AIMS For a better birth...

An Interview with Soo Downe by the AIMS Campaigns Team

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Soo Downe

Interview by Jo Dagustun

AIMS recognises that many different types of organisations, alongside many individuals, play an important part in the mission to improve UK maternity services for all. Academics, and the research work they do in universities, are an important part of the maternity services improvement community. In the UK we are fortunate to have a flourishing maternity research sector, including academics with a midwifery background who play an increasingly important role. In this interview for AIMS, Professor Soo Downe – who leads a thriving research team at the University of Central Lancashire – explains her role, how she manages to keep her work grounded and policy-relevant, as well as her position in England's national Maternity Transformation Programme's Stakeholder Council.

Can you please start by telling us about what drives your passion for maternity service improvement, and what first attracted you to getting involved in working with birth?

I first came across labour and birth when I was in the second year of my undergraduate degree (which was a degree in literature and linguistics: nothing to do with health care!). I happened to find myself in Boputhaswana, one of the South African homelands, at a time when apartheid was still prevalent. For complicated reasons I was staying on a maternity station run by nuns. There, I saw birth for the first time

and seeing the women there give birth, it struck me (almost like a coup de foudre) that if we get birth right, we get the world right. And that is something I continue to believe to this day.

As a midwife and working professor at the University of Central Lancashire, what does an average work day for you look like?

Currently, under lockdown, my day probably looks very much like many other people's days! Getting up at about 7 in the morning, working through most of the day on the computer, linking up with people all around the world online. I may be dealing with a student query or meeting a student I supervise one hour. Then the next hour, I may be meeting with the World Health Organisation about a review or a study we're doing. Then I might be talking on Teams with some of our colleagues who are working on a large research programme – our NIHR-funded ASPIRE-COVID 19 study about maternity care organisation during the pandemic in the UK and the Netherlands. Then I may join one of the national policy meetings about a key issue that we feel to be particularly important at the time. If possible, I'll have a break for a local walk or a cycle – I am extremely lucky to have the Forest of Bowland down the road. Then I might be back in the evening to work on some presentations, or perhaps to give a presentation in a different timezone, through the wonders of broadband.

Then there's organising our normal labour and birth international research conference, or our masters module on normal birth, or talking with team members about possible new blue skies innovations. (Team members are, for instance, working on studies using gaming and VR technology, thermal imaging and innovative media, linking all this with sociological or psychological theory in the domain of maternity care…) That is the really exciting part of research! Oh, and getting the email to say that a paper that you think might make a real difference has finally been accepted for publication, or that a bid for a project that you think might finally be The One to change the world is actually funded!

Can you tell us about the piece of research you've been involved in that you remember most fondly, and – if different – what element of your academic work you think has done the most for improving maternity care in the UK?

I suppose my first research study is one that I remember with some degree of fondness, although I also remember not really knowing what I was doing. It was a large survey of midwives to find out about the experiences of those who trained as direct entrants, at a time when it looked like direct entry was going to be vanishing from the UK. I decided to survey a whole range of midwives to find out if they were direct entrants or not, with questions about how they felt about their job or how they got into the job, and so on. I think, from memory, I got hundreds of responses back. Given that this was pre computers, analysing all those responses was a huge job. I only ever managed to write it up as a short piece in MIDIRS (Midwives Information & Resource Service) and always intended to go back to the data because it seemed to me there was an awful lot of extremely interesting information in there.

In terms of the work that we've done recently that made the most difference, the most influential is probably our reviews of what matters to women, undertaken for the World Health Organisation for their

recent guidelines. The finding (which is not surprising to anybody really) is that women want and need a positive pregnancy, labour, birth, and postnatal experience. The findings were based on world-wide reviews of all the qualitative research published in each area in all languages and were instrumental in re-framing the WHO guidelines for maternity care, so that they now have the term 'positive experience' in their title. This does seem to have provided legitimacy to talking about the personal individual humanised aspects of maternity care globally, in parallel with all of the work being done by many people to identify, call out and reduce disrespect and abuse.

In England, we have just been marking the fifth anniversary of the 2016 Better Births report. In your opinion, how much of an impact has that report had in driving maternity service improvement so far, and what are you keen to see delivered still?

I was a member of one of the sub groups that preceded the Better Births report, namely the sub group on models of care. What that group worked out is that in order to really change the way maternity services are performed, delivered, managed, and practised in the UK (and possibly around the world), it was really important to completely start again with a blank sheet. So, rather than saying 'we have these buildings, we have this design, we have these referral patterns that are all based around how organisations function most effectively', it was critical to sweep all that away and to truly and authentically start with the woman at the centre and build the service around her.

There was a genuine enthusiasm in the models of care and the other pre-Better Births groups to do this. I'm now a member of the Stakeholder Council that advises the Maternity Transformation Board on what is happening on the ground and how to tackle possibly difficult bumps in the implementation road. We're all still saying you can't just bolt change on the top of existing services. You have to do it by making change happen at a very fundamental level, and this is a message which is proving very very hard to implement, perhaps not surprisingly. Probably, along with most members of the Stakeholder Council, I'd say that getting this right is all about having that difficult but essential conversation. Whether at government level, commissioners, CEOs of Trusts, Directors of Services, or at the level of practice, and maybe also learning from where people have done this well. There are examples of good practice that show it is possible to reconfigure effectively even during a pandemic. It is perhaps critical that we learn from these in order to be able to go forward.

As a member of the Maternity Transformation Programme's Stakeholder Council in England, can you say a little more about your role and what the group has achieved to date?

See above. The Stakeholder Council meets regularly, every couple of months, usually to discuss particular elements of the strategy and propose ways of enhancing progress towards fulfilling the Better Births goals. So I think what the Council has achieved to date has been to make sure that some of the targets are kept high on the government's agenda, both those associated with safety – like the care bundles – and, critically, those associated with personalisation (which is also actually safety), namely the continuity of care targets. These have of course been disrupted to an extent by COVID, but the Stakeholder Council has continued to work through the pandemic and has continued to say that these

elements are critical and can't be dropped, because they are about the long-term wellbeing of mothers and babies and families. The other advantage of the group is how it brings together key players from a range of organisations, which helps with friendly and constructive conversations, even where the starting positions or the underlying philosophies of the individuals concerned might vary quite considerably.

You have written about a salutogenic approach to maternity care. Please could you explain what you mean by this and how this approach might lead to improvements in the maternity services? Could you also share some specific examples of where a salutogenic approach has been adopted to the benefit of maternity service users?

Salutogenesis is a concept developed by Aaron Antonovsky. He was a medical sociologist who, when dealing with survivors of the Holocaust, was surprised to find that some individuals were remarkably positive about life, given all they had been through. The theory is relevant to every life phase, from birth to death. The three basic concepts that make up what he called the overall Sense of Coherence for an individual are that life is meaningful, manageable, and comprehensible. The theory goes that if an individual possesses high levels of those three qualities, then their sense of coherence is high and their capacity to deal with complications in life is also high.

There is growing evidence in maternity care that people who start with a high sense of coherence in the maternity journey do better. Also, women who have positive birth experiences can enhance their sense of coherence into the longer term, even though Antonovsky originally believed that your sense of coherence was fairly fixed by your early 20s. Conversely, negative birth experiences can quite profoundly damage a person's sense of coherence into the longer term. Just before Antonovsky died, he was beginning to talk about salutogenic organisations and communities, and this really is where the application might be in maternity organisations and systems.

In this case, the salutogenic approach would say we have to pay attention to what makes things go well in maternity services as well as what makes them go badly, both at the level of the individual and at the level of the organisation. So, for example, an individual may have, on the face of it, certain risk factors, but may also have, for example, familial traits or experiences or histories that mean those risk factors are mitigated. An example in maternity care might be somebody who is at 41 weeks, but is otherwise well, and who has a family history going back generations of longer pregnancies with good outcomes. This suggests, for this particular individual, that giving birth beyond 41 weeks is genetic or physiological as opposed to being grounds for induction.

There are many other examples, of course. At the organisational level, as noted, above, the theory would suggest that what we should be doing is looking at organisations that manage both healthy women and babies and those with complications or risk factors really well. So you might look for an organisation, for example, (controlled for case mix), that has low rates of adverse outcomes, high rates of spontaneous physiological birth, high rates of maternal wellbeing, high rates of maternal choice being delivered (whether that's for elective caesarean or home birth), and high rates of staff wellbeing, with low staff

turnover rates. What are they doing right that other places can learn from?

What do you think is the biggest challenge faced in maternity service improvement work in the UK today?

We have some of the best evidence, policies and targets for maternity services in the world. The challenge is to get this to drive authentic change deep into practice, so it becomes part of maternity services' DNA. Now is probably the greatest opportunity we have had for decades to really get maternity care right by ensuring that we keep in balance BOTH optimal clinical care and outcomes AND genuinely humanised care throughout the maternity episode. It is also a time when such care is coming under sustained pressure from increasing bureaucracy, risk aversion, social media pressure, journalistic 'click-bait' sensationalism, and more and more pressure on time for care. The only way that this chance for authentic renewal can succeed is if midwives, service users, medical staff, policy makers, managers, commissioners, social influencers, media leads and others can genuinely cross the divide between each others' sometimes highly entrenched positions. We need to shift our gaze once and for all to the consideration of values based care provision, with attention to the life course implications of what is provided, said, done, and valued during the maternity episode.

In 2020, AIMS celebrated our first 60 years, and we are now looking towards the future. Can you tell us a little about what AIMS means to you, and where you think our efforts would be best placed over, say, the next five years?

Since I joined the Association of Radical Midwives (the ARM) in the mid-1980s, I have always seen AIMS as a sister organisation, working with the ARM to foreground what matters to women and other maternity service users, their babies and their families. The Trent survey on interventions in normal birth, published in 2001[1] and based on work that Beverley Beech and colleagues had published earlier in the AIMS journal, was a profound wake-up call to the RCM and other professional organisations about the state of normal physiological birth in the UK. Though the legacy of that work has been subject to severe critique recently, I stand by it. These findings show that every year, thousands of women and babies who would like to labour and birth physiologically are not supported to do so (this was also unfortunately mirrored in the recent NMPA (National Maternity and Perinatal Audit) data[2]). We now also have evidence from microbiome and epigenome studies, suggesting that this may have profound and long-term consequences on rates of chronic auto-immune disease over the life course[3]. This cause is still an important one.

AIMS has always fought for the rights of women in maternity care, whatever they are, and the current focus on the terrible inequalities for Black African, Asian, and minority group women and babies is critical. Getting beyond simple platitudes and developing solutions that get to primary causes is just the kind of work that AIMS has always been at the forefront of. I see this as the other essential focus for AIMS going forward.

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1 Johanson R, Newburn M. Promoting normality in childbirth [published correction appears in BMJ 2002

Jan 12;324(7329):98]. *BMJ*. 2001;323(7322):1142-1143. doi:10.1136/bmj.323.7322.1142

2 National Maternity and Perinatal Audit 2019 Available at: maternityaudit.org.uk/FilesUploaded/NMPA%20Organisational%20Report%202019.pdf

3 Downe S. & Byrom S. (eds.) (2019) *Squaring the circle: Normal birth research, theory and practice in a technological age*. London: Pinter & Martin Ltd, Chapters 13 and 14