highlight where you may hold unconscious bias. Answering these questions will assist in supporting a conscious awareness:

- How do you feel about losing/gaining weight in your own body?
- How do you feel when people in your life lose/gain weight?
- What assumptions do you make about fat folks based on looking at them?

**Challenge**

Change often starts close to home. Consider what you can do to recognise and challenge the bias you might hold for people in bigger bodies. Aim to:

- Demonstrate support regardless of the size of their body.
- Diversify your social media feed to see Black, fat, trans, Brown and disabled bodies.
- Notice the language you use to talk about your own body and others’ bodies. Is the language neutral, or does it imply negativity?

**Notice**
Much of what we do in healthcare is because “it’s how it has always been done”. When studying or on clinical placements, reflect on how your own, or other people’s, biases impact your support of fat folks. Be aware of:

- Statements linking poor-quality research or where the researcher has drawn conclusions from anti-fat biases.
- Protocols with a different action based on weight or BMI, without adequate, quality evidence.
- Conversations and comments about people's bodies in or out of earshot.

**Lead**

Often student or newly-qualified midwives feel unable to influence the status quo. Be kind to yourself and focus your efforts on what you can personally change. Consider how small actions can ensure that fat people feel safer in your care, contributing to wider change. These actions could include:

- Providing choice around weighing.
- Not making assumptions about a person’s diet and movement habits; ask the same questions you would ask someone in a smaller body.
- Asking if they have ever experienced disordered eating/ eating disorders. Consider how conversations about food and weight could impact on mental health.
- Being prepared with appropriate equipment, including a larger blood pressure cuff, appropriate seating, disposable bedpans to assist with urine samples and larger sizes in gowns and disposable knickers.

**Conclusion**

Fat folks deserve the same level of humanised care and respect as anyone else. Speak to them and touch their bodies with kindness, and do not make assumptions about their health or ability to maintain a pregnancy and give birth based on their body size. **TSM**

**References**

Health, Leadership and Innovation

Emma Hamilton [she/her] - Student Midwife, Bournemouth University

Instagram: emma_hamilton2018

Introduction
In March 2020, the Coronavirus pandemic introduced disruption, uncertainty and a period of uninvited change to humankind. The Nursing and Midwifery Council (NMC) issued Emergency Regulations that affected student’s practice placements and as a Bournemouth University (BU) midwifery student, my studies were disrupted. The BU Lead Midwife for Education (LME) recognised and responded to the changing situation quickly and decisively, demonstrating qualities of an allostatic leader, (someone who learns, adapts and changes their behaviour to meet demand and maintain homeostasis). This article focuses on three key skills/qualities the LME used to guide us successfully through the crisis and enable the continuation of our degree: communication, compassion and decisiveness.

**Leading through crises**

Leadership is understood as motivating, inspiring and empowering others to work towards a common goal. The goal during this unsettling time was to maintain our studies, as prolonged gaps in education can negatively impact engagement and psychological wellbeing. A principal standard of the NMC Code is prioritising people and, demonstrating altruistic behaviour, the LME put the needs of her students above her own. Working long hours, deciphering changing governance and organising spur-of-the-moment ‘Snackchat’ meetings, a servant leadership approach was effectively applied. This theory operates on philosophies also embedded in the NMC Code: integrity, humility, building trust with followers and making them feel valued. The meetings provided a valuable two-way platform for communication: students were able to voice concerns, needs and ask questions, which promoted essential and psychological wellbeing.

Good communication is necessary for effective leadership and incorporates “listening with fascination”, spoken words, tone of voice and body language. During uncertain times, we look to leaders for answers; however, not knowing these answers is sometimes their honest response. Transparent and open in her communication, the LME exhibited authentic and compassionate leadership. As a humanistic approach, compassionate leadership is deemed particularly appropriate within healthcare, and was applied well by the LME through active listening, empathy and continuous assessment of our wellbeing.

Hougaard et al suggest that, while necessary, compassionate leadership is inadequate on its own, and should be used with judiciousness when making difficult decisions. Goleman, however, claims the qualities required to be a compassionate leader are characteristic of emotional intelligence and self-awareness, traits that are deemed highly effective in stressful situations and beneficial for unbiased decision-making.
confinement to our homes presented new challenges to studying. Working collaboratively with BU, students and fellow lecturers, the LME acted with immediacy to move to a remote method of teaching, providing us with a new “normal” way of studying. This strategy exhibited decisiveness, adaptability, team working and effective problem-solving skills, which are attributes of a strong leader. In crises, speed and decisiveness are essential for instilling confidence in followers and are therefore not generally associated with leadership styles that promote shared decision making (i.e. democratic leadership).

In contrast, hierarchical styles adopting unilateral decision making are more commonly affiliated with this quality, but “command and obey” attitudes of autocratic leaders are unsuccessful when inspiring followership during times of uncertainty. The LME’s actions were more indicative of transformational leadership, whereby the philosophy of inspiring and stimulating followers intellectually to create future leaders was achieved through successful acquisition of student/staff followership and empowerment to achieve our joint goal.

**Future leadership aspirations**

Witnessing crisis leadership first-hand highlighted how similar the leadership methods and qualities used by the LME were to those required of a midwife. In much the same way as the pandemic, midwifery is ever-evolving, requiring midwives to adapt in order to meet the needs of the birthing person, and their situation. I believe knowledge gained from this experience will be highly beneficial for my future practice. One theory that particularly resonated with me was that of servant leadership. Cronk described midwives as “professional servants”, and from my time as a student, I have realised that putting the needs of the women and birthing people in my care before my own is an instinctive trait I already possess.

Although leadership can be learnt, I believe this skill set is individualistic and most effective when utilising already existing qualities and strengths. One of my strengths is my ability to communicate with people. This experience has reiterated how important effective communication is during times of unfamiliarity, such as pregnancy and childbirth, or a crisis such as the Coronavirus pandemic. To this end, I aim to use knowledge gained from this experience in conjunction with my excellent communication skills, compassionate nature and decision-making ability to support me in becoming an effective transformational leader. Lack of self-confidence may threaten this goal however, as I sometimes experience “imposter syndrome”.

According to Wang et al, this phenomenon is linked to perfectionism and feelings of being exposed as a fraud. Although I believe this feeling arises due to my student status and the fact I am still learning the profession, my ability to lead well could be threatened. Sudmann states self-leadership should come before leading others, and I hope that increasing my self-confidence will help me develop in this area. Recognising this weakness is the first step towards self-improvement, and I plan to use my remaining studentship taking the lead in care planning to build my self-confidence. TSM
References:


A brand new resource for midwifery students wanting to expand their knowledge and experience of reflective writing.

This new product from The Happy Student Company is a hyperlinked PDF document allowing you to choose from a range of reflective model templates to plan out your reflective writing, then write up your reflections in full. There’s also a handy place for you to keep all your references in one place. Take the overwhelm out of reflective writing and explore the reflective model that suits you best.
All4Maternity members can receive a **huge 20% off the normal price** of £10.50:

Just enter *code: RJMZ2022* at checkout – follow the link below:

https://www.thehappystudentcompany.com/shop/digital-reflective-journal/

*Code expires 30/9/2022

**About the new Digital Reflective Journal From Sophie Lee, Owner of The Happy Student Company**

**Don’t be overwhelmed by reflective models!**

The digital reflective journal is a resource that contains reflective summaries, templates and writing tools to help you perfect your reflective skills. The digital reflective journal contains explanations of how to use the following reflective models: Gibbs, Johns, Driscoll, Kolb, and Schön

Try each model by using the summary templates to make notes, then write up your reflection in full. Using a note taking app will allow you to duplicate pages to make as many notes, templates and summaries as you want.

There are pages to help you keep your references in one place, and also an index of the reflections you’ve written. Full instructions, notes, and other questions also included. Reflective writing has never been so simple!
The digital reflective journal is a hyperlinked PDF file that works best on an iPad or computer. I recommend importing it into a note taking app such as GoodNotes or Notability, but it will work with any PDF reader that you can annotate!
How to use this resource

Get ready, it’s time to sharpen your tool!

To get the most out of this digital reflective journal, first, take some time to read through the accompanying PDF instructions to help you understand how to work the edit, read and hypothesis functions. With a good note-taking tip, you can duplicate so many pages or you need to create multiple templates and reflections. Pages can also be printed.

1. Choose the reflective model you’d like to use today.
2. Check out the list of resources for this model.
3. Read through the summary, expand to understand the presence of the model.
4. Fill out the reflective template with brief notes to begin the foundation of your reflection and journaling stream.
5. Use your template to write out your full reflection. Include a reference to this page number. You can duplicate this page without losing any notes.
6. Using your reflection reference and design variables, create an index of reflections for each reflective model.
7. Use all references used for each reflection. Duplicate this page for new templates.
8. Check out “follow” tips for further questions to help you write more within each reflection.
A Summary of the Gibbs Reflective Model

Developed by Graham Gibbs in 1988, the Gibbs model uses a reflective cycle with the headings: Description, Feelings, Evaluation Analysis, Conclusion, and Action Plan.

- **Action Plan**: What would you do next time? Do you need to review anything?
- **Description**: What happened?
- **Feelings**: What did you think and feel?
- **Conclusion**: What else could you have done; what have you learned?
- **Analysis**: What seems to you made of this situation?
- **Evaluation**: What went well and what went bad about the situation?
Summary

The aim of this article is to encourage midwives to reflect on hermeneutic studies in relation to their own practice or to consider using it for qualitative research, discussing the applicability of Heideggerian hermeneutic phenomenology. Hermeneutic approaches take into account the subject’s prior experience and knowledge, making it useful for working with women and understanding their perspectives. This article is grounded in my experience of undertaking my own PhD – a study on the transition to parenthood for couples with an in vitro fertilisation (IVF) pregnancy. It explains some of the broad concepts of hermeneutic phenomenology and how they align with the practice and underlying theoretical concepts of midwifery.

Introduction

Many readers may be wondering why a midwife would choose to use the work of a white, middle-class male philosopher from 1930s Germany (moreover, one with troubling associations with the political climate of the time) to study the experiences of pregnant women in contemporary Britain. Within this article, I hope the rationale for that becomes evident as the work of Heidegger is explored and its applicability to both my own study and midwifery research will be demonstrated.
Identifying an appropriate methodology

On commencing my PhD six years ago, I knew what I wanted to study but had no firm methodology underpinning how. The study focused on the experiences of couples with an IVF pregnancy through the transition to early parenthood, so by definition, it had to be qualitative. In working through a range of possible methodologies – all of which could have been utilised for the study – I found that I was being drawn between a more sociological perspective – social constructionism or ethnography, for example – or a more psychological one such as interpretive phenomenological analysis. In considering methodologies, it is useful to reflect upon what exactly is the focus of the study – differing methodologies are better suited to drawing out different aspects to a study, or indeed to different researchers’ personalities. Thus, there is no one correct or ideal methodology, only the one that best fits both the research question and the researcher themselves. When I was first reading about Heideggerian phenomenology, there was an immediate resonance with it; a sense of ‘I also think like that’. Phenomenology is the study of phenomena and the experiencing of that, whilst also recognising the socio-cultural environment in which the experiencing takes place.

Take for instance, a Pinard stethoscope. Some people may not recognise one – if asked, ‘What is its purpose?’, they may struggle. Is it a toy telescope? Could you put it on a shelf with a plastic flower in it? Others may recognise it as a medical instrument that is used by practitioners to hear a fetal heart. Yet for ourselves as midwives, it represents our profession – we recognise it as not just a tool we use regularly, but a historic symbol of our profession; its meaning for us embraces our personal psychosocial understanding. Phenomenology seemed to reflect the balance between psychology and sociology that I had been seeking, and that I’d argue midwives also recognise within their work. It does not seek to give answers or build a theory, but to aid understanding of how an experience may affect an individual.
Descriptive and hermeneutic phenomenology

Phenomenology may be either descriptive or hermeneutic (interpretive). Descriptive phenomenology comes from the work of Husserl. A key aspect of descriptive phenomenology is ‘bracketing’ – being able to identify and suspend prior beliefs and suppositions to avoid contamination of the data, which may initially appear an appropriate, if difficult, aspect. However, within hermeneutic phenomenology, prior beliefs, whilst also being acknowledged, are used rather than ignored completely and form, together with the data from participants, a co-constitution of findings. Dahlberg\(^2\) refers to this acknowledgement as ‘bridling’ – recognising and managing prior experience for the benefit of the study. This concept derives from Gadamer’s\(^3\) acknowledgement of prejudice, not in the contemporary understanding of the word as pejorative, but as ‘pre-judgement’ or prior understanding. As midwives, we bring with us a wealth of previous experience as well as prior reading and research which may be pertinent to a study. Within hermeneutic phenomenology that is considered of value and, whilst not overwhelming the insight and experiences of participants, is used to extend understanding in a ‘fusion of horizons’.\(^3\) This is an aspect familiar to midwives in working with women and birthing people – listening to them and formulating an individualised plan of care together that recognises an individual’s situation and expectations.

Existing hermeneutic phenomenological studies of midwifery highlight the importance of working with women, as they uncover women’s experiences and feelings beneath previous assumptions. From my own study of couples becoming parents following IVF, the tentative nature of pregnancy and the differing points at which they felt back on the planned trajectory to parenthood were significant; through understanding a parent’s perspective, one can start to address their needs. Similarly, Feeley’s\(^4\) study of freebirthing was able to uncover how freebirthing enabled women to claim their birth as their own and highlighted perceived coercion; a finding which may challenge midwives to reflect upon their own practice of information sharing.

Heidegger was a student of Husserl’s, and whilst Husserl considered that experience could be understood in isolation from context, Heidegger emphasised the importance of time and place as influences on our experience (exemplified in the title of his major work Being and Time).\(^5\) In considering our previous suppositions, he refers to forestructures as the basis of interpretation which include: forehaving – our familiarity and understanding of the phenomena; foresight – the interpretive approach; and foreconception – our expectation of what may be found reflecting the past, present and future of our thinking. This links with a reflective approach that underpins our professional development.

Whilst acknowledging the influences on our thinking, it is important that subjectivity should not unduly influence the gathering of data through interviews. Within hermeneutic methodology, interviews should be open-ended and unstructured using only occasional ‘encouragement’ prompts such as ‘tell me about when...’; ‘could you tell me more’ to elicit the participants’ understanding of what mattered to them. For my own study, I used couple interviews which revealed a specific perspective; not his, nor hers, but theirs. This may differ from the responses that just the mother or just the father may offer, but hermeneutic phenomenology recognises that there is no absolute truth – everything is subjective and dependent upon time and place. For example, within midwifery, a woman’s perspective on epidural analgesia may change from the antenatal period, during labour and in her postpartum reflections – one would not dispute that she was expressing the truth of how she felt at those differing points in time. Similarly her accounts will change if she is discussing it with her own mother, a pregnant friend or her midwife - one would not claim that they were untruthful accounts.

In considering methodologies, it is useful to reflect upon what exactly is the focus of the study – differing methodologies are better suited to drawing out different aspects to a study, or indeed to different researchers’ personalities.
Philosophy as a research method

Heidegger was a philosopher; he did not propose methods of research, and it lies with researchers themselves to consider appropriate data analysis. For my own study, I used Diekelmann et al. which I adapted to reflect the time point and longitudinal trajectories of the data. Whilst focusing on individual interviews it also considers the whole – reflecting the concept of the whole being made up of constituent parts and the parts making up the whole. This reflects person-centred care. Themes arising do not relate to how often an idea is mentioned, but instead to its significance of meaning, with interpretation beginning during the interview itself in the areas that are encouraged and followed and those that are not. Data analysis requires technical process and rigour, but also intuitive insight in considering meanings; thus it is both a science and an art – reflecting the midwifery profession itself.

Heidegger and his philosophy encourage us to think for ourselves, not replicating others’ views. This ‘dwelling with’ the data, whilst initially daunting, can enable differing insight than that gained by traditional thematic analysis. The concepts behind the meanings arise from Heideggerian philosophy with findings comprising participants’ insight, the researchers’ understanding and application of philosophical ideas. Thus, it is a unique piece of work itself and its applicability is evidenced in the ‘phenomenological nod’ as others relate to and acknowledge the resonance within the findings. Hermeneutic work is not supposed to develop theory, nor prove a point – instead it is about suggesting how individuals may perceive and interpret their experience, assisting the intuitive health professional to understand and propose support for a mother or parents. Hermeneutic studies of midwives' experiences enhance management and understanding of possible support needed. Rather than broad data of retention rates and sickness levels, it can drill down to indicate how midwives feel, prior to how they may then respond, to enable proactive intervention. This is why it is useful for midwifery research and knowledge.

Heidegger makes no differentiation about the roles of women or men – only of people, and rarely directly refers to
healthcare. The value of using his philosophy within research is that it encourages deeper thinking, maintains a focus on meaning rather than responses and provides a structure in which application to practice becomes possible. As a research methodology it is immersive and reflective, which can appeal to those midwives who seek insight into what may lie behind an individual’s actions or behaviours. The person Heidegger was may not seem relevant to contemporary midwifery studies, but the concept of the nature of being is pertinent to any study seeking to understand experience.

**Practice and critical learning points**

- Consider how your own experiences and perspectives influence the care you provide – in acknowledging this, recognise how it may influence the advice and guidance you may offer women in your care.
- Reflect upon how you interact with those in your care – do you always consider how they may perceive their past and current experiences?
- When reading or undertaking research, maintain a critical approach and consider the synergy between underlying methodology and research aims. **TPM**

**References**


Clare O’Brien - Senior Research Midwife, South Warwickshire NHS Foundation Trust

Sandra Murphy - Research Midwife Marie-Clare Balaam Researcher, University of Central Lancashire

Twitter: @Research_SWFT

Published in The Practising Midwife Volume 25 Issue 01 January 2022

Summary

The research team at South Warwickshire NHS Foundation Trust (SWFT) worked with the University of Central Lancashire (UCLan) on the ASPIRE (Achieving Safe and Personalised maternity care In Response to Epidemics) COVID-19 study. We conducted 55 stakeholder interviews to gain insight into the hospital’s response to the pandemic. Working on the project presented many opportunities and challenges for us, including qualitative interviewing, using digital technology and engaging representative populations. This article, the fourth in the series, explains how the ASPIRE study gave us a unique opportunity to be part of a rare qualitative, midwifery-led research project which we fully embraced. We hope that this is the start of a new era of research that encourages midwife-led projects and qualitative studies.
Background

The ASPIRE COVID-19-CENTRE study is an in-depth case study of eight NHS hospitals from across the country, of which SWFT is one. Its main aim is to examine each hospital's response to the pandemic in terms of changes to service provision, as well as the views and experiences of patients and staff throughout the pandemic through semi-structured qualitative interviews.

SWFT has a medium-sized maternity unit with around 3,000 births per year. We have a small but well-established reproductive health and childbirth research team, which was established in 2012. The team currently consists of two part-time midwives and one part-time research assistant. Over recent years, our maternity services have been recognised for providing high-quality care and won the 2020 Royal College of Midwives 'Service of the year' award. As a result of this, we were the first hospital that ASPIRE COVID-19 UK approached to be part of the project.

Prior to the study, our experience as research midwives had been fairly typical. We are involved in a variety of National Institute for Health Research (NIHR) portfolio projects including large, multi-centred randomised controlled trials (RCTs), registry studies and some smaller mixed methodology studies. As a smaller unit, we have focused more on registry studies and prospective cohort studies compared to some of the larger maternity units participating in ASPIRE COVID-19, which tend to be more focused on large scale, obstetric-led RCTs. Perhaps as a result of this focus, we have noticed a welcome shift towards the acceptance of midwives as principal investigators (PI) and I have had the opportunity to be PI on several research projects. ASPIRE COVID-19 offered us a unique opportunity to expand our portfolio into midwife-led research and learn new skills in qualitative research techniques. It was the first fully decentralised research project that we have participated in and this presented us with many challenges, such as the use of new technologies. However, the research team at UCLan was supportive, and ensured we had the relevant skills needed to deliver the project and maximise our learning opportunities.

Qualitative interviewing skills and challenges

My colleague Sandra and I had never conducted qualitative interviewing before in our roles as research midwives. I had learnt the theory of qualitative research and qualitative interviewing during the research modules of both my university degrees (BSc Psychology, the University of Warwick and BSc Midwifery, Coventry University), but had never put the theory into practice. One of the main challenges we encountered as novice interviewers was ensuring that each interview wasn’t just a recorded two-way conversation.
The art of good qualitative interviewing lies in the ability of the interviewer to elicit as much relevant information as possible from the participant, without influencing their responses by sharing their own thoughts. We found this to be much easier said than done. In a two-way conversation you interact and interject with your converser, particularly when they are discussing an emotive topic that they may be struggling to make sense of themselves. However, during a qualitative interview, this could be considered as leading the participant to your own conclusions. The art of keeping quiet is something we, and possibly many other midwives, find particularly difficult. As a profession we tend to be social chameleons, always striving to put others at ease by showing we understand them; it is one of those intangible skills that the very best midwives possess. In contrast, as an interviewer, whilst you must make the participant feel comfortable, the real skill is to sit back and allow the interviewee’s own thoughts to flow and, if they stumble, to allow them time to find their own words rather than stepping in to support them with your own.

The other aspect of qualitative interviewing we found to be challenging was keeping the service users on topic during their interviews. It is natural for some women to want to discuss their birth to help them process what happened to them during this life-changing event. However, in the context of a research project, it was important to guide the participant to discuss experiences relevant to the study rather than just to provide a birth story monologue. Most service users described generally positive experiences, however for some participants their experiences were not as positive. In this situation, as both researchers and midwives, it was important to find a balance between listening and providing a witness to the woman’s experiences, and if necessary, escalating any concerns and signposting women to help as appropriate, while trying to keep the interview relevant to the research study.

The art of good qualitative interviewing lies in the ability of the interviewer to elicit as much relevant
information as possible from the participant, without influencing their responses by sharing their own thoughts.

A unique insight

One of the unexpected privileges of conducting qualitative interviews was the chance to hear a large variety of perspectives on the experiences of our colleagues during the peak of the pandemic. This increased our understanding of the pressures faced by different areas within maternity services, but also the innovative ways in which staff managed to navigate the restrictions to ensure that patients received the best possible care, even if this was by unconventional means. Many staff also reported to us that they found the interview process very cathartic, as it was the first time many of them had had the opportunity to stop and reflect since the pandemic had begun.

Technology skills and challenges

The ASPIRE COVID-19 study is the first fully decentralised trial we have participated in. This meant we had the challenge of conducting virtual interviews and recording them digitally for analysis. Whilst we have become more accustomed to Microsoft Teams during the pandemic, the process of setting up, conducting and storing the interviews was not straightforward. Every part of the set-up, interview and completion process for each interview had to follow a strict protocol to ensure everything was recorded and stored in the right place, and in line with the trial’s data protection guidelines. If one part of this process was missed or completed incorrectly, it could potentially mean the interview couldn’t be accessed or could be in breach of data protection. My colleague Sandra and I practised relentlessly with each other, ensuring we got every step right. During the first few nerve-wracking interviews we completed, we did encounter a few technical problems which we managed to quickly resolve with each other’s support. After the first few interviews, our confidence in the technology grew and by the end of the project, we were both very proud of the new skills we had learned.

Achieving diversity

Diversity was a dimension we needed to achieve in all three interview categories: service users, health professionals and heads of service. This was to ensure the views of those we interviewed were as representative as possible of their wider
populations. For our service users, we wanted to ensure we represented the diversity of women and birth experiences within our hospital in this period. Despite our population not being particularly ethnically diverse, it was important to try and interview women and birthing people that represented the ethnic diversity we do have in our area. Our primary source of recruitment for service users was through social media, however we found that this predominantly attracted women of a white ethnic background. We therefore devised some strategies to reach out to a more diverse audience; these included attending the six-week BCG clinic and using our other COVID-19 study databases to approach women of under-represented ethnic backgrounds. These strategies were successful and we had representation from five different ethnic groups within our service user population.

We also wanted to ensure we covered other areas of diversity such as mode of birth, birthplace, parity and age. We achieved this by screening those who self-referred to us via social media, to ensure we had a good spread within these categories. For some subgroups such as home births, it was hard to find participants through the usual self-referral channels, so we used our connections with other midwives to identify women who may be suitable and approached them directly where appropriate.

Diversity within the health professionals and heads of service categories was also important in relation to the breadth of roles we included. We started with a brainstorming session to think about every health professional or head of service role that directly relates to maternity, and used social media and a targeted approach to achieve this diversity. We were delighted with the breadth of roles we were able to include. For our service users, we wanted to ensure we represented the diversity of women and birth experiences within our hospital in this period.

Conclusion

ASPIRE COVID-19 was a truly unique research project to be part of. It presented an opportunity to gain many new skills, including qualitative interviewing and the use of Microsoft Teams. It has been such a privilege to be part of this large-scale midwife-led project and I am really hopeful that its success will galvanise midwifery-led research moving forward. Midwives are capable, autonomous practitioners who are well-positioned to conduct impactful research which ultimately improves care. As a result of this study, we are actively seeking more qualitative and midwife-led research and would encourage other hospitals with a similar opportunity to do the same. TPM

For our service users, we wanted to ensure we represented the diversity of women and birth experiences within our hospital in this period.

Acknowledgements

This work is part of the ASPIRE COVID-19 study: https://www.aspire-covid19.com

Funding statement

ASPIRE is funded by the Economic and Social Research Council (ESRC), as part of UK Research and Innovation’s rapid response to COVID-19 [grant number ES/V004581/1].
Further information

Full details of the ASPIRE study are available on the Research Registry (ID: researchregistry5911) at https://www.researchregistry.com/browse-the-registry-home/registrationdetails/5f36aaf27a896d0015764485 and UKRI Gateway at https://gtr.ukri.org/projects?ref=ES%2FV004581%2F1.