

AIMS JOURNAL

Birth of a
pandemic:
How we coped

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What just happened?

by Alex Smith



The title of the editorial for this issue of the journal is, ‘What just happened?’ I feel a little bit like ‘baby bear’ from Goldilocks when I want to add, ‘...and still is!...’ – I imagine the pandemic is here to stay for a while – but the very happy thing that has just happened for the AIMS journal, is the warmly welcomed addition of two new co-editors. Gemma Reece joined me just in time to start work on this December issue. She is a mother, a Hypnobirthing practitioner, and has professional experience as an editor. Gemma opens this issue by setting our journal articles into the wider context of what is known about the impact of the pandemic on people’s pregnancy and birth experiences. Salli then joined us in October and together our editorial team of three has been restored. Salli also has professional experience as an editor. She is a new grandmother and lives on a boat. Like me, Salli has a particular interest in the Deaf community and has studied British Sign Language to level 3 (whereas I am only level 2). Salli follows Gemma’s editorial by introducing the very interesting range of articles for this quarter’s issue of the AIMS journal.



There is no doubt that we have all just lived through a peculiar and difficult part of history, and, as we all come blinking into the light, many conversations with friends I haven’t seen for a while seem to run along the lines of, ‘What just happened?!’

Making sense of the Covid pandemic (if that’s ever possible) will take some time for us all. The December issue of the AIMS journal looks at some of the effects of the pandemic on experiences of pregnancy and birth. Little by little, as we begin to unravel the threads of what took place, we can start to build a clearer picture of the impact of the whole thing on our lives at this time. As studies start to be published, we can be hopeful that lessons learned from the pandemic can be used to inform practice in the future to make sure all maternity service users have better care in pregnancy and birth.

At a time in their life when pregnant women and people should feel – need to feel – at their most secure and safe, we now know that the pandemic meant they could not even be sure if they would be able to have a birth partner with them during labour[1]. The uncertainty and stress involved in this was likely to have led to fewer healthy pregnancies, more interventions and more complicated births. One study reports that the rate of intrapartum stillbirth saw a

significant rise after the start of the pandemic, pointing to factors such as poor communication, triage by telephone rather than in-person, and hospital scans being temporarily paused[2].

Some research reflects upon how pre-existing issues with our hospital maternity protocols were magnified by policies hastily ushered in due to the pandemic. For instance, to limit the numbers of people present in the wards, at times, birthing women and their partners were only permitted onto the labour ward once established labour could be ‘proven’ by the woman consenting to a vaginal examination (VE)[3]. Women who would be otherwise denied the support of their partner then felt coerced into having a vaginal examination. We already know that VEs are not the only way that labour can be established, but in these instances, where more was at stake for the birthing person, consenting to the procedure would have felt like the only option.

The possibility of having midwife support for a home birth was also cut off to many people during this time – even outside of a pandemic we know that home can be one of the safest places to give birth, so this consequence is particularly hard to process[4]. For those women who wanted to give birth at home, and who may have had increased anxiety about the hospital environment because of previous experiences or simply given the risks of COVID, the decision to remove support for home birth, will have taken a huge toll on their mental and physical health as we know from the many calls to the AIMS helpline. One study reports that this may have given rise to a larger number of people considering freebirth[5].

It is clear that the cost of the pandemic to women’s experiences of childbirth and pregnancy has been huge, with reports of trauma and distress painting a bleak picture[6], with “studies including systematic reviews and meta-analyses [finding] a 3 to 5 fold increase in perinatal depression and anxiety during the COVID-19 pandemic compared to non-pandemic times”. [7] Yet there are also interesting aspects to the huge shifts in practice we saw during this chaotic time. One study shows that a significantly higher rate of non-surgical management of ectopic pregnancies was brought about by the first wave of Covid, and asks whether this might be routinely adopted for future practice[8]. For all the women feeling isolated by lack of contact with extended family and support networks, there may have been

a great many others who were hugely relieved to have their partners working from home while they were dealing with a newborn, rather than out of the house for hours each day. Perhaps they felt more able to take good care of themselves in the later stages of pregnancy, if their work or social commitments were lessened.



In this issue of the AIMS journal, NCT-trained practitioner [Frances Attenborough](#) opens with a discussion regarding the Maternal Mental Health Alliance review of Covid-19’s impact. Another perinatal practitioner, [Suzy Alexandra-Troy](#) gives us an account of her experience delivering support online during the depths – and occasional rewards – of lockdown. There follows a personal story from [Caroline Basden](#), who chose homebirth to feel safe and supported during the pandemic, before we hear from [Hannah Lyons](#) describing her wonderful experience of giving birth at home after a challenging time finding the support and care that she and her partner needed.

Nadia Higson lets us in on the challenges of keeping the AIMS website up-to-date with the latest coronavirus research and maternity care guidelines. Three separate articles follow, exploring specific and often personal responses and stories that will become part of the heritage of our understanding of the Covid-19 years. [Katharine Handel](#) looks at the effects of that time on menstrual cycles. Liz Thomas speaks about giving birth to her premature daughter, before we hear from midwife [Jenny Smith](#) reflecting on supporting parents during the pandemic.

We share the results of the AIMS poetry competition, which give us insights into diverse experiences and perspectives on choice in childbirth and care. The winning

entry and runners-up will provoke feelings of anger and sympathy and highlight how much campaign work still needs doing.

Three book reviews explore birthing choices, undisturbed birth, and maternal mental health. [Charlotte Tonkin Edun](#) reviews Catherine Bell's book about birth plans; [Sue Boughton](#) looks at Dr Sarah J. Buckley's guide to natural childbirth and parental choices; [Rachel Boldero](#) lets us know about a new book by Jane Fisher aiming to support young children whose mummies 'have a poorly mind'.

Finally, we return to AIMS and its campaigning activities. Our regular [Birth Activist Briefing](#) considers pledges made by NHS England with regard to Black, Asian and mixed ethnicity parents and children. [The Campaigns Team](#) reviews an NMPA look at maternity outcomes for women with a body mass index over 30 kg/m², before giving us an update on their campaigning activities over the past few months.

We are very grateful to all the volunteers who help in the production of our journal: our authors, peer reviewers, proofreaders, uploaders and, of course, our readers and supporters. This edition especially benefited from the help of: Megan Disley, Ami Groves, Julie Milan, Anne Glover, Caroline Mayers, Julie Ann Crowley, Veronica Blanco, Carolyn Warrington, Josey Smith, Judith Payne, Jo Dagustun, and Danielle Gilmour.

We really hope you will enjoy this issue. In our next Journal coming in March we will be exploring the ever increasing use of induction of labour.

ENDNOTES

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Article

Maternal Mental Health During a Pandemic

A look at the rapid evidence review of the impact of Covid-19 and the subsequent recommendations made by the Maternal Mental Health Alliance

by Frances Attenborough



I'm an NCT practitioner [1], supporting parents both before and after their babies are born. The last 18 months have been hard going. I've observed distressed mothers and fathers who have found birth to be not at all what they expected. I've spoken to parents who feel completely isolated, with no support from friends or family, and in some incidences with little support from health care professionals. I've heard stories of how pressurised pregnant people feel and how so many seem to be coerced into induction, without the support of a partner. NHS staff are overstretched and burnt out. But I'm also aware that I'm only seeing my little bit of the picture, supporting those that come to me. So, I read the rapid review of evidence by Papworth *et al* (2021)[2] of the impact of the Covid-19 pandemic on maternal mental health with interest. Would my anecdotal viewpoint be confirmed, or was I seeing a small subsection of parents for whom Covid-19 had a particular negative impact? How would the recommendations fit into the existing checklist called for by AIMS in 2019?[3]

The rapid review was published in early 2021, having been written in October and November 2020. It is therefore reporting on the impact of the first UK lockdown. It reviews both published research and papers that were still in pre-print[4] in Autumn 2020 considering mental health and Covid-19. Papworth *et al* also looked at data sets on services and service users covering October 2019 – September 20 in England (the only nation where this data was available), undertook an online survey of voluntary and community-based services and asked for evidence submissions from institutes, professional bodies, commissioners and voluntary and community-based services. They are upfront in acknowledging the limitations of this evidence. For example, questions can be raised about the use of pre-print papers as they have not completed the peer review process and may be subject to changes, however, it can also be argued that, due to the very rapid time frame the review has been completed in, it would exclude much valuable data to only include published work. There are selection biases in those that fill in surveys, especially when the pressures that the last 18 months have brought are considered. Partners' mental health was not considered because there was insufficient data. There are two main limitations. Firstly that the research is limited to the first lockdown, which in retrospect may have been different to subsequent lockdowns. Secondly, because this is a rapid review early on in a pandemic it is too soon to understand what the full impact may be.

My impressions of the review were that it was both thorough and valid in scope and methodology. The themes that came out from each of the data sets (i.e. the literature review, the numbers from the databases, the survey and the calls for evidence) confirmed each other, suggesting that these are indeed common themes, and that further investigation would not add anything new. The results and conclusions form interlocking themes, some of which are now being confirmed by other authors.

It was clear that there were already issues with perinatal mental health services and maternity services around the four nations before Covid-19 (AIMS, 2019) [3]. The authors describe how the pandemic has made this situation much worse, leading to mothers experiencing worsening perinatal mental health. This is caused in part by the anxieties around the pandemic itself, but also by the restrictions, adaptations and reduction in services. Parents were left unsure what services were available, whether it was safe to give birth, who would be able to support them, and what would happen if things didn't go as planned. There was a dearth of

information because this is a new disease and parents struggled with knowing how to make the right decisions. Choices were removed; home births were suspended in some areas[5]. Choices for some birthing people might still change if Covid rates increase dramatically again, or if a birthing person tests positive for Covid within 10 days of birth[6],[7]. This has led to parents grieving the birth they had thought they were going to have as well as increasing anxiety. In addition, some parents were also grieving for lost family members or had family who were at risk or were ill.

Isolation came out as a very strong theme in the review. We know it takes a village to raise a child, but what happens when that village – including immediate close family and partners – is taken away, all a time of increased anxiety? One of the things that struck me through supporting people contacting the NCT infant feeding line throughout the pandemic is that parents were missing normalisation; the lack of peer and family members giving their perspective on things lead to parents concentrating on the negatives, and worrying about things being wrong even if they weren't.

Up-to-date analysis by Public Health England[8] shows that the mental health of the population as a whole declined and recovered to coincide with various lockdowns and easing of restrictions, however, this hid differences in subsections of the population. The authors describe how the response to Covid-19 has acted as an amplifier of risk; those people who were already at risk or were disadvantaged have been disproportionately affected by the pandemic response (confirmed by later research)[9,10,11,12]. These risk factors included simply being pregnant[13]. Worryingly, whilst it is clear that domestic abuse has increased during the first lockdown[14], the review notes that safeguarding referrals went down. It is clear how the less confident mothers, or those less adept at navigating the systems, or those excluded from the systems put in place (e.g. because they have no private, safe space in which to talk, or they have no internet access) will get less support, even though these are the very people that might need the support the most. Research by the Mental Health Foundation [15] has also shown that people with long-term conditions were also anxious about the shift towards taking personal responsibility for their own Covid-19 safety, which I've also heard pregnant people being concerned about.

As mentioned above, service provision was not adequate prior to Covid. The authors commend that pregnant women and new mothers were recognised early on in the pandemic as being vulnerable and a priority group, yet in many areas (including my own) midwives and health visitors were redeployed elsewhere in the NHS. Services switched online, but took a little time to get up and running. Services were also reduced as staff became ill with Covid-19 themselves or had increased caring responsibilities. It is clear that the redeployment of health visitors and midwives was a mistake. Papworth *et al* (2021) state quite clearly 'it turns out that what was deemed "unessential" was, in fact, essential'. In other words, highly skilled staff such as health visitors and midwives were moved from supporting mothers and new families (considered less important) to supporting the Covid crisis (considered more important). The assumption that maternity and postnatal care was less important than treating Covid patients has since been shown to be incorrect. We know services were already stretched with shortages in the numbers of midwives and health visitors pre-pandemic. Those left have worked through unprecedented pressure and are burning out. They have gone through the pandemic the same as the rest of us with merely a few minutes clapping as a reward. I know from my own practice that those that support others must be supported in turn.

The result of this reduction was that the third sector[16] was put under increased pressure to pick up the slack at a time when their own funding stream may have been at risk, staff were furloughed, sick or had childcare issues. Some third sector services supported mothers with more severe illness than they expected or were commissioned to support.

One of the concerns that I frequently came across in my own work was that more women and birthing people were experiencing a traumatic birth. I was fascinated to read in the review that, whilst health visitors were also reporting this, midwives were not. To my mind this is unsurprising because it takes time for people to process their experiences of birth and with many new families receiving fewer, or online, midwifery visits, this may be something that midwives are not seeing. However, as time goes by, I suspect that the numbers of families who report a traumatic birth may well increase. We know the risk factors for traumatic birth [17] and it is clear how these could well be amplified at a time when the pandemic caused a reduction in staff and as the pressures on the staff (such as infection control) increased. Isolated mothers may have felt less in control at a time when they had no advocate in the form of a birth partner or doula.

The review describes several ‘silver linings’ of the pandemic. These could indicate ways that the situation of families might be improved as we return to a more normal life. Mothers reported that having a partner around more (possibly due to furlough, possibly due to working from home) was beneficial, as was the reduction in pressure and expectations from families and friends. Fewer visitors meant that new parents and babies could bond in their own bubble. There may be positives to consider around moving services online too, especially if it helps people to access services. However, the potential negatives, such as making access harder for some or the risks around missing important information, must also be fully explored. Whilst the picture is bleak, it is not unremittingly so.

The authors remind us that the crisis is not yet over, and at the time of writing (August 2021), with increasing Covid rates due to the Delta variant, I would concur that we are not yet through this. Furthermore, it is too soon to know what any long-term outcomes might be.

In the light of the evidence discussed, Papworth *et al* make a list of eight recommendations. These are:

1. To assess the true level of demand for perinatal mental health services
2. To future-proof perinatal mental health services against future pandemics or similar public health crises
3. To have up-to-date data to understand the changing picture
4. To tackle racial discrimination within health systems and adverse outcomes for people of colour
5. To have better research
6. To understand the impact of ‘remote’ mental health care
7. Government and NHS must recognise the importance of voluntary and community organisations
8. To support the mental health of all health and care staff.

It is somewhat disheartening to see that concerns raised before the pandemic do not seem to have led to lasting change. AIMS clearly reiterates the need to prevent traumatic birth, and to support perinatal mental health much more effectively. If staff had already been trained to provide culturally safe care to all women and families, if staff had not been redeployed, if services had been appropriately funded pre-pandemic and then not been suspended or disrupted – might we be in a different position now, without the increases in demand and the increases in complexity of cases? The long-term impact is not yet known, and resources need to be allocated to fully understand what this new level of demand really is. The true levels may never be known if mothers are not listened to properly or if they can’t access timely support. This needs to include removing any time barriers on receiving care or making a complaint. Lessons do need to be learnt in order to future-proof services. It will take time for everyone, including NHS staff, to recover from the pandemic and some issues may only come out when parents realise that what they have been through is not normal.

We need more, high-quality research, because without understanding what happened, why, and what the effects are we can’t make decisions about the future. This is especially true in the area of remote support, which might look very attractive to commissioners, but for which the effectiveness is not yet known. As Patel [18] states, ‘People aren’t hard to reach, they are just easy to ignore’. We must ensure that no one is ignored no matter what their background is, where they live, where they give birth or whatever care they have received. The Maternal Mental Health Alliance (MMHA) [19] has started a new campaign calling for *all* women and families to have access to high-quality, comprehensive care which, if implemented, could make a massive difference to families in the UK.

Despite the limitations of the report, it reads as a blunt wake-up call showing that mistakes were made, the repercussions of which are not yet fully understood. It is important to support mental health, especially during a pandemic; the long-term impacts of getting this wrong may be felt for some time to come.

One year on, the picture is not rosy. We are, as a population, ground down by ongoing stress, and whilst some people seem to be coping, for others the situation is no better one year on, or is worse [20].

I can conclude by saying that what I was seeing and hearing was not from a unique subsection of the population. There is a clear need for more research into the long-term effects of the multiple lockdowns, and a clear need for more funding to be dedicated to support mental health across the board.

Author Bio: Frances Attenborough lives in the North West of England and originally pursued a career in Materials Science before having children and realising that supporting mothers was much more worthwhile.

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Article

I will always remember this time: supporting parents during the pandemic

by *Suzy Alexandra-Troy*



In this piece, I will be looking at my involvement, with other colleagues, on an intense project designed to support parents and parents-to-be, virtually, during the pandemic. I will reflect on conversations I had with these parents;

conversations with colleagues, and the emotional impact of working on a project supporting parents struggling through a transitional time, whilst also negotiating my own way through the pandemic.

The spring and summer of 2020 were the beginning of the season of Zoom. I was still working as a tutor for NCT and we had to quickly train teachers to be able to take all of NCT's offerings online, as it became clear that the pandemic was taking a firm hold and swift action was needed to keep parent education accessible, for at least the foreseeable future. Before long, furlough became a familiar word, and indeed, I was furloughed from my day job. Soon after this, I took voluntary redundancy and began to consider my options. Then, a previous tutor colleague got in touch to say that an organisation called Best Beginnings had received a large grant from Barnardo's to offer online antenatal and postnatal classes for parents. These would be provided free of charge, with the aim of supporting parents and parents-to-be through this period. Because of the situation, this was to be started as quickly as possible. We undertook training online, and met the others who would also be delivering the sessions. We were all qualified as antenatal or postnatal

teachers/tutors, midwives or other health professionals. We also had co-facilitators, who worked for the charity, handling the Zoom Waiting Room, answering questions, and sharing videos and links which had been specifically created for the project.

A few short weeks later, with sessions booked in our diaries, we were ready to go live. Each session was planned, and there were three sessions per group. We were informed that sessions should be responsive to whoever turned up on the day, and that the programme would evolve in response to parent feedback. It took a little while for the word to get out, so we had a couple of weeks of low numbers on the sessions, but soon, we were busy and the groups grew rapidly. We were up and running. We had busy WhatsApp groups, in which we could ask questions, share ideas and debrief conversations we'd had during the sessions.

It was a steep learning curve, and, as we really got stuck in to facilitating the sessions, I learned how important it is to make sure everyone is on mute when they need to be! This took a lot of adjustment, as I am used to being in the centre of a group, where everyone can easily have their say. It was definitely harder to get people to ask questions, as the Zoom experience can be intimidating, and is not always conducive to group working. I suspect that participants found it more difficult to speak up when looking at a screen, rather than being in a room together. There seemed to be more of an expectation of the 'classroom' environment, which I have always tried to avoid in face-to-face classes. As we have all learned, teaching from home with the high frequency of interruptions – whether it is post arriving and making the dog bark, partners working in adjoining rooms, chairs not designed to be comfortable for sitting still for an hour and a half, and drilling, or tree cutting in the street below – is definitely not without challenges!

The first impression I formed was of how frightened the people I was talking to on these sessions had become. They were having few antenatal appointments, having to attend scans – sometimes even anomaly scans – by themselves, and they talked of feeling alone and scared. One story which remains with me is about a woman who had been hit by a car whilst she was heavily pregnant. She was bleeding, and was taken to hospital in an ambulance. She was able to contact her husband, but he was required to stay in the car park for several hours with no updates or information. The woman spoke of how terrified she was being alone, and he was similarly anguished as he waited in the car park. He told me, ‘I didn’t even know how she was, or if our baby was still alive’. I was soon bombarded in the sessions with questions that women had not been able to ask because of cancelled or curtailed midwife appointments.

As the weeks went by, one of the more heart-breaking themes became the loss of support, especially during first pregnancies, where no grandmas or granddads, sisters or best friends were allowed to be there to undertake those rituals of pregnancy, which give so much support and help to make the pregnancy seem exciting and real. Many women, whose parents lived abroad, were full of sorrow that extended trips had to be cancelled and their parents could no longer be with them in their pregnancy. There were also many women speaking of feeling isolated. Some had moved to new areas just before the pandemic and had been counting on antenatal classes and baby groups to make new friends.

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After the first month or two, those of us who felt able began to offer one-to-one support. This was mainly via Zoom calls and phone calls to women who felt lost and who needed to talk to someone about how hard they were finding their pregnancies, or the early days with their babies, their world stripped, suddenly, of support and social activities. At times I absolutely felt out of my depth. Although I am trained

in education and active listening, I am not a counsellor. However, I soon realised that what these women wanted was someone to listen – someone with no agenda to whom they could express their darkest fears. I talked to women about their anxiety, which was keeping them up at night, their fear that they couldn’t stand up for themselves and how they wanted to parent, and their fear that their child would be somehow damaged by the lack of real human contact in their lives.

At about this time, I began to struggle. I feel it is important to mention this here, because I know that many of you reading this will have felt similar emotions. I am a highly sensitive person (if you haven’t read up on this type of personality please do – it will help!) as are many who choose to work in healthcare and the complementary fields. I over-empathise. I feel a strong sense of responsibility towards those I am there to support. I want so badly to be able to help; to ease people’s pain. This began to feel like a weight on me. Every day there were new stories, stories of pain, of loss, of anxiety and sometimes, I have to be honest, stories of women and their partners being treated badly, dismissed, given bad or conflicting advice and not receiving the level of care they should have been. It bears mentioning here that I fully understand the levels of stress and pressure which NHS staff were under during this time. Nonetheless, I felt overwhelmed and I know some of my colleagues did, too.

Best Beginnings took good care of us and arranged regular supervision, which we could do in small groups with a supervisor who had a huge amount of experience in supporting those who do this kind of emotionally intense work. We could talk and we could share. We could give each other suggestions, or just listen and be heard, which helped enormously. During this time, I was struggling with other aspects of my life, which added to these levels of stress. I was applying for and being interviewed for jobs. All of our children were struggling with home-schooling, exam pressure and huge uncertainty. Worst of all, one of my parents was continuing cancer treatment amidst all of the fear and anxiety that the clinically extremely vulnerable were feeling at this time in the pandemic. My colleagues and I would log on early to our sessions and share. Some had Covid, others also had sick relatives or partners who had to be away for work, and we carried all of the stress of combining working from home with trying to support

children in home-schooling. It felt amazing to have those few minutes where we listened to each other, empathised, and ultimately knew that we were not alone.

As time moved on, things began to change, almost imperceptibly at first, then more noticeably.

... What had been new, punitive and scary was becoming normal.

The levels of anxiety began to lower, certainly antenatally. The time that used to be needed for the venting of fear and anxiety began to lessen, and I wondered what was happening. The conclusion I came to was that people were becoming re-institutionalised. What had been new, punitive and scary was becoming normal. The women I was working with no longer expected that their partners would be at every appointment with them. They became accustomed to phone appointments with their midwives, and to time with their close family being something that happened virtually. There was a level of resignation which in some ways, might have been a good thing – an acceptance of sorts.

However, this was not the case when you talked to women in the postnatal sessions.

However, this was not the case when you talked to women in the postnatal sessions. Lots of these women talked of feeling so alone and so vulnerable. They knew that this was not what they had planned for. They had planned maternity leave, with time with friends and family to support them as they moved through this hugely transformative period of their lives. They imagined their early days with their new babies to be full of joy, with their parents, relatives and friends being part of this time, supporting them and easing the burden of those early days. Another issue which loomed large at this time was the lack of (or at the least the huge reduction in) postnatal support from healthcare staff. Women talked about struggling with breastfeeding and trying to get support from overstretched midwives and health visitors, who often could not come into their homes. Other women talked of not having any postnatal checks for them or their babies and how, when this was their first child,

they had no baseline for what was normal. Some women talked about trying to access their GPs with serious issues about their baby's health such as skin rashes or persistent vomiting, and trying to receive some kind of diagnosis by sending photos to the doctor.

Every single woman who shared these stories was careful to articulate that they understood that the NHS was over stretched, and that they did not blame staff, but that the inability to access support was having serious effects on their mental health. These were some of the hardest conversations for me. I felt – and still feel – conflicted about the way this time in the lives of these families played out. It seems that there was, at all times, a trade-off between safety and the security and mental health of many of these families.

I still wonder how much difference it would have made if parents who live together, for example, had been able to attend appointments together, and if GPs and health visitors had been given access to video conferencing...

Women talked about how hard it felt that they could go to the supermarket and be surrounded by people, but could not access vital health care that is so important to the whole family during the postnatal period – a time that can feel anxiety-ridden under normal circumstances. Of course, we all knew that the NHS was working under ever-changing guidance, but I still wonder how much difference it would have made if parents who live together, for example, had been able to attend appointments together, and if GPs and health visitors had been given access to video conferencing to ensure that vital postnatal checks had still taken place.

At the same time this was occurring, I was witnessing one of my parents go through regular and invasive cancer treatment. I talked to her about this recently and she said that she always felt safe, appointments were extremely carefully managed, and her treatment carried on as planned. Of course, I understand that cancer is higher up the priority of the NHS than antenatal and postnatal care but again, it feels like a huge experiment was carried out on all of these

families, which I believe will have inevitable and ongoing repercussions.

As this spring began to unfold, we knew that we were reaching the time when the project was coming to an end. This was a bittersweet feeling; I felt exhausted by all of the anxiety and fear I had discussed with parents, yet at the same time did not feel that life was anywhere near 'back to normal' and that we were no longer needed. When I look back on that time now, I feel a real sense of pride in what we achieved – individually and collectively. I know that we helped people; we gave them a space to share their fears safely. We filled in gaps in their knowledge, and we helped them to forge a support network, albeit remotely.

I want to bring this reflective piece to a close by discussing what I learned and what we can learn more broadly from this hugely challenging and rewarding work.

Firstly, I would say that there is a real place for making this type of ante and postnatal education available online, and available to everyone. We definitely reached the broadest range of people I have ever worked with in a 20-year career educating parents. We had parents from all over the world who were living in the UK and really missing family support. These parents often don't take up paid-for education, and often struggle to negotiate the UK maternity system. We had young parents, much older parents, single parents and attendees from across the spectrum in terms of socio-economic grouping. The real joy in this is that, somehow, in this pandemic, and in this virtual environment, all of those barriers dissolved, and everyone jumped in to offer support, guidance and friendship to people from this wide range of backgrounds. The people who already had children were also a huge source of support and reassurance to those having their first child.

Secondly, I return to my point about what decisions are made in any future pandemics or resurgences of this one. How do we keep people as safe as possible, whilst also considering the mental health of all parents as they navigate this world which is so new to them? We, as a society, have to make decisions about what we prioritise. It seems to me that supporting families, as they begin their journey, is the very definition of early intervention, thus giving them the best start and possibly avoiding problems in the future.

What can we incorporate into healthcare, from the lessons learned in this pandemic? Can we utilise remote technology in order to allow more appointments to happen by video call, thus ensuring that vulnerable parents are supported? After all, most of us have sat in a waiting room at a GP surgery, surrounded by sick people, and felt vulnerable to illness, even before Covid became an additional threat. Can we make more of the system where patients stay outside, or in their cars, and are brought inside by staff so that contact with other patients is minimised? Can we make important information available in video format, so that parents can watch it at home?

For example: What to expect from antenatal appointments; What their options are for place of birth; and, What will happen after their baby is born. The Best Beginnings app provided our parents with masses of this type of information, and the feedback was overwhelmingly positive. It seems clear that we have to consider at this point whether we want to go back to how things used to be, or if we want to make changes to make healthcare as safe and accessible as possible.

I will always remember this time. I remember many of the faces. I remember the woman feeding her newborn, wearing a mask because her baby had Covid. I remember the women who cried because they missed their mothers; the men who, suddenly, were combining working from home with supporting hugely anxious partners, whilst being locked out of their appointments. I remember the solemn-faced woman who told us "I never wanted a baby and I don't know if I want this one." I remember the woman whose mum had just died, as she was heavily pregnant, and the women who worried that the lack of socialisation would permanently harm their babies. I remember how they all held each other, and how my worry about my parent, sat alongside my worry for them. I must also mention all of my co-facilitators who supported me and who rushed around finding links to support for issues mentioned in the sessions. Together, I know we did some good in a time where we all had our own burdens to carry.

Author Bio: Suzy has worked teaching expectant parents and student perinatal education practitioners since 2002. She is currently teaching yoga and searching for the next challenge in her work life.

Article

Worries about Covid-19 and the homebirth solution

by Caroline Basden



I was six months pregnant with my third baby when lockdown started in March 2020.

I remember the press conference when shielding was first announced. Suddenly there was so much confusion for those of us who were pregnant. Were we meant to shield? Was the risk actually higher for us? We immediately pulled our two boys out of school and preschool and were fortunate to both work from home, so aside from the odd 7.30am supermarket run, we began our new normal: homeschooling and more family time than we ever imagined!

Nerves about what this meant for my birth plan immediately crept in. My first two births hadn't been the easiest. My first-born was induced, and I had an epidural and required forceps in theatre. My second-born came naturally, with minimal pain relief, but required neonatal care for the first 48 hours and we spent almost a week in hospital. I had always felt safe in hospital but now, for the first time, I began to question that.

My other big concern was childcare and whether my husband would be able to be present at the birth. My mum and sister live close by and the plan had been for them to look after the boys when my labour started but the worry now was, what if one of us contracted Covid?

My husband can be a bit of a worrier and previously the thought of a homebirth would have terrified him, but we had attended the first session of a hypnobirthing course in early March. One of the points discussed at this was the importance of the birth environment and the benefits of homebirth or a home-like environment. Thanks to this, and his worries about Covid now outweighing his worries about the birth, my husband amazed me by suggesting we try a homebirth.

I switched to the homebirth midwife team. We were lucky that our hospital prioritised keeping them running. One of the key benefits of this was that I actually got to see my named midwife face to face and have appointments at home.

I also continued my hypnobirthing course via Zoom and tried to gather as much information on homebirths through the supportive local homebirth group on Facebook. This fantastic group met online monthly and shared positive birth stories, and the parents who'd had their babies came back and answered questions and gave helpful tips. I slowly began to feel more confident, although a part of me worried after my previous two experiences that there was no way this would all go to plan.

I did visit the hospital, right at the end of March, after a day when I had barely felt the baby move. I was scared to go in, but went late on a Sunday night and I've never seen the normally busy hospital so quiet. I was monitored and of course the baby began moving straightaway. It did give me a

massive relief to be checked over and I absolutely think the stress of lockdown had caused my worries.

I remember my last couple of months of pregnancy quite fondly. Which is weird as not only were we mid global pandemic, but we had some pretty traumatic times and losses within our extended family. I think perhaps these factors and the fact I was homeschooling my boys distracted me from any pregnancy worries!

Our baby was due on the 10th of June and things did begin reopening just before this; however, we didn't want to take any risks. There was no way I wanted to send the boys back to school and preschool only to have one of them catch a cough. We remained locked down.

My due date passed, and I then became the only pregnant person ever to want to go more overdue as it was my second son's birthday on the 14th. Luckily, baby stayed put and we had a lovely party just for the four of us. The excitement of a drive-thru McDonald's made his day!

I did then start to get a bit more impatient and when the midwife came to see me on the 17th I was happy for her to do a post-date treatment. This involved acupressure, aromatherapy and a sweep. That afternoon we went for a long walk, I bounced on my yoga ball, we had a spicy curry for dinner, I expressed some colostrum and did everything to encourage labour to kick-start. The midwife had seemed very optimistic, but there was no sign of the baby's arrival.

I was adamant that I didn't want to be induced. It had been a bad experience the first time and, in the pandemic, an extended time in hospital alone (at least initially) was the last thing I wanted. The midwife said she had to follow procedures and book me in, but she said the homebirth team would be supportive if I wanted to push it back a few days. And so, I was booked in for induction on the 20th of June.

On the 18th I remember having a fairly relaxed day. I'd tried everything the day before, so we just got on with our regular day-to-day lockdown life. That evening we got the boys to bed as normal and my husband had his regular weekly computer games night, so I had an evening of bouncing on my yoga ball whilst watching TV.

As the evening progressed, I started to feel a bit of discomfort and at around 9.30pm, I realised that it might be the night. I decided to go and get some sleep. I think the nerves were kicking in and now I wanted to slow things down.

The baby, however, didn't want to slow down and by 10pm I realised I definitely wasn't getting to sleep. I went back downstairs and told my husband who had just finished his games night. Within another half hour we were sure enough to call the midwife who arrived around 11pm.

My previous labours had been long, so when she offered to examine me, I said yes, definitely. I wanted to know how far along I was. When I couldn't get into a comfy position to be examined I remember her saying that it didn't matter, she was confident I was in established labour and her only question was whether the baby would be born that day (within the hour) or the next day.

The next hour is a bit of a blur and I mostly remember lots of "I can't do this ..." and the reassurance from my husband and midwives that I could!

Our little girl, Daisy, was born at 12.10am in our living room, something that I'm not sure would have happened if it was not for Covid. After an hour or so of breastfeeding I was able to enjoy a shower and some crumpets before heading up to my own bed.



Caroline with newborn baby breastfeeding



Newborn baby

The boys slept through it all and were surprised with a baby sister when they came in to wake us the next morning. This was a beautiful moment, and I can't imagine how I would have felt if I'd been alone in hospital and they weren't able to meet her so soon.

Having a baby in the pandemic certainly wasn't the easiest experience but in the weeks afterwards it had its advantages. My 9lb baby breastfed so much and so well that she was 10lb by two weeks old![1] There was no pressure to pass her around to visitors. The boys got to spend so much time with their little sister and now, one year later, the three of them are so close.

We've had an unusual first year with more homeschooling and a lack of the normal support systems, such as baby groups, for much of the year. However, I have been fortunate to spend lots of time with my family and close friends and towards the end of my maternity leave I managed some normality.

Daisy is a happy, confident little girl who has been on fast-forward to learn everything, walking at 10 months to try and catch up with her brothers. She is now at nursery and settled in so easily I think she was a bit bored of all the time at home with me! Whilst the later months of my pregnancy weren't what I planned, I am still fortunate to have an amazing daughter and to overall have had a positive experience.

Author Bio: Caroline lives in Reading with her husband and three children. She enjoys her day job as a Financial Adviser and in her spare time is a volunteer for her local NCT branch, Maternity Voices Partnership and the school PTA.



Article

Keeping up with the updates

by *Nadia Higson*



In March 2020 as the country went into lockdown, calls to the AIMS Helpline shot up. We were hearing from women who'd been told with almost no notice that midwifery support for a long-planned homebirth would not be provided; that they would have to attend scans alone, that they could not have their partner with them in hospital until a midwife deemed them to be in 'active labour' – or sometimes, even at all. It quickly became clear that, whilst some NHS Trusts were making imaginative efforts to maintain choice and ensure that pregnant women and people could have the support they needed, others seemed to have just thrown up their hands and decided that it was all too difficult.

On 9 April, NHS England published a '[Clinical guide for the temporary reorganisation of intrapartum maternity care during the coronavirus pandemic](#)' [1]. AIMS welcomed this with the comment that “it provides a good reflection of what women are telling us they need at this difficult time, and should provide a useful guide for Trust Boards across the country.” There was much to applaud in this guidance. It included recommendations that Trusts should: publish information about their current maternity care provision in

a readily accessible format; not suspend any services unless they had considered “alternative options, such as deploying returning retirees and independent midwives”; and that they should keep “as many options available for as long as possible” and “consider maintaining at least one midwifery care option”. We also welcomed the recognition of the need to prevent “avoidable perinatal mortality and morbidity (including issues relating to mental health and wellbeing)” and continue “to provide a personalised risk assessment” (for our full response see [AIMS Response to the NHS Clinical Guide to Trusts on Maternity Service arrangements during the Coronavirus period](#))^[2].

Despite this, in many areas it continued to be the case that midwifery care models disappeared or were severely restricted, blanket restrictions on supporters were being imposed, and maternity services users were struggling to find reliable information. In response to this, I hastily drafted the first version of the AIMS [Coronavirus and your maternity care](#) ^[3] information page – little knowing what I was letting myself in for over the next 18 months.

The first version was relatively short. It included links to the NHS England guidance, and the additional guidance which began to be published by the Royal College of Obstetricians and Gynaecologists. It described what little was then known about the risks of coronavirus in pregnancy and for babies, and detailed what care and support (according to the guidelines) pregnant women and people should be being offered.

But then there were updates to the guidance. And further updates. And additional guidance covering particular aspects of maternity care, and new questions that needed to be addressed. My ‘baby’ started to grow at an alarming rate! At the last count it stood at about 12,000 words. It also needed constant ‘feeding,’ as every time a new version of the guidance was published or a new document came out, I had to read it, digest it and update the page. RCOG in particular had an annoying habit of publishing updates on a Friday afternoon. I lost quite a few weekends that way.

As the pandemic progressed, I discovered that the four nations of the UK were each publishing their own guidance. As AIMS is a UK-wide charity, that meant locating and including the different guidance for Wales, Scotland and Northern Ireland, and then checking at intervals to see whether anything in those had changed.

This meant that I experienced a very weird mix of feelings whenever new guidance appeared. Pleasure, when things were being clarified or positive recommendations added. Frustration when things remained unclear or seemingly unreasonable recommendations were left in – despite AIMS lobbying. And an overwhelming sinking feeling of “Oh no, I’ve got to update it *again!*”

But it has been worthwhile. Our website statistics show that up to March 2021, the page had been accessed almost 27,000 times – so hopefully it has helped a lot of people. Usually, AIMS Birth Information pages go through a process of peer review before they are published, but, strangely, I found it hard to persuade anyone else to read all the guidance and check that I’d got it right – so any errors are entirely my fault. I am, however, very grateful to the various Helpline colleagues who proofread it for me, and also checked all the links every time a document was moved to a new web location.

Nadia Higson is an AIMS Trustee. She also volunteers as AIMS Coordinator, and as a member of the AIMS Helpline team and the Campaigns Steering Group. She was the principal author of the AIMS Guide to Induction of Labour and has written several of the Birth Information pages on the AIMS website, including “Coronavirus and your maternity care.” She is also an NCT Practitioner and a user representative on her local Maternity Voices Partnership.

ENDNOTES

- [1] madeinheene.hee.nhs.uk/Portals/0/Clinical%20guide%20for%20the%20temporary%20reorganisation%20of%20intrapartum%20maternity%20care.pdf
- [2] www.aims.org.uk/campaigning/item/response-clinical-guidance-coronavirus
- [3] www.aims.org.uk/information/item/coronavirus

Article

“A Colossal Failure of Workforce Planning”: exploring the 2021 NHS Midwifery Crisis

by Dr Lisa Common RM, Consultant Midwife

AIMS Campaigns Team comment: As we go to press, thousands of people – service users, service providers and others – are preparing to protest as part of the nationwide vigils being organised under the [March With Midwives\[1\]](#) banner. They are seeking attention for what is being discussed as the worst UK midwifery staffing crisis in living memory. The AIMS Campaigns Team is pleased to publish this piece by Lisa Common, Consultant Midwife, which offers an important perspective on the current situation: how it came to be, the impact it is having on midwives and service users, and how we might move forward together. A shorter version of the piece was originally published as a guest editorial in Roy Lilley’s e-letter on 8 November 2021: “It doesn’t add up: counting the cost of the midwifery workforce crisis” [\[2\]](#). We thank Lisa for offering AIMS this excellent briefing, and for giving us permission to share it here with our readers.

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Giving birth continues to be the most common reason for admission to hospital. In 2020, England and Wales welcomed over [615,000\[3\]](#) babies into the world. At its best, midwifery is supporting families through pregnancy, birth and into the early days of parenthood. If we agree that every birthing person needs a midwife at their side, why then have midwifery workforce numbers been left to shrink to dangerous levels?

NHSE/I (NHS England and NHS Improvement) refer rather quaintly to ‘gaps’ in the workforce. This really does not do justice to the scale of the current recruitment and retention crisis in midwifery. Donna Ockenden, Chair of the review into maternity cases at Shrewsbury and Telford NHS Trust, recently likened the staffing crisis to a bathtub without a plug – seeing midwives disappearing down the plughole and leaving the profession forever. The current numbers of student midwives in training will not be enough to refill the bathtub – or replace the experience and skills of those midwives who have already drained away. We

need to put a plug back in.

The workforce supply problem has certainly been exacerbated by the pandemic, but the multitude of challenges that were laid out by the [RCM\[4\]](#) in 2017 warned of a gathering storm. The report highlighted that over a third of midwives were already in their fifties or sixties – signalling a ticking retirement timebomb. At the same time, student finance changes ended student bursaries and introduced tuition fees. The [RCM\[5\]](#) warned that this would impact on application rates. This has now been confirmed by HEE (NHS Health Education England)’s [RePAIR Report\[6\]](#). We know that applications to become a midwife have decreased ([c.35%](#)) [\[7\]](#). We also know that student midwife attrition has increased ([c.31%](#)) [\[7\]](#). The most common reason students gave for quitting was ‘financial’. The Chancellor’s latest budget made no mention of funding for HEE, the arms-length organisation that arranges and pays for all the training of new midwives.

In April 2021, NHSE/I [announced\[8\]](#) that maternity units could use a share of their recent £95.9m investment into the service to help recruit 1,000 midwives. Their expectation is that all maternity services will be fully staffed before April 2022 in line with [Birthrate Plus\[9\]](#), the approved safe staffing toolkit. This rings hollow when there are few midwives on the market to recruit and the [parliamentary committee \(p52\)\[10\]](#) reported in July 2021 that a *minimum* of 1,932 were needed.

Current NHS strategies to cover midwifery workforce ‘gaps’ commit over £70m annually for agency, bank staff and overtime. The [announcement\[11\]](#) of £4.5m to support the recruitment of 400 international midwives by the end of this

financial year has the feel of a sticking plaster solution. There is no global over-supply of midwives. Not only does this raise concerning ethical questions regarding the drain of midwives from where they are needed in their countries of origin, owing to much higher maternal and neonatal mortality and morbidity, it demonstrates a colossal failure in proactively planning for a sustainable midwifery workforce.

Chronic staff shortages have led to despair and burnout. A recent [survey\[12\]](#) of midwives by their Royal College identified that 8 out of 10 felt concerned about staffing levels and over two-thirds were not satisfied with the quality of care they were able to deliver. Midwives want to be able to provide safe and compassionate care, but when some units have midwifery vacancy rates and maternity leave and sickness absence in the region of 20-30%, and shifts sometimes staffed with just 50-60% of what they need to be safe, the system is seriously failing them and the families they care for.

[The parliamentary report into the safety of maternity services\[10\]](#) investigated how the under-investment in workforce was contributing to an exponential rise in the cost of clinical negligence claims to [NHS Resolution \(p.46\)\[13\]](#) for obstetric harm. In 2020-21 this accounted for a whopping 59% of the £7.1 billion total, up 9% from last year.

So, what does a maternity unit in distress look and feel like?

- Midwives feel increasingly fearful that they cannot deliver against the professional standards detailed in the NMC Code[14].
- There are not enough staff to manage the demands on the service, meaning women get less time and care from midwives.
- There is a lack of capacity to ensure women living in areas with high levels of social deprivation, or women from Black, Asian or ethnic minority backgrounds, are receiving the level of care needed to prevent [worse outcomes for them and their babies\[15\]](#).
- Units find they must close temporarily more often as there aren't enough staff or beds, which means women are asked to travel further to get to a unit that can provide care.
- Midwives, under workload pressures, struggle to give one-to-one care during birth, meaning opportunities to spot the early signs of deterioration and avert a disaster might be missed.
- Home birth services get suspended, depriving women of this choice (see editor's note)[16].
- There are delays for women trying to speak to a midwife when they are worried about themselves or their babies, leaving them feeling frightened, alone and at risk.
- Changes to services during the pandemic have led to a rise in [anger and aggression towards staff\[17\]](#) who already feel despair and that they are letting families down.
- Services are being stripped down to basics, meaning vital antenatal education - that helps prepare parents for the emotional and physical demands they can expect when a new baby arrives - is sparse.
- Capacity to deliver public health priorities - such as supporting smoking cessation or breastfeeding, or ensuring women receive appropriate mental health support - becomes patchy.
- Midwives not having enough time to do home visits - visits where they can spot warning signs that families are struggling emotionally or financially or if there may be any threats to safety in the home.
- More parents leave maternity care having experienced trauma and being left with symptoms of PTSD, leaving individuals to deal with the fall-out of anxiety and depression and potentially contributing to family breakdowns.
- Vulnerable families fall through the cracks that can lead to [Adverse Childhood Experiences \(ACEs\)\[18\]](#) that cast a long shadow over the lives and life chances of babies born today.

What may help change all this? Here are my top five suggestions:

1. A sharper focus on the retention of existing midwives. [Data from the past decade\[19\]](#) shows a real-terms fall in midwife pay of £1,813 pa. Pay midwives what they are worth. Commit to offering flexible working patterns to midwives who need more support during the menopause or as they approach the end of their careers.

2. Given the impact that changes to student finance have had on student midwife applications and retention, why not scrap tuition fees and re-introduce bursaries to help widen participation? Or even forgive student debt once a midwife has served at least five years?
3. Mandate best practice for preceptorships[20] so that we close the ‘flaky bridge’[21] and [ease the transition from student to newly qualified practitioner](#)[22] with better support.
4. We could diversify the maternity workforce by accelerating implementation of the [Maternity Support Worker \(MSW\) Career Development Framework](#)[23] to improve workforce capacity at pace.
5. Why not task universities and NHS trusts to work together to offer the [midwifery degree apprenticeship](#)?[24]
This has the potential to create a sustainable pipeline of staff who could use the apprenticeship framework for MSWs to progress to Assistant Practitioners and onto a midwifery degree apprenticeship.

A nationwide grass-roots initiative has emerged to help facilitate the organisation of vigils around the country and to establish a network of allies to share their outrage at this growing national calamity in maternity services. Visit the [March With Midwives UK Facebook page](#)[25]. Midwives cannot keep [consuming their own smoke](#)[26] – they need birthing people, parents, grandparents and advocates to amplify their voices.

The NHS is failing midwives. They are burnt-out, fearful, angry, and abandoning the profession as a result. In turn, this means that the NHS is also failing too many birthing people, babies, and families: putting them in harm’s way. This is not the type of service that midwives can tolerate providing any longer. We all deserve better.

Dr Lisa Common
Consultant Midwife

Disclaimer: All views expressed in this article are my own and not those of my employing organisation or their affiliates

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Article

Covid-19 and women's reproductive health

by Katherine Handel



In this issue of the AIMS journal, we have heard stories from women who experienced pregnancy, birth, and life with a newborn during the lockdowns brought about by the Covid-19 pandemic. Alongside these women, there were those who experienced another phenomenon: a change in their menstrual cycle. I have personal experience of this because I was

one of them. Ironically, as life became more monotonous, there was at least one element of surprise, though it was of a most unwelcome kind. My cycle length, which had sat around 23 days since the birth of my son nearly three years previously, suddenly started to vary to between 20 and 42 days. Initially, I didn't connect this to the pandemic because I'd suffered from irregular periods as a teenager and also during my early twenties. However, when I learned that other women were experiencing the same thing and that the pandemic and its associated lockdowns were potentially the cause, I became curious. What was going on?

When I looked more closely, I found that there is a link between increased stress and changes to the menstrual cycle. Constant stress can lead to unregulated levels of the hormone cortisol, which is usually only released in order to respond to perceived threats. Excess cortisol can suppress the reproductive hormones in the body, disrupting the menstrual cycle and leading to increased symptoms of PMS. In this way, mental and emotional stress is also expressed in the body.

Although a lot of research in this area is still in its initial stages, there have been some studies. An informal survey by Dr Anita Singh via her Instagram account showed that

65% of the women who responded said that their cycles or hormonal symptoms had changed[1], and she is currently carrying out a more formal study [2]. Another study of female healthcare providers in Turkey who had previously been experiencing regular menstrual cycles found an association between symptoms of ill mental health brought on by the Covid-19 pandemic, including anxiety, stress, and depression, and an increased likelihood of an irregular menstrual cycle, with 273 of the 952 participants reporting changes to their cycles[3]. Another paper, which is awaiting peer review, shows a significant association between increased stress and worrying about family and personal health, along with stress about job security, and changes in menstrual symptoms[4]. Finally, there is some evidence that Covid-19 itself can cause changes to menstrual cycles, although as the sample size in this study was quite small, more research is needed[5].

These studies demonstrate the disruption that a situation of high and constant stress can cause to the menstrual cycle. And the lockdowns certainly brought plenty of additional stress: aside from worries about the virus itself, other factors such as employment insecurity and associated financial strain, the need to combine working from home with childcare and/or homeschooling, fears about obtaining adequate supplies and medications, and isolation from normal support networks also played a role in making life more stressful. Given that in many families, women bore the brunt of many of these difficulties[7], it's perhaps not surprising that many of us experienced changes to our menstrual cycles.

When we look back on this time, it is likely we will find that the pandemic's effects on women will extend beyond the menstrual cycle to affect other phases of their reproductive lives. Some parallels may be drawn from other events in recent history, such as data gathered from the Spanish flu pandemic in the early twentieth century

and in the aftermath of the 9/11 terror attacks in 2001, both of which had notable consequences for pregnant women and their babies[7]. The long-term implications of the changes that women have experienced during the Covid-19 pandemic and their potential knock-on effect to women's reproductive health are yet to be determined, and it is clear that more research is needed[8]. This highlights both an increased need for awareness of how stressful situations can affect women's menstrual cycles and one of the many gaps in our knowledge of the workings of the female body[9]. The increasing reports that the Covid-19 vaccine causes disruption to women's menstrual cycles have highlighted another blind spot in this area that requires further research[10]. Speaking personally, as someone who was considering trying to conceive during this time, the changes to my cycle brought additional challenges and uncertainty, but also increased insight into how my body responds to stress – a timely reminder of the connection between mental and physical health, and the importance of taking care of both.

Katharine Handel is an editor and researcher, and a former co-editor of the AIMS journal. She is also one of the coordinators of The Motherkind Café and the Oxfordshire post-natal peer support group for women who are concerned about their mental health after having a baby. She lives in Oxfordshire with her husband and son.

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Article

Maternity in a pandemic: a personal perspective

by Jenny Smith



Nothing can prepare you for the unexpected shock of a pandemic and it certainly caused a ‘swirling in my head’. I had an overwhelming sense of responsibility for the safety of the mothers, babies, families and my ‘professional family’ on top of my own family at home. In maternity, as with the rest of the NHS,

the changes to fight this killer virus, came thick and fast and there were so many adaptations in quick succession to try to get ahead of the curve.

On entry to hospital at the beginning of the pandemic, all visitors had to be stopped and asked about Covid symptoms and to have their temperature taken with a thermometer. This soon extended to staff too; temperatures were checked and registered on hospital identity cards when checking in. The ‘new normal’ quickly became a sea of temperature checks, hand gels, Covid testing and PPE.

At the outset, there was much confusion as to what was best for pregnant people. Initial recommendations included masks and isolation, avoiding all busy public areas. Now guidance is much clearer.^[1]

I remember all too well that, in January 2020, a pregnant woman told me that she could not taste or smell but felt well. This, of course, is now recognised as one of the main symptoms of Covid. There were women I looked after who had to begin labour and give birth without their partners who had to look after the other children at home, so as midwives we had to take over the role of the partner too.

This was hard for the women, but through telephone calls and FaceTime we did our best to involve their loved ones as much as possible.

Perhaps the most unpredictable aspect of this virus is that a person can be symptom free but can pass it on at an alarming rate as a ‘super-spreader’. This is especially dangerous in hospitals, as pregnant women are immunosuppressed and other patients are also more susceptible to infection.

As for vaccination in maternity, there was initial uncertainty around its safety. Understandably, this created a ‘minefield for the mind’ – increasing anxiety amongst pregnant women, knowing they were in a vulnerable group. Globally, scientific knowledge has now clarified that, as far as we know, vaccination in pregnancy is safe, and not having one poses a greater risk to health.

Meeting Alice

Over decades I feel incredibly happy to have been a caseload midwife offering pure one-to-one care: ‘holding women by the hand’ throughout pregnancy, birth and afterwards. I first met Alice in her first pregnancy, and she was booked for a planned caesarean in the pandemic. I will never forget her pregnancy and birth; I was amazed at her strength in circumventing her unexpected journey and felt so fortunate to be her midwife.

Alice in her own words

Following the routine pre-op tests in advance of an elective section, I was told the night before my operation that I had tested positive for Covid, which meant my husband wasn’t allowed to join me for the birth of our first baby. It was suggested that I could bring another person if they tested negative, but this would mean that they would need to isolate for 10 days afterwards and I felt this was too much to ask.

We were both devastated, and I rang Jenny immediately afterwards to talk about the process, which now seemed more than slightly overwhelming. Luckily, Jenny and I had formed a strong bond through the previous months and she expertly and empathetically guided me through what was going to happen the following day.

Following many tears, my husband dropped me at the hospital early in the morning and Jenny met me at the door to take me to the ward. As I was positive, they had to take extensive precautions including full PPE for any member of staff who came into my isolation room. Jenny stayed with me the whole morning to discuss every tiny detail of the process and perform all my observations.

At the time, some women with Covid had unfortunately been found to decline rapidly following caesarean operations and were ending up in ICU. The surgeon came to see us to discuss this, and we had to decide whether to proceed with the operation or wait in isolation longer still and without my husband. Jenny and I were left to digest the information and, following lengthy discussions with the anaesthetist, my husband (via FaceTime) and the surgeon, we decided to go ahead as planned.

On balance, I decided that it would be better to get the baby out safely while my body was still healthy, rather than wait and risk my health declining. I had read an article called 'The natural caesarean: a woman-centred technique',^[2] watched a film of the same name on YouTube by the Jentle Childbirth Foundation^[3] and knew this was what I wanted for the birth of my little boy.

Jenny and I walked to the theatre together and met the team who were all incredibly kind and understanding. It was a bit surreal seeing the whole team in complete Covid protection PPE: 3M masks, special gowns, full visors, glasses and gloves.

As the natural caesarean started, Jenny talked me through every step and I remember the strange feeling in my tummy as my baby was born safely. It was so wonderful having my baby skin-to-skin in theatre and holding him tightly, which made the rest of the operation go quickly and it was so lovely to have all the photographs of the birth to show my husband afterwards.

I was then transferred to an isolated room for my recovery, where Jenny stayed with me to do all the observations and guide me through my first attempts at

breastfeeding. Unfortunately, later that day my temperature spiked and my son and I both had to go on antibiotics, as the team were worried it was a deterioration of my Covid condition. We stayed in hospital for three days and Jenny was ever present, coming in to check on us whenever she could.

Despite it being incredibly difficult not having my husband with me, the medical team made it as peaceful an experience as possible. That said, I would not have been able to do it without Jenny by my side. Her knowledge, warmth and support made what could have been an incredibly difficult few days, into a manageable and calm experience.

Saying goodbye to Jenny when we were finally allowed to go home was an incredibly emotional experience. She had single handedly guided me through the birth of my first child and my first few days of motherhood – words will never be able to express how grateful I am to her.

Jenny again – a personal reflection

I feel so grateful that I chose midwifery as my career path. The relationships with women and their families are so special and became even more so during the pandemic when many did not have their loved ones with them during labour and birth. The 'professional team' is like a second family and, on a day-to-day basis, working in the NHS is all encompassing.

In my lifetime, I would never have imagined that we would have experienced a pandemic, where everyone knows someone who was ill or died from complications related to Covid, and yet we all experienced the best of humanity at the same time.

Jenny is a clinical NHS midwife, Founder of Jentle Childbirth Charity and Birth Continua. She believes in 'comfortable' childbirth and her mission is to change 'maternity architecture'.

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Story

My pandemic birth story

by *Liz Thomas*



Last week, as I watched my baby daughter taking her first steps, I thought about what a strong and determined kid she has become, and how her reaching this milestone is really something of a miracle given that for a long time we weren't sure whether she'd be with us at all.

In September 2019 Owen, my husband, and I found out

we were expecting our third child. We'd recently moved house and – both of us teachers – had found new jobs in the area. We were looking forward to this chaotic but exciting new chapter of our lives, with a new baby sibling on the way for our son Matthew, four, and daughter Anna, two.

In the December that followed, our lives changed dramatically. I was at work teaching French to a class of year 7 students, when I suddenly started bleeding. I was taken to hospital just 17 weeks into my pregnancy. Blood clots had formed in my womb and I continued to bleed for several weeks. At 20 weeks we had a scare when it was thought I could be in early labour and was taken to the labour ward in Southampton hospital. Luckily, this was not the case; I could leave hospital, but the doctors had advised bed rest to protect the baby. We realised that we would need to temporarily move in with my parents, as I would be unable to care for my other children. However, at 30 weeks pregnant, and as the very real threat of the coronavirus pandemic became apparent, staying at my parents' home was no longer an option. We needed to move back home to protect my parents from contracting Covid-19.

To get to 31 weeks of pregnancy felt like an achievement as we had already experienced a rollercoaster of emotion not knowing if the baby would survive. She was born on 23 March 2020 – nine weeks early – weighing just 2lb 15oz. It was the same day that the prime minister announced Britain

would be going into national lockdown and the same day that the neonatal ward had to close its doors to more than one parent. After the birth, the superb team of staff quickly checked she was breathing and for vital signs and then allowed Owen and I to have a brief cuddle with her before she was taken away in an incubator to the neonatal ward.



I was initially mostly just overjoyed that she had made it, which at the time overrode any fear of Covid-19, and Owen and I were in complete agreement that it was the right decision to keep NHS staff, babies and parents as safe as possible. However, the impact of the pandemic soon became apparent. Our tiny baby had to stay in hospital and only I could enter the building to see her and then, I could only hold her when wearing full PPE. Even deciding on a name was hard without Owen even having seen his daughter since the birth, but after three weeks, we chose Julia.

Owen, in particular, was experiencing stress as he adapted to remote teaching for work whilst trying to take care of our now five- and three-year-olds. We had to effectively split our responsibilities for looking after our family. Every day, I'd have to drive the 1½ hr round trip to Southampton hospital, then put on apron and mask so I could see Julia and express milk to syringe-feed her. After the stresses of the pregnancy, this was exhausting, and so once or twice a week Owen would drive all four of us to the hospital. He would have to



wait for up to five hours outside in the car park, keeping our other two children entertained whilst I was inside with Julia. I remember one time looking down over the almost empty car park and seeing my son on his bike. One of the staff kindly held baby Julia up to the window so that Owen could see her. This was his first glimpse of his baby daughter

since her birth, which was a surreal but significant moment.

Things became more difficult when Julia began to have various complications, most of which were things that we had never imagined. In particular, I remember a phone conversation with the excellent endocrine doctor who told us that, amongst other complications, she may not have any ovaries. This would have usually been a face-to-face conversation and was very hard to process whilst listening on a speakerphone in the kitchen with our other two children in the next room.

We had complete trust in the NHS staff but the conditions imposed by the pandemic made it very hard for Owen to connect with Julia in those early weeks. vCreate, an NHS-trusted video messaging service for sharing pictures securely, helped a little, but of course was nothing compared to real human contact and I think he felt he missed out on having time with her at the start.

After nearly six weeks in hospital, Julia came home and our family could finally be together for the first time. Once she was home, I found the round-the-clock care needed for a premature baby to be extremely intense, especially as Julia wasn't gaining weight or breastfeeding well. The main difficulty caused by Covid-19 was that we couldn't have any help from friends and family with looking after the other two children despite them living close by. But I was also grateful to have Owen working at home because I don't think I could have coped without him. The NHS home team were also very supportive and helped us through a very difficult time. Friends were kind but people were naturally focused on the pandemic, and so we were so grateful for the NHS staff who understood what we were going through and made time for us.

Julia has had a very challenging start to life and for a long time I was taking her to nearly weekly appointments at the

hospital for physio, though the necessary restrictions meant that Owen wasn't able to attend any of these. We also needed to take Julia to A&E a few times – once after staff discovered haemangiomas[1] on her liver which I remember reading about as a condition that could possibly lead to heart failure. This was very hard to process. It seemed that as one issue was sorted, another would appear and all at a time when Covid restricted our ability to be in those difficult moments together and seek support from family.

By Christmas 2020, when Julia was nine months old, Owen said he felt he'd been able to bond with her a bit more, and to see her smiling and growing is so wonderful after everything that's happened. As parents we have had to become more resilient and looking back we can see how far we have come.

Looking at Julia now, she is a bright and joyful little girl and seemingly fearless of the world she's growing into. In the 18 months since she was born we've overcome so much as a family. The challenges of Covid continue to come and go but I feel that since last year our sense of reality has changed and I'm not surprised by things when they happen any more. And I must say that we will forever feel hugely grateful to the NHS staff for all they have done and continue to do for Julia and we will always count our blessings.[2]



Liz Thomas is a part-time secondary foreign languages teacher and lives in Lymington with her husband Owen and her 3 children.

[1] Editor's note: Hemangiomas are benign (noncancerous) growths made up of blood vessels.

[2] Editor's note: Unlike in the early days of the pandemic when Julia was born, most neonatal units now allow both parents to visit together, for all or a large part of the day. This AIMS information page may help keep you up-to-date - Coronavirus and your maternity care

Article

My Story

by Hannah Lyons



I gave birth to Stephanie Joy in February 2021. Being pregnant, giving birth and being postpartum in the pandemic was extremely hard, both because of the effect on our lives in general and on maternity services. Stephanie is my second baby, and having conceived her towards the end of the first lockdown I rapidly hired an independent midwife. I had been dissatisfied with my NHS care when birthing my first, Charlie, at home, and I was eager not to have any issues with the NHS Reading Homebirth Team's availability during the pandemic. I was terrified in particular of issues with access to the birthing centre for my husband. I knew independent midwives would be in greater demand than usual but, unlike the NHS Homebirth Team, she was able to keep doing all antenatal appointments at home throughout the pandemic.

Not long into the pregnancy I contracted food poisoning, and my midwife recommended I go to the Early Pregnancy Unit (EPU) at our local hospital, the Royal Berkshire (RBH) – my symptoms suggested an ectopic pregnancy. Partners were not being admitted due to COVID. Scan pictures could not be obtained, and photographing the screen was forbidden.^[1] It was too early to see a heartbeat, so I was told I had a Pregnancy of Uncertain Viability and given a follow-up appointment. It was extremely distressing for me to go alone, and I drew pictures of the scans for my husband; at this point the

embryo looked like a grain of rice. The next appointment showed a heartbeat. I was diagnosed with a *Campylobacter* infection (the previous theory had been viral gastroenteritis), which came with a significant miscarriage risk. I was given a third appointment a fortnight later to check if the heart was still beating, which was even harder – we were finding out if our baby was still alive rather than if they had ever been 'viable'.

Communication regarding partners' access to appointments was terrible. The announcement that partners could now attend scans and antenatal clinic appointments was made on Facebook – it was unclear exactly what was included. I was furious. Why was this communicated via a social media platform? What if women turned up alone without having heard only to find that others had brought partners? The posts seemed annoyingly chirpy – as if we should all be thrilled to have access to something that should be a right. At this point I had two appointments booked – my third at the EPU and one at Rushey Birth Centre in RBH, for booking-bloods^[2]. Although the post had suggested both would be covered by the policy change I called the EPU to ask if they were included and was heartbroken to hear that they were not. The EPU fell under gynaecology, not maternity, so this was not an 'antenatal' appointment, and they had cancer patients who were not being allowed visitors, and who would not handle it well if I was walking past with a partner. I felt that the stress of complicated issues of policy-making was being passed to me, the patient, and that concern over complaints was eroding empathy in decision-making. I was appalled to hear that Reading Maternity Voices could not represent me as the Early Pregnancy Unit, despite its name, did not fall under their remit. The impression given was that the hospital did not regard me as actually pregnant – mine was a gynaecological issue. I felt like the suggestion was that I was not supposed to be emotionally attached to a pregnancy and baby which did not, in the institution's eyes, exist yet, and so I should not need support to hear if I had miscarried.

The impression given was that the hospital did not regard me as actually pregnant – mine was a gynaecological issue.

This shines a light on a general issue in terms of the NHS's attitude to the father in pregnancy, at birth and postpartum. RBH already had restricted visiting hours for partners on postnatal wards before the pandemic. When the pandemic hit, visiting on postnatal wards was axed. A father has a right to be there to hear that a pregnancy has been lost, and he has a right to bond with his baby. Restricting his access gives the impression that childcare is women's work. I had lived in fear of needing postnatal admission with my first baby because of the conflict of my husband refusing to leave if we couldn't obtain a side room (for which we would need to pay). This stress was dramatically increased second-time round by knowing that fathers can't refuse to leave if they're not admitted, and are being blamed for infection hazard to others and for supposedly not joining in the mass project of pandemic-fighting. In such circumstances expecting access to one's baby is viewed as practically unpatriotic.

Now the system was being set up as a guardian angel and I felt small, powerless and angry in the face of it.

The rainbows in windows and 'We love you NHS' signs felt uncomfortable to me – the NHS had already seemed almost impregnable on complaint. Now the system was being set up as a guardian angel and I felt small, powerless and angry in the face of it. I was already traumatised by my care when I was injured in a car crash when Charlie was four months old. My week-long hospital stay had been dogged by incident after incident of terrible treatment regarding me keeping him with me and exclusively breastfeeding. My pages-long complaint had caused me to be invited to address the Trust Board there, and the Chairman had apologised that they had failed me, and said that they would endeavour not to fail others. I could not blindly trust the NHS, and I was frightened by a world that seemed determined to.

Having got through the EPU appointment, thankfully with good news, I had my booking telephone appointment with my allocated NHS midwife, who confirmed that I could bring my husband for booking-bloods. Thrilled to finally go to the hospital together, I arranged childcare for Charlie. I was then called by a midwife at the birthing centre to check I had no COVID symptoms before coming in, and told that I must come alone.

As I was still very seriously ill at this point due to an inexcusable delay in getting the correct prescription, I told the midwife that I would not come without my husband, and to cancel the appointment. She insisted that I must speak to someone more senior, so I then had the community lead midwife on the phone to remonstrate with me. I pointed out that this was a routine appointment – it was not to treat anything wrong with me. I was tired of going alone and not well enough to make it remotely worthwhile. She told me that it was important I be tested for conditions like sickle cell anaemia. Horrifiedly amused, I told her that I had had booking-bloods for my first baby, and I was not going to have developed any genetic conditions in the intervening period. I asked for a full list of things tested for, and identified antibodies as the only one of interest. Since I didn't really need that information until after the birth, I told her there was no need for me to have the blood tests now.

I expressed my complaint at how partners' access was being handled, and the community lead midwife agreed to pass it on. The email I then got from the matron said that she'd been told I wanted to discuss my care (rather than that I had complained); I was exhausted and deflated enough that I never replied.

When I asked my allocated midwife she said she had realised her mistake after telling me that my husband would be able to attend the booking-bloods, but had not thought to update me as she had so many people to deal with. She had expressed bemusement at my choice to hire an independent midwife, and I pointed out that not being one of many was one of the reasons why I had done so. I felt that she was treating being able to bring a partner as a minor detail; it seemed like nobody in the system was paying attention to how important the issue was.

I gradually recovered, although I had significant post-infection food intolerances. I arranged private scans in order to be able to bring my toddler as well as my husband. By the time I had issues with bleeding in the second trimester I was able to bring my husband with me to RBH. I had my booking-bloods while I was there – I was told they couldn't release anti-D1 [3] to me unless I had them, partly as they couldn't access my records from my previous pregnancy. This was quite convenient – I also doubled-up my follow-up bloods later in the pregnancy with being in A&E for vertigo (checking for concussion).

As I headed into the third trimester we headed into another lockdown, and my mental health deteriorated. Having my husband working from home throughout the pandemic was a blessing, but it was difficult to keep Charlie occupied so he could work, and I felt lonely and isolated. Pre-pandemic we had gone to four baby groups a week and I had spent plenty of time chatting with friends including fellow Breastfeeding Peer Supporters and fellow tandem feeders. Now we felt very alone, and Charlie went months without seeing another child he knew. My midwife's visits were a major highlight – partly as she was the only person allowed in the house.

We missed our family terribly, and after the blow of the cancellation of the Christmas bubble because of local case rates I developed breastfeeding aversion. Charlie was feeding far more than he would have without lockdown due to the lack of activity; I had always fed on demand and learning to limit feeds when I felt resentful of needing to do so has been a slow and painful process.

The support bubble was a godsend, but also deeply frustrating. It seemed to make little sense to have to wait until after the birth when we desperately needed a mood boost beforehand. It was an emotional nightmare – who were we to pick? Could we legally use the childcare bubble, or would we recruit an additional birth partner? Switching bubbles was not an option for us – there was no way I was going to be able to give up external company for ten days. We decided to support-bubble with my parents. Despite them visiting regularly, I found the lack of variety of company postpartum extremely difficult – it was particularly painful not to be able to see my sister and show her the baby.

In the run-up to the birth there were increasing issues locally with ambulance availability, and we planned out the drive to the hospital should I need to transfer in labour. I was infuriated to read that in London some homebirths were being discouraged to try to relieve pressure on ambulances.

Stephanie was born in our bedroom, healthy and happy. The process took five hours, half of which we spent ascertaining that I was in labour! I went rapidly from working out that this was the real thing to transition, and my poor mental health was noticeable with me being very agitated and full of self-doubt.

Once our midwife arrived and I got in the pool everything settled. The water seemed magical.



I took my customary pre-birth nap floating in the water, then sprang awake to say that my waters had broken and the baby was coming. The midwives came running, and my independent midwife was a wonderful grounding presence. Having built a rapport with her across the pregnancy was completely invaluable.

Stephanie came eight minutes later and I lifted her out of the pool. My husband and Charlie leaned over the side to meet her. The placenta came of its own accord when I stood up, and she latched on after we'd got to the bed.

Nine months on, Stephanie is an eager crawler, and a wonderfully smiley, happy girl. The effects of the pandemic on having her have been wide-ranging and largely negative, but we are very blessed to have her father still working from home so we can all be together.

Author Bio: Hannah is a mother of two and loves books, comics, films and countryside walks. She has degrees in Biology and Publishing and is currently enjoying learning all about dinosaurs with her very enthusiastic three-year-old.

ENDNOTES

[1] Editor's note: Patients have a legal right to record a consultation as this article from the British Medical Association confirms: "Information disclosed during a consultation is confidential to the patient. Therefore, patients do not need

doctors' permission to make an audio or visual recording of a consultation". www.bma.org.uk/advice-and-support/ethics/confidentiality-and-health-records/patients-recording-consultations

Birthrights have obtained a lawyers opinion on this and confirm that partners should be able to join maternity scans remotely: www.themdu.com/guidance-and-advice/journals/good-practice-june-2014/patients-recording-consultations

[2] Editor's note: Booking-bloods are the standard blood tests offered to a mother when she books for her maternity care.

[3] Editor's note: Anti-D is an immunoglobulin, given to a mother with rhesus negative blood, that neutralises any RhD positive antigens that may have entered her blood during pregnancy. If the antigens have been neutralised, the mother's blood won't produce antibodies that could cross the placenta and harm a rhesus positive baby.

Choice in the Maternity Services – Expressing ourselves via poetry

When the AIMS Campaigns Team spotted that the theme of this year's National Poetry Day (October 7) was 'choice', they just knew this had the makings of an AIMS competition/book giveaway! With the help of the AIMS Journal Team, who agreed to take on the very tricky job of deciding our winner, the competition was underway...

Thank you to everyone who entered the competition. We really enjoyed reading all of your entries. The judges were tasked with selecting just one winning poem, and we are delighted to share that with you here.

So, congratulations to Catherine Bell, for the poem that the judges selected as overall winner. Alex, one of the judges, told us why she chose this chilling poem: "I was taken by the way that, as the reader, my attention was focused on the midwife and the father. This made me feel complicit, as if I too was ignoring the mother. I was disturbed by the way that we do not see the woman giving birth until the end - and then, only at the point of her defeat. It beautifully illustrates the idea that 'choice' is not part of what we see... when no one knows we are looking."

We hope that you enjoy reading Catherine's poem, and also the poems of our two runners up, Paula Cleary and Tessa Kowaliw.

Competition winner

Consenting number 3

a poem by Catherine Bell

"I'm off to consent Number Three"
Said the midwife on the busy ward.
Checking her watch, she marched away.
More checks on her arrival, in Number Three,
A monitor thumped, a machine beeped
And the midwife noted it all down.
A man sat in the corner of Number Three.
Looking lost, worried and bored.
The midwife smiled at him.
"I'm just going to see where you are at"
The midwife said, to no one in particular.
As she snapped on the latex gloves.
A groan rolled around room Number Three.
A low, primal, sound that was ignored.
"Time to get things moving along" was announced.
The man blinked in the corner of Number Three
As the midwife suggested it was time for surgery.
The source of the groan muttered.
The midwife and the man looked at the woman in Number Three.
She was saying 'I do not want surgery' between groans.
"Of course you do dear, you want the best for your baby"
The man nodded, as he stepped over to the woman in Number
Three.
"I just need more time", whispered the woman.
As she was patted and soothed condescendingly.
A doctor came presently to assist in consenting Number Three,
To get the ball rolling, to explain the reasoning
Interrupted and confused, the woman seemed to agree.

naïve hope over reality. The phrase ‘it all goes out of the window’ is a familiar refrain for pregnant women, subjected to the horror stories of their traumatised peers, and in truth it is evident that writing a birth plan is no guarantee of a positive birth experience.

It is in this context that Catherine Bell – Australia-based ‘birth cartographer’ – brings forth her new book *The Birth Map*. Boldly going where no birth plan has gone before. It is indeed a bold claim, as the literature on birth plans is not lacking – Google returns 18,400,000 results for ‘UK birth plan template’. However, Catherine Bell does succeed in offering both a refreshing perspective and a functional framework for ‘first-timers’ (or at least ‘first-time-birth-planners’).

Bell sets aside the standard chronological birth plan format, which works in a direct line from latent phase to the Golden Hour. Her Birth Map encourages parents-to-be to conceptualise their birth planning as a sort of spider-diagram, a logical and accessible way to think about options, alternatives and preferences. A benefit of this is that both ‘expected’ and ‘contingency’ outcomes are considered and catalogued in an equally integral, non-hierarchical way, which invites the reader to suspend their judgement about – and therefore their emotional attachment to – what is the ‘best’ way to have their baby. I anticipate this might be more useful in real life than a standard, linear birth plan.

The book is a practical and sensible guide to informed and personalised birth preparation. Although there is an evident preference towards an approach that highly values a straightforward and undisturbed birth, the focus remains consistently on knowledge acquisition and clear communication with care providers, rather than outcomes. Bell maintains a firm but gentle insistence that while birth ‘might not be predictable, it is preparable.’ (p43). Whatever path a birth takes, the ‘informed decisions’ developed during birth mapping can be applied, and Bell emphasises the grounded and rational nature of these, over the more vague and dismissible ‘wishes’ or ‘preferences’ (p44). In this, her clarification of the constituent parts of informed decision making (p27) is helpful, as are her realistic reflections on the implications of intervention (p29) and her insistence that all birth options are valid, so long as the mother feels ‘safe, comfortable and supported’ (p45). ‘Each point...[in your birth map]...is an Informed Decision’, she says. ‘You

don’t need to expand it with justification.’ Helpfully, Bell constantly contextualises the Birth Map, with references to further reading and alternative resources (although how helpful these are to a UK audience relying on free-at-the-point-of use NHS care is questionable). She further exhorts her readers to consider their options as whole humans, reflecting on their attitudes prior to pregnancy and thinking ahead to parenthood. Nearly a third of the book covers ‘Beyond Birth’, a vital reminder that the hard work doesn’t stop here.

However, while *The Birth Map* talks practical sense, I felt that it lacks some embodied reality. For example, when recommending appropriate clothing (p56), Bell describes how women may ‘feel hot’ during labour... in my experience, what most labouring women experience is a searing internal furnace. More substantively, as with most birth plans, Bell’s focus is arguably on the overt and obvious: those decisions that can be navigated rationally and calmly, and the complex, the emotional and the nuanced are neglected. Despite references to ‘detours and alternative routes...unexpected obstacle(s)’ there’s nothing here about how the process of birth itself, the roller-coaster of hormones, emotions and physical exertion, can effect decisions, nor yet the more shaded subtexts and subtle influences, such as heavy traffic en route to the birth place, the looming clock on the wall marking ‘progress’, or the act of coercion with kindness.

The challenge all birth plan formats face is how to prepare women to navigate issues that are not in their control.

The challenge all birth plan formats face is how to prepare women to navigate issues that are not in their control. Those who know birth recognise that outcomes are influenced by the philosophy of care on the day^[1]. A truly bold approach to birth planning might include information on the responsibility of clinicians and care providers to keep labouring women safe, secure and truly cared for. Of course, this is unrealistic in a system staffed by traumatised midwives and closely managed medics, and I don’t hold Catherine Bell to account for this. However, as a birth worker I confess I did not feel *The Birth Map* boldly

resolved the dilemma that consumes so many of us: how do we encourage women to demand what ought to be available to them while also bracing them for the reality?

All that said, *The Birth Map* is a constructive and pragmatic addition to the birth preparation canon and provides much food for thought. For anyone interested in the possibilities and politics of effective birth preparation, this text would make for an interesting and enjoyable read.

Reviewer Bio: Charlotte Tonkin Edun is a birth doula & hypnobirthing practitioner in Kent. She is writing an MA exploring women's experiences of birth plans at the Centre for Women's in Studies at the University of York.

ENDNOTES

[1] (2016) Beyond too little, too late and too much, too soon: a pathway towards evidence-based, respectful maternity care worldwide. [www.thelancet.com/journals/lancet/article/PIIS0140-6736\(16\)31472-6/fulltext](http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(16)31472-6/fulltext)

Book Review

Gentle Birth, Gentle Mothering: A Doctor's Guide to Natural Childbirth and Gentle Early Parenting Choices

by Sarah J. Buckley, MD

ISBN: 978-1587613227

Published by Celestial Arts

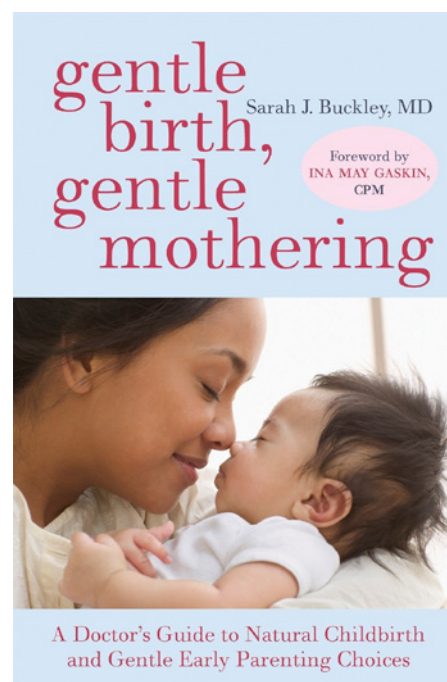
352 pages

Publisher's recommended price £12.99

Reviewed for AIMS by Sue Boughton

Sarah Buckley's book is an authoritative, incredibly well researched, guide to natural childbirth and parenting options. Some may find it reassuring that she is a family physician and a mother of four home-birthing babies. Skilfully blending ancient wisdom with up-to-date medical research, Sarah explains how a woman's body is perfectly designed to grow a baby in utero, give birth without assistance and protect and nourish her baby. There are many aspects of preparation, mental, emotional and physical, that

are important to ensure that the birthing process unfolds in the optimal way. One of the most important aspects is that the birthing woman feels safe, respected and does not feel observed during her labour; also, ideally she would be attended by a midwife that she is familiar with and feels safe with. Sarah Buckley's book explains why these are the basic needs for an undisturbed birth.



This is a beautifully written book that doesn't preach or try to tell you what actions and decisions you should take. It helps parents-to-be to become knowledgeable about birth physiology and medical interventions that will enable them to work towards trusting their bodies and their instincts. Sarah's book continues into the postpartum experience with wise words and well researched information about all the essential topics such as breastfeeding, sleeping and bed sharing, and early infant development. Again the emphasis is on following your instincts, equipped with wisdom and knowledge to help you make the right decisions for you and your family.

I find that this is a great book for partners as well as mothers-to-be; it often appeals to them because it contains excellent medical research as well as lived experience. Many people feel reassured as Sarah Buckley is a medical professional as well as a mother of four children. I have been recommending this book to my doula clients for years, I love it!

Reviewer Bio: Sue Boughton is a longstanding AIMS member and is a massage practitioner and doula from the North-East of England now living in London.

Book Review

The Sun Will Shine Again 'My Mummy Has a Poorly Mind'

by Jane Fisher

Illustrations by Amy Dignam

ISBN: 978-1-78972-866-8

Published by Independent Publishing Network

24 pages



This book is intended for families where the mother is going through mental health difficulties and is especially targeted at families with young children. It is a lovely book, with a positive message throughout, which reinforces the love within families despite difficult times. Having two children under seven, we read a lot of children's books and I've never seen anything quite like this. This book attempts to start the conversation about mental health with children; it is a conversation opener regarding what their parents may be experiencing. The book explores – in a way that should

make sense to even young children – how one's mind can be poorly, much like a physical part of the body. This is definitely how we should be thinking of mental health challenges. The whole concept of the book is fantastic – this is such a fundamental topic.

The illustrations are beautiful. This helps to keep younger ones engaged, and as an adult I loved looking at them, too! These illustrations also provide some easy to understand analogies, such as gloomy days vs. sunny days, which helps little ones understand some of the feelings articulated. The concept of the medicine bag at the end of the book was lovely, both simple and containing the fundamentals (e.g. kind words) without overcomplicating the issue for children. The illustrations are cleverly done: for example, the 'mummy' is looking away a lot and there are not many detailed pictures of a face: this means she can be imagined as lots of children's mummies and creates a more inclusive feel.

The overall message is summed up beautifully at the end; there is a focus on hope (i.e. things won't always be easy but positivity is key and things can get better with the right steps) and also (and most important for me) that mummy loves you. This is such a special book for children of parents who are struggling with their mental health, to reinforce the reality that they are loved.

The mental health specifics were perhaps a little one-dimensional, as they focused on depressive traits (i.e., there was no mention of some of other challenging mental health elements that can exist such as anxiety or psychosis). However, it is tricky to cover the whole spectrum and, indeed, this likely would be complex for the young reader. Obviously the book is also very much focused on maternal mental health; it would be lovely to see another version to use in cases of poor mental health on the part of a dad or partner.

I loved this book. My six-year-old daughter leapt up and gave me big hugs and kisses after reading it, and we had a discussion about the power of hugs, kind words and how they can make others feel. I hope that many other families will benefit from this lovely book in the years ahead.

Reviewer Bio: Rachel Boldero is an AIMS Volunteer who recently decided to pursue a career change to become a midwife. She is in her second year of study in South Yorkshire and loving the course.

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Birth Activists Briefing: NHS England Equity and Equality initiatives

by The AIMS Campaign Team

In response to recent MBRRACE[1] reports that show worse maternal and perinatal outcomes for those of Black, Asian and mixed ethnicity or from areas of social deprivation (see previous AIMS articles by Gemma McKenzie[2], Tinuke Awe & Clotilde Rebecca Abe[3], and Megan Disley[4]), NHS England has adopted two aims:

- * To improve equity for mothers and babies from Black, Asian and mixed ethnic groups and those living in the most deprived areas (where equity means that all “will achieve health outcomes that are as good as the groups with the best health outcomes”)
- * To improve equality in experience for staff from minority ethnic groups

Two recently published documents set out firstly, four pledges[5] for achieving these aims, and secondly, guidance for Local Maternity Systems (LMSs)[6] on how to align their Equity and Equality action plans with the health inequalities which exist in their areas. Their guidance highlights five priorities.

The four pledges

Pledge 1: The NHS will take action to improve equity for mothers and babies and race equality for NHS staff

This will be through a five-pronged approach. The ‘five prongs’ mostly consist of vague statements such as “take action on maternal mortality, morbidity and experience”. However, “underlying interventions” that aim to achieve these are detailed in the guidance to LMSs.

Pledge 2: Local maternity systems will set out plans to improve equity and equality

LMSs have until 30 November 2021 to submit an equity and equality analysis and to set out how they plan to co-produce an Equity and Equality Action Plan – the plan itself to be submitted by 28 February 2022. It is good to see the urgency of tackling these issues reflected in the tight time frame. However, AIMS wonders how much opportunity there will really be in such a short time to “work in partnership with women and their families to draw up the plans” especially when those most affected by health inequalities include many hard-to-reach groups. Accessing these groups and building trust is likely to need longer than this timetable allows.

Pledge 3: LMSs will receive support to improve equity and equality

£6.8m is being allocated to LMSs both to cover the development and implementation of their action plans and to “implement targeted and enhanced continuity of carer”.

AIMS believes that relational midwifery[7] care (Continuity of Carer) can make a substantial contribution to equity through the delivery of safe and personalised maternity care. Whilst any focus on improving the provision of Continuity of Carer is to be welcomed, we note that this is not a new target. The NHS Long Term Plan of 2019 stated that, “By 2024, 75% of women from BAME communities and a similar percentage of women from the most deprived groups will receive continuity of care from their midwife throughout pregnancy, labour and the postnatal period.”[8] AIMS hopes that a substantial portion of the budget allocated to LMSs will go towards ensuring that a robust and sustainable model of relational care is put in place at least for these groups.

Pledge 4: The NHS will measure progress towards the equity aims

As well as continuing to track maternal and perinatal mortality rates in Black, Asian and mixed ethnic groups and those living in deprived areas, there are also plans to develop ways of identifying ‘near misses.’ This should provide a broader picture of health inequalities than mortality rates alone.

The five priorities

The second document consists of guidance to LMSs.⁶ It sets out five priorities for tackling health inequalities with a list of possible interventions and suggested indicators for monitoring implementation.

Priority 1: Restore NHS services inclusively

This is about addressing the widening disparities in access to NHS services that developed during the pandemic.

Priority 2: Mitigate against digital exclusion

This includes ensuring that face-to-face care is offered to those who cannot use remote services, and that, “personalised care and support plans (PCSPs) are available in a range of languages and formats, including hard copy PCSPs for those experiencing digital exclusion”.

Priority 3: Ensure datasets are complete and timely

In particular, better collection and recording of data on ethnicity and postcode to help with monitoring health outcomes and the prioritisation of service improvements.

Priority 4: Accelerate preventative programmes that engage those at greatest risk of poor health outcomes

This is the longest section, setting out a number of interventions that LMSs can adopt to improve equity and equality. Though little in this list is new, (much of it drawing on Better Births, the Maternity Transformation programme and the NHS Long Term Plan) hopefully the increased focus on pregnant women and people who are Black, Asian or of mixed ethnicity, as well as those experiencing social deprivation, will mean that the long-standing health inequalities for these groups will begin to be addressed.

It is positive to see recognition that “different approaches are needed for different populations” – which of course underlines the importance of genuine co-production with the relevant communities. Also helpful is the reminder that, “The effective use of data is central to tackling health inequalities” – as what gets measured is at least a bit more likely to get done! AIMS hopes that this data will not only be collected but shared transparently, to enable proper scrutiny of the effectiveness of any initiatives undertaken.

It is a matter of concern that there is no explicit recognition of the role that either institutional racism or unconscious bias on the part of the maternity staff might play in the poorer outcomes experienced by maternity service users of Black, Asian and mixed ethnicity. The only place where this is touched on is in the section on ‘Support for maternity and neonatal staff’, which talks of the need to “equip maternity and neonatal staff to provide culturally competent care”. The suggested interventions are multidisciplinary training in cultural competence, and that services, “when investigating serious incidents, consider the impact of culture, ethnicity and language”. Unfortunately, the focus there is on “whether the impact of culture, ethnicity and language on the woman’s needs was discussed and considered during the antenatal risk assessment process, initial assessment and follow-up” with no mention of exploring how staff attitudes in relation to ethnicity or cultural assumptions might have impacted on the quality of care given.

Priority 5: Strengthen leadership and accountability

This section sets out expectations for how LMS action plans should be developed and what they should contain. This list includes “strong evidence of co-production from the outset and how parents and staff will be involved in implementation”. AIMS hopes that all LMSs will deliver on this co-production requirement, which we believe is vital to ensuring that plans are relevant and effective.

We are also pleased to see the requirement for “actions, milestones and metrics... with responsible owners, timescales and monitoring arrangements”. We call on LMSs to make sure that both these detailed action plans and the monitoring data are published in a publicly accessible form to enable local service users to scrutinise progress against the initiatives. There is mention of “a high-level stakeholder communication plan” and we trust that this will include communication with the most important stakeholders – local maternity service users and their families.

In summary, it is good to see NHS England putting a long-overdue focus on improving equity for pregnant women and people of Black, Asian and mixed ethnicity, and those experiencing social deprivation. The test will be whether the LMS action plans are truly based on co-production with the groups concerned, and whether they are implemented effectively.

Ideas for Birth Activists

- Contact your LMS to ask how they are co-producing their action plans, including details of how they are involving different groups from your local community. Also ask them for details of where they plan to publish the action plans and monitoring data.
- Ask your LMS and NHS Hospital Trust what progress they have made so far towards the target of 75% of women from BAME communities and the most deprived groups receiving Continuity of Carer by 2024, and how they plan to ensure that the target is met.

Editor’s note: The Equality Strategy guidance goes beyond ethnicity and social deprivation. It calls on LMSs to look at their own population demographics and include any other cohorts of people who might suffer worse health outcomes. For whatever reason, if any of these issues are a concern for you, or if you have been affected by any of the issues raised in this article and you would like to share your experience or speak with someone, you can do so by contacting us through the AIMS helpline: helpline@aims.org.uk

ENDNOTES

- [1] Editor’s note: MBRRACE-UK: Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK Latest MBRRACE reports: www.npeu.ox.ac.uk/mbrance-uk/reports
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- [6] NHS (2021) Equity and equality Guidance for local maternity systems. www.england.nhs.uk/wp-content/uploads/2021/09/C0734-equity-and-equality-guidance-for-local-maternity-systems.pdf
- [7] Editor’s note: Relational care in midwifery is usually linked with continuity of carer. Relational continuity has been explained in one study thus: “Relational continuity is a key concept in the context of a positive birth experience. Quality in the relation gives the woman a possibility to experience positivity during the childbearing process. Continuity in care and personal growth related to birth promote empowerment for both the woman and her partner. Relational continuity gives an opportunity for midwives to provide care in a more holistic manner.” www.sciencedirect.com/science/article/pii/S026661381200174X
- [8] NHS (2019) The NHS Long Term Plan. page 41. www.longtermplan.nhs.uk/wp-content/uploads/2019/08/nhs-long-term-plan-version-1.2.pdf

Campaigning

How does BMI influence maternity care and outcomes? A review of NMPA's report:

NHS Maternity Care for Women with a Body Mass Index of 30 kg/m² or Above

by *The AIMS Campaign Team*

[All charts are taken from or adapted from the report]

The National Maternity and Perinatal Audit (NMPA) is a group led by the Royal College of Obstetricians and Gynaecologists (RCOG) and including the Royal College of Midwives (RCM), the Royal College of Paediatrics and Child Health (RCPCH) and the London School of Hygiene & Tropical Medicine (LSHTM). AIMS is represented on the NMPA's Clinical Reference Group, which provides us with an opportunity to comment on reports at a draft stage.

The NMPA is commissioned by the Healthcare Quality Improvement Partnership (HQIP) as part of the National Clinical Audit and Patient Outcomes Programme (NCAPOP), on behalf of NHS England, the Welsh Government and the Health Department of the Scottish Government, to carry out audits of the maternity services in England, Wales and Scotland, using data collected from hospitals. In addition to ongoing clinical audits and organisational surveys, this work includes carrying out 'sprint audits' looking at particular aspects of maternity care. The main purpose of these is to explore the feasibility of adding further categories of clinical data to the regular audits, but they can also throw valuable light on the experience of particular groups of maternity service users.

A strength of these sprint audits is the involvement of a lay advisory group, in this case made up of members who had themselves experienced pregnancy with a BMI of 30 kg/m² or more. For example, they were consulted on the language to be used, which led to the decision to refer to groups by their BMI^[1] thresholds rather than using terms such as 'obese' or 'high BMI'. The group also recommended outcome measures they thought were important to include, made some very insightful comments on the interpretation of the findings, and reviewed the draft of the key findings and recommendations.

About the sprint audit

The audit (NMPA BMI Over 30 Report.pdf^[2]) reviewed the available data on births in the two years from 1 April 2015 to 31 March 2017 in England, Wales and Scotland. The audit provides "a unique opportunity to describe the diversity of the women who gave birth during the audit period, including how their characteristics differ by category of BMI". Its main purpose was to compare rates of intervention and outcomes for those with a BMI of 30 kg/m² or above in pregnancy to the rates for those with a BMI in the range 18.5–24.9 kg/m². In doing so, the audit team sought to determine the characteristics of women in these two BMI categories; to determine where they give birth; and to "explore the feasibility of reporting NMPA outcome measures for women and their babies, according to BMI category, parity and maternal risk status at birth." The measures used are ones previously developed by the NMPA for their clinical audits.

A report such as this has limitations; while it can tell us what pregnant women and people with a higher BMI have experienced, it has limited ability to identify why this was the case. It is helpful that the authors have identified a number of areas where better data or more research is needed. For example, several measures requested by the lay advisory group

unfortunately could not be analysed due to lack of sufficient data. These included access to birth in water, monitoring of fetal growth by ultrasound, access to perinatal mental health services and prevention of venous thromboembolism. Hopefully, the report's recommendations to record and report this data will enable these important measures to be looked at in future.

The report presents the measures for three categories: mothers who had not birthed before (nulliparous); those who had birthed before (multiparous^[3]) and only had vaginal births, and those who had birthed before and had at least one caesarean. This proved to be very helpful in demonstrating how the risks of interventions and of undesirable outcomes are not the same for everyone with a BMI of 30 kg/m² or above, as described below. This illustrates the need for personalised care rather than blanket recommendations based on BMI alone.

The importance of this report's focus is underlined by the fact that over 20% of those in the sample for whom the BMI was recorded fell into the category of BMI of 30 kg/m² or above. Recommendations or guidelines based on BMI therefore have the potential to affect the birth experiences of huge numbers of pregnant women and people.

The audit comments on the ethnic make-up of the different BMI groups. There was a higher proportion of women categorised as "of South Asian ethnicity" in both the group with a BMI under 18.5 kg/m² and that with a BMI between 30 and 34.9 kg/m². Those with BMI of 35 kg/m² or above were more likely to be of white or Black ethnicity. Unfortunately, there is no analysis of how ethnicity and BMI might interact to affect maternity outcomes, but hopefully the forthcoming sprint audit on Ethnic and Socio-economic Inequalities will shed some light on this.

Is BMI in itself a risk factor for poor birth outcomes?

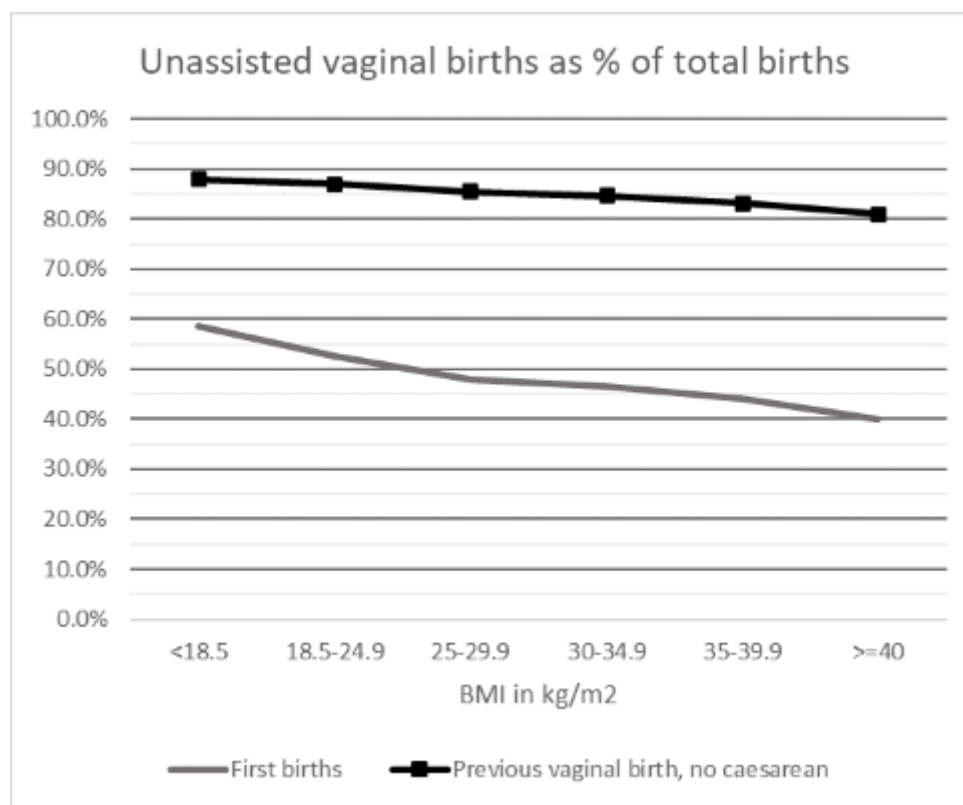
It is probably no surprise that the chances of experiencing a medical procedure such as induction or unplanned caesarean, or a serious birth-related health problem for mother or baby, were found to increase with increasing BMI. However, as the report makes clear "[w]e do not know whether this is because women with higher BMI are more likely to develop complications requiring intervention or because of differences in the clinicians' threshold to intervene." In other words, is labelling someone with a BMI of 30 kg/m² or above as 'high risk' a self-fulfilling prophecy, at least in some cases? As one of the lay group (Mari), quoted in the report, commented:

"There's a tendency in obstetric circles to [assume that] all emergency caesareans must have been necessary, all inductions must have been necessary, and not acknowledge that actually the previous care can be that conveyor belt of interventions that ends up in that, whether that's repeated scans, or whether that's going through an induction process, leading to a caesarean."

The audit identified that a number of risk factors, including diabetes and high blood pressure, were increasingly common as BMI increased. Also, those living in the most deprived areas were more likely to either have a BMI of 30 kg/m² or above, or one under 18.5 kg/m². It is probable that the association of these risk factors with a BMI of 30 kg/m² or above is at least part – and perhaps a major part – of the reason for more interventions or birth-related problems occurring with this level of BMI.

It is also important to remember that being 'at higher risk' does not mean that a problem is inevitable. The report comments that though "[w]omen with BMI of 30 kg/m² or above have at least a two-fold higher risk of complications" (such as gestational diabetes and caesarean birth) compared to women with a BMI in the 'healthy range' (18.5–24.9 kg/m²), "approximately one-third of these women have a pregnancy and birth without complication."

One telling finding - illustrated in the chart below - was that for the group who had previously given birth vaginally but never had a caesarean, a higher BMI only marginally reduced the chance of having an unassisted (by which they mean a vaginal birth without the assistance of forceps or ventouse) vaginal birth next time. At least 80% of those in this group who had a BMI of 30 kg/m² or above had an unassisted vaginal birth, compared with just under 90% of those with a BMI between 18.5 and 24.9 kg/m². Treating a person who has birthed before and not had a caesarean as 'high risk' purely because of their BMI therefore seems illogical.

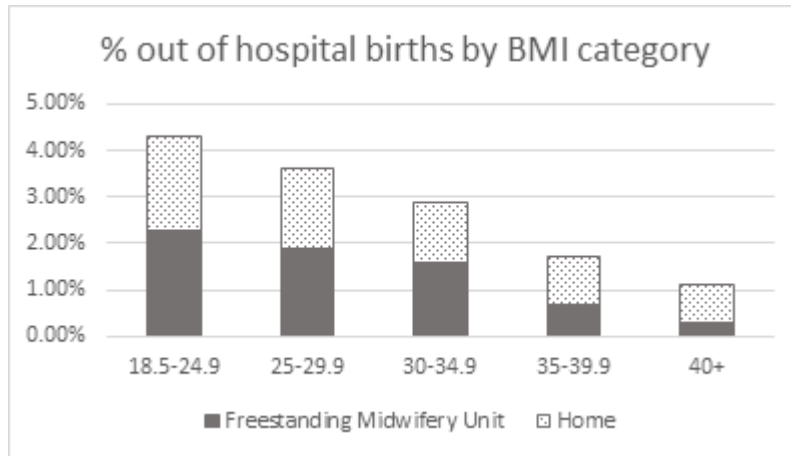


For those giving birth for the first time, the chances of an unassisted vaginal birth dropped more steeply with increasing BMI. However, even with a BMI of 40 kg/m² or above, 40% experienced this, compared with just over 50% of those with a BMI between 18.5 and 24.9 kg/m².

Another interesting measure is “birth without intervention”. NMPA uses two definitions for this: definition 1 reports birth with spontaneous onset and progression and spontaneous birth, without epidural and without episiotomy; definition 2 omits spontaneous progression. The proportion of births meeting these definitions declined with increasing BMI for all three groups. However, “approximately one in five women with a BMI of 30 kg/m² or above have a birth without intervention”. For those with previous vaginal births but no caesareans, the figure was 50% for those with a BMI of 30 – 34.9 kg/m². The lay group “hoped that this finding may be used to support clinicians to offer birth in alongside midwifery units (AMUs) to more women with a BMI of 30 kg/m² or above” – a hope which AIMS shares.

Place of birth

The AIMS Helpline frequently hears from women who are being refused support for a homebirth or admission to a Birthing Centre purely because of their BMI, so it is not surprising that the audit found a decrease in the proportion of births taking place in these settings with increasing BMI, as this chart shows. However, it is worth noting that some people were supported to use a Freestanding Midwifery Unit, even in the group with a BMI of 40 kg/m² or above. Given that interventions are typically lower for births outside hospital than in an Obstetric Unit this could be another factor affecting the increase in intervention rates with increasing BMI. Unfortunately, the data does not distinguish birth in an Alongside Midwifery Unit from those in an Obstetric Unit. It also only records where the birth took place, not where the labour started, so we cannot tell what transfer rates were like.

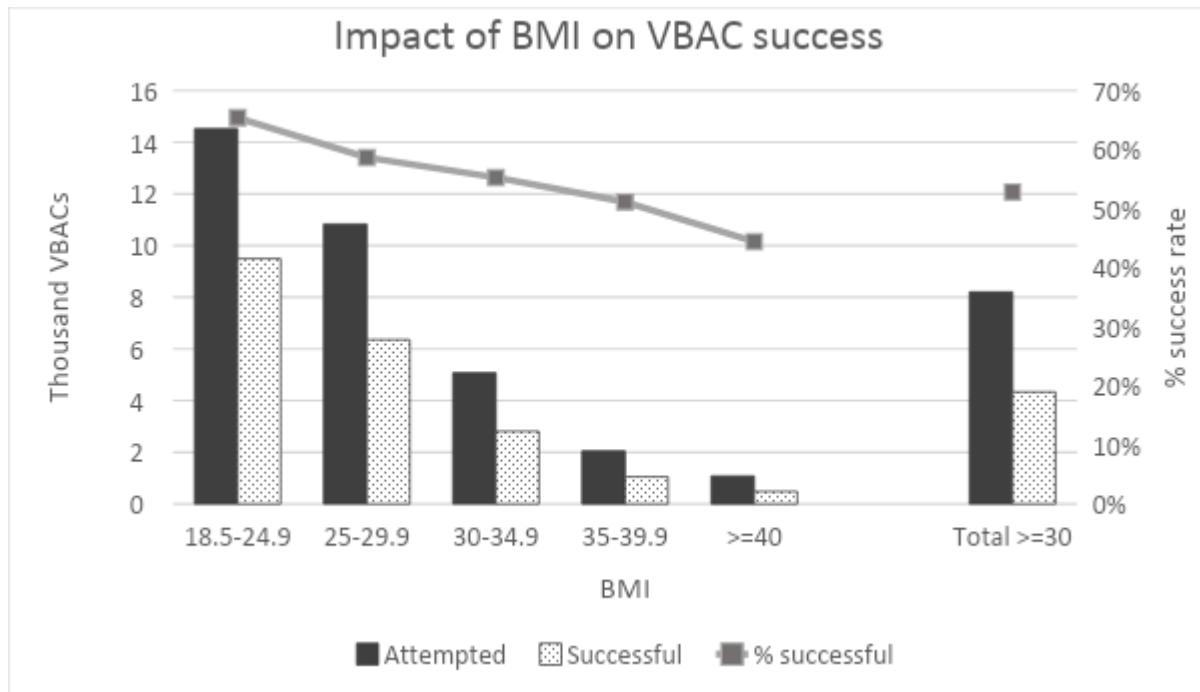


The report comments that for women with a BMI of 30 kg/m² or above but no other risk factors “births without complication or intervention are more likely and they may therefore be suited to giving birth in midwifery-led birthing centres, particularly if they have previously given birth vaginally.” AIMS hopes that all NHS Trusts/Boards will recognise this and amend their guidelines for Birth Centre admission accordingly. Similarly, we feel that the fact that someone has a higher BMI should not be put forward as an argument against planning a homebirth.

Impact of BMI on caesareans and VBAC

The rate of planned (elective) caesareans appears to be little affected by BMI for first births or births after a previous vaginal birth but no caesarean, remaining under 10% for all BMI ranges. Repeat planned caesareans are more common with increasing BMI, but how many are at the mother’s request and how many at the consultant’s urging we do not know.

Unplanned (emergency) caesareans increase with BMI, especially in the case of first births, but much less so for those who have birthed vaginally before. For this group they did not rise above 10% of all births even with a BMI over 40 kg/m².



The proportion of women who planned a VBAC and the proportion who achieved a vaginal birth both declined with increasing BMI. However, 50% of those with a BMI of 30 kg/m² or above who planned a VBAC were successful, compared with around 65% of those with a BMI of range 18.5–24.9 kg/m². A higher BMI is clearly not a barrier to a successful VBAC or a reason not to plan one.

Outcomes for babies

The chances of a stillbirth, a premature birth or a baby with a birthweight in the top 10% of the population (called large for gestational age or LGA), though still uncommon, do increase somewhat with increasing BMI. The stillbirth rate for mothers with a BMI of 30 kg/m² or above was six in one thousand births, compared to three in one thousand for those with a BMI of range 18.5–24.9 kg/m². It is not known why this is, and the report calls for more research to investigate and explore whether it is possible to identify which babies are at risk.

The report points out that the higher chance of having an LGA baby may be linked to the higher rates of diabetes and gestational diabetes in mothers with a BMI of 30 kg/m² or above.

Babies born to mothers with a BMI of 30 kg/m² or above were found to be more likely to be judged in poor condition at birth (with an APGAR score under 7/10). However, the increase was small and rates still low – no more than 2% for the highest BMI groups. Similarly, there was an increase in the proportion of babies admitted to a neonatal unit (from around 6% to around 10%) or needing mechanical ventilation (from around 0.5% to around 1%) with increasing BMI. The increase was more marked for first births.

As with the increase in interventions, we do not know the reason for the higher level of health problems in babies with increasing maternal BMI. The authors comment that “[g]iven that women with a BMI of 30 kg/m² or above are more likely to be from the most deprived areas, with different distributions of ethnicity and higher prevalence of comorbidities, these characteristics may contribute to some of the differences seen” in outcomes for their babies. They also speculate on the impact of difficulties in monitoring the well-being of babies if the mother has a higher BMI, and that the higher number of LGA babies could lead to more cases of shoulder dystocia^[4]. However, there is a lack of evidence on the risks and benefits of offering induction at term for LGA babies of mothers with a BMI of 30 kg/m² or above.

Babies born to mothers with a BMI of 30 kg/m² or above were also less likely to have skin-to-skin contact in the first hour after birth, or to have breastmilk as their first feed. The lay advisory group commented that this was likely to be due to a lack of individualised support, and they could see no good reason for skin-to-skin contact being less common. The report calls for all women (regardless of BMI) and their babies to be supported to experience skin-to-skin contact within an hour of birth and for all women to be offered breastfeeding information and support during pregnancy and again shortly after the birth. It is worrying that this needs to be a recommendation! However, given that it appears to be so, AIMS hopes that all maternity services will take note that “[w]omen with a BMI of 30 kg/m² or above may require support to be tailored to their specific needs and to be provided by a healthcare professional who is trained to adapt breastfeeding techniques for women with a higher BMI.” With one in five mothers falling into this category, the need for tailored support and training for staff is clear.

Feasibility of reporting outcomes according to maternal risk status

The audit explored whether it would be feasible for future audits to categorise “maternal and neonatal outcomes according to maternal parity and risk status at the time of admission for birth.” This was in recognition of the fact that “women with a BMI of 30 kg/m² or above are not equal in terms of their risk of receiving interventions or experiencing adverse outcomes. Women vary in terms of their BMI category and parity, but also by their past obstetric history, antenatal complications and medical comorbidities, as well as in their values and choices.” Although AIMS was pleased to see this recognition by the NMPA, we would hope that midwives and doctors would consider all these individual factors in drawing up a personalised care plan, rather than the BMI alone.

This section of the report looked at selected outcomes for five categories (using data for England only):

- nulliparous women without additional risk factors (low risk)
- nulliparous women with additional risk factors (high risk)
- multiparous women without risk factors (low risk), previously only experienced vaginal births

- multiparous women with risk factors (high risk), previously only experienced vaginal births
- multiparous women who have previously experienced at least one caesarean birth (high risk).

The level of risk was assessed using the criteria in the NICE guideline Intrapartum care for healthy women and babies.^[5] They decided not to split the fifth group into high and low risk “because a previous caesarean birth itself is a significant risk factor.” This seems like a missed opportunity to consider potential differences within this group.

The findings were similar to those in the main report, but it was clear that outcomes at a given level of BMI tended to be better for those categorised as ‘low risk’, especially in the case of those giving birth for the first time.

Dividing pregnant women and people into low and high risk groups in this way may help a little in encouraging midwives and doctors to tailor care to their needs, compared with the attitude that considers all those with a higher BMI to be ‘high risk’. However, truly personalised care that looks at the whole person, their circumstances, needs and wishes, would be so much better.

ENDNOTES

[1] Editor’s note: For those new to the concept of BMI, and to BMI as a measure of health risk, the following articles explain what it is and why it is a controversial measure of health:

Fogoros R N (2021) Is Being a Little Overweight Really OK? Resolving the controversy over BMI measurements.

www.verywellhealth.com/is-being-a-little-overweight-ok-bmi-controversy-1746304

Humphreys S. (2010) The unethical use of BMI in contemporary general practice. www.ncbi.nlm.nih.gov/pmc/articles/PMC2930234

[2] NPEU (2021) National Maternity and Perinatal Audit NHS - Maternity Care for Women with a Body Mass Index of 30 kg/m² or Above <https://maternityaudit.org.uk/FilesUploaded/NMPA%20BMI%20Over%2030%20Report.pdf>

[3] Editor’s note: In some definitions, multiparous is defined as having given birth (after 24 weeks) more than once prior to the current pregnancy and primiparous is defined as a woman who has given birth (after 24 weeks) only once before the current pregnancy. In the NMPA report, women who have only given birth after 24 weeks only once before are included under the multiparous definition. <https://patient.info/doctor/gravidity-and-parity-definitions-and-their-implications-in-risk-assessment>

[4] RCOG (2013) Information for you: Shoulder dystocia. www.rcog.org.uk/globalassets/documents/patients/patient-information-leaflets/pregnancy/pi-shoulder-dystocia.pdf

[5] NICE (2014) Intrapartum care for healthy women and babies. www.nice.org.uk/guidance/cg190 (updated 2017)

Campaigning

What has the AIMS campaigns team been up to this quarter?

by The AIMS Campaign Team

Covid-19:

- With other members of the But Not Maternity Alliance[1] we wrote to all Trusts and boards that were still limiting partners' postnatal attendance to one to two hours a day, asking them to publish their plans for lifting remaining restrictions.
- We updated our 'Coronavirus and your maternity care'[2] web page with the most recent version of the RCOG guidance, the revised rules for Wales and Northern Ireland on visiting in maternity services and the latest research on the impact of Covid-19 on babies.
- We updated the AIMS Birth Information page 'Vaccinations in Pregnancy'[3] to include information on the Covid-19 vaccine.

Other written outputs:

- Review of the NMPA (National, Maternity and Perinatal Audit) 'sprint audit' on 'NHS Maternity Care for Women with a Body Mass Index of 30 kg/m² or Above [4]
- We have published six AIMS Position Papers[5] on our website on a variety of key maternity service improvement topics.
- A full review has been undertaken of the draft IDECIDE documentation, offered to members of the Stakeholder Council for review, with comments provided to NHS England. For a good overview of the project, see here: IDECIDE – a new consent tool is on its way[6]
- We have reviewed and commented on the [NHS England Equity and Equality pledges and guidance to LMSs](#) (Local Maternity Systems)[7]
- A review has been undertaken of the updated NICE Guideline on Inducing Labour.[8]

- Submitted comments to RCOG for the consultation on their Planned Caesarean Birth consent document. [9]
- A statement has been drafted concerning the nationwide March With Midwives[10] vigil.

Conferences and meetings attended:

- Three AIMS Volunteers attended the MBRRACE-UK Stakeholder Zoom Meeting on the 24th September 2021.
- We attended the online launch of the 'MBRRACE-UK Perinatal Mortality Surveillance Report UK Perinatal Deaths for Births from January to December 2019'. [11]
- We participated in the regular meeting of the NHS England organised Maternity Transformation Programme Stakeholder Council[12].
- We participated in a meeting of the Royal College of Midwives Re:Birth[13] Project Oversight Group.
- We attended and participated in the Maternity & Midwifery Hour online meetings, including the sessions on Continuity of Carer. You can read more about this series of meetings here[14].
- We viewed the Royal Society of Medicine: The OASI Care Bundle[15] conference.
- We attended the ARM Conference 2021: Is Normal Birth Radical? [16]

What we have been reading:

- The Healthcare Safety Investigation Branch (HSIB) report on intrapartum stillbirths during the pandemic. [17]
- The latest MBRRACE-UK Perinatal Mortality Surveillance Report.[18]
- The NHS Pay Review Body's annual report, published in July.[19]

- The new planning, implementation and monitoring guidance for the roll out of the Continuity of Carer model of care (relational care) at full-scale, published by NHS England in October. [20]
- Dr Lisa Common's summary of the current midwifery workforce crisis.[21]

What we have been watching:

- The new feature-length Birth Time documentary film. [22]
- Two new stunning short films which are available to view on YouTube: The Physiology of Childbirth[23] and Respectful Maternity Care - Know Your Rights[24]– The White Ribbon Alliance. Please watch them – we're sure you'll want to share them.

Thanks to all the AIMS Campaigns volunteers who have made all this work possible. We are very keen to expand our campaigns team work, so please do get in touch with campaigns@aims.org.uk if you'd like to help!

ENDNOTES

- [1] AIMS (2021) We have roadmap for the nation But Not For Maternity. www.aims.org.uk/assets/media/647/press-release-but-not-maternity-march-2021.pdf
- [2] AIMS (2021) Coronavirus and your maternity care: www.aims.org.uk/information/item/coronavirus
- [3] AIMS (2021) Vaccination During Pregnancy: www.aims.org.uk/information/item/vaccination-during-pregnancy
- [4] AIMS (2021) How does BMI influence maternity care and outcomes? A review of NMPA Audit: NHS Maternity Care for Women with a Body Mass Index of 30 kg/m² or Above. AIMS Journal, Vol 33, No 4 Add www.aims.org.uk/journal/item/bmi-maternity-care
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- [8] AIMS comments on the draft guideline (June 21) and review can be found here: www.aims.org.uk/campaigning/item/nice-iol-comments
- [9] AIMS Comments submitted to RCOG for the consultation on their Planned Caesarean Birth consent document www.aims.org.uk/campaigning/item/rcog-planned-caesarean-birth
- [10] AIMS (2021) March With Midwives - AIMS statement. www.aims.org.uk/campaigning/item/march-with-midwives
- [11] MBRRACE-UK Perinatal Mortality Surveillance Report UK Perinatal Deaths for Births from January to December 2019 www.npeu.ox.ac.uk/mbrrace-uk/reports#mbrrace-uk-perinatal-mortality-surveillance-report-for-births-in-2019

[report-for-births-in-2019](http://www.aims.org.uk/campaigning/item/march-with-midwives)

- [12] NHS Maternity Transformation Programme: www.england.nhs.uk/mat-transformation
- [13] RCM (2021) Re:Birth project: www.rcm.org.uk/what-is-the-rebirth-project
- [14] Maternity & Midwifery Forum (2021) www.maternityandmidwifery.co.uk/the-maternity-and-midwifery-hour
- [15] The Royal Society of Medicine (2021) Live stream: The obstetric anal sphincter injury (OASI) Care Bundle: Reviewing the evidence and exploring impact on clinical practice. (This event has now passed) www.rsm.ac.uk/events/maternity-and-newborn/2021-22/mbq50
- [16] The Association of Radical Midwives (2021) Is Normal Birth Radical? Conference. (This event has now passed) www.midwifery.org.uk/event/arm-national-conference-is-normal-birth-radical
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- [23] The Physiology of Birth video. www.youtube.com/watch?v=OaJukSJJFWs
- [24] Respectful Maternity Care: Know your rights video. www.youtube.com/watch?v=iUrt3sc4C-o



The AIMS Guide to

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The AIMS Guide to Twin Pregnancy & Birth provides essential, evidence-based information to aid you in asking for and accessing the best possible care throughout your twin pregnancy and birth.

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