THE MAGAZINE OF THE ROYAL COLLEGE OF MIDWIVES

midwives

VOLUME 28 / APRIL 2025

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1. National Health Service (NHS), Itching and intrahepatic cholestasis of pregnancy, https://www.nhs.uk/pregnancy/related-conditions/complications/itching-and-intrahepatic-cholestasis/ (last accessed 17th March 2025)
2. Black MM, Ambros-Rudolph C, Edwards L, Lynch PJ. Obstetric and Gynecologic Dermatology. London: Elsevier Health Sciences UK; 2008.

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RCM CEO Gill Walton cannot wait to see you at conference

Welcome

As I write this, the sun is shining and there is blossom on the trees. It feels like winter is – for now, at least – behind us and we can look forward to lighter mornings and evenings. Most of all, the change of seasons always gives me a sense of renewal and an urge to try new things.

And I can't wait for you to see the new things we have in store at our conference in Birmingham. This year, we've got practical workshops taking place across both days and we're holding welcome receptions for members across the regions and nations, for students and for first time conference delegates. It's going to be such a wonderful opportunity for us to come together and celebrate the midwifery community.

There are so few opportunities for us to just be together. Getting the chance to meet people from across different Trusts and Boards and hearing about what they're doing to tackle exactly the same issues you're facing in your workplace is what makes RCM conference so special. There is literally nothing like it in the UK, and I really hope you can join us.

Of course, RCM conference isn't the only source of celebration. Just days after conference ends, we've got International Day of the Midwife on 5 May, which this year lands on a bank holiday. I know that, for many of you, bank holidays don't feel the same as they do for the rest of the population, but I do hope you'll be able to take some time to reflect – and be celebrated.

It's going to be such a wonderful opportunity for us

Even though Maternity Support Worker (MSW) Celebration Day is in November, I hope you can find some time to celebrate MSWs and maternity care assistants (MCAs) too. MSWs and MCAs are the glue that holds so many maternity services together, often invisibly. I know from my time on the front line that I couldn't have done my job without them.

I hope the sun is shining – whether actually or metaphorically – as you read this, and I hope to see you in Birmingham.

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Date of Revision of Text: January 2024

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1. Derma UK Ltd, Hibitane™ Obstetric Cream Summary of Product Characteristics (SPC). 2021.
2. A, Fayez Bakr et al, Effect of Cleansing the Birth Canal with Antiseptic Solution on Maternal and Neonatal Mortality in Alexandria, American Journal of Paediatrics. July 2002, p. 379-383

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News in brief

FOR ALL THE LATEST NEWS AND VIEWS,

Restructuring

Behind the headline: NHS England to be scrapped

The prime minister has stated the management of the health service in England will return to Government.

RCM CEO Gill Walton said: "Both the prime minister and the health secretary have said that abolishing NHS England will put more money into frontline services. Every midwife and maternity support worker will wholeheartedly applaud that sentiment, but many will also be fearful that another top-down restructure of the NHS will take the necessary eyes off the ball when it comes to maternity safety.

"For far too long our members in England have been working in a service that has not supported them to deliver the best maternity care that they know they can – this undoubtedly impacts the experience and outcomes of women using maternity services. We all need to work together to improve the safety and equality issues blighting maternity services. We will be supporting RCM members working at NHS England during this period of transition."

The RCM is encouraging members who work at NHS England to update their workplace details via RCM Connect to ensure they receive up-to-date information and advice.

St David's Day Conference

This year's conference – with the theme of 'Belong, thrive, unite: celebrating midwifery in Wales' – certainly did not disappoint. It showcased the innovative and inspiring research and quality improvement work that is happening throughout Wales. Read a full account of the day at *rcm.org.uk/midwives*

I-LEARN OF THE MONTH

June is Sands Awareness Month. RCM i-learn module *One chance to get it right: bereavement care* (study time: 3.5 hours): *b.link/RCM-ilearn-bereavement*

This module covers how to provide parent-led, sensitive and empathic care for parents whose baby dies before, during or shortly after birth.

SPREAD THE WORD

Many pregnant women and new mothers in England do not realise that they are entitled to free prescriptions. Maternity Action is trying to raise awareness of the NHS Maternity Exemption scheme, so help spread the word by visiting *b.link/MA-prescriptions*

Inequality

You said, we did

The RCM used the TUC Women's Conference to call on Westminster to do more to tackle inequalities in maternity outcomes, especially those faced by Black and Asian women, as well as address the inadequate provision of interpreters.

This is the latest in the RCM's drive to address inequalities in maternal care.

The RCM has:

1 called on the TUC to campaign for ringfenced investment for NHS interpreting and translating services

2 called on the TUC to acknowledge that racism and social microaggressions – both interpersonal and structural – are a factor in the current disparities

3 set out what is needed to support maternity services and midwives to give more culturally competent care and address inequalities

4 released its *Decolonising midwifery practice* statement following its decolonising midwifery education toolkit: *b.link/RCM-decolonising*

5 developed a Maternity Disadvantage Assessment Tool (MatDAT) for women facing high levels of social disadvantage to receive the right care and the right support from other agencies: *b.link/RCM-MatDATtool*

VISIT RCM.ORG.UK/NEWS

Hazardous substances

Nitrous oxide exposure

New guidance to protect Britain's midwives from excessive nitrous oxide exposure has been published by the Health and Safety Executive (HSE). Nitrous oxide is subject to the Control of Substances Hazardous to Health Regulations 2002. It has a long-term workplace exposure limit of 100ppm or 183mg/m^3 eight-hour time-weighted average.

Helen Jones at the HSE said: "[The guidance] should be taken on board by those responsible for managing health and safety in maternity units and for controlling the risks faced by staff who work with nitrous oxide."

The three control measures used on maternity wards are:

- a demand valve and mouthpiece or facemask
- an associated extraction system
- general ventilation.

Read the HSE guidance at *b.link/HSE-nitrousoxide*

Wales

New maternity care standards

The Welsh Government's new *Quality statement on maternity and neonatal services* and Perinatal Engagement Framework have been developed by listening to the experiences of families.

The RCM's national officer for Wales Vicky Richards said: "We welcome the Welsh Government's ambitions to achieve safe high-quality maternity care for all women in Wales. These new standards for maternity must be the catalyst for safety improvements across all services.

"Both are dependent on investing in staff, in the right places, with the right education and training.

"This is particularly relevant as our members are seeing an increase in more complex pregnancies, with women presenting to maternity services with underlying health conditions such as higher BMI, mental ill health and social complexities."

"I love my job as an integrated midwife and feel privileged to work with the women and families of Orkney"

– Melissa Lindsay, Midwife of the Year, Scotland's 2024 Health Awards

Find out what happened when RCM director for Scotland Jaki Lambert visited to see remote and rural best practice – visit rcm.org.uk/midwives-magazine

IMAGES: KATE DARKINS, SHUTTERSTOCK, ALAMY

JUNE IS CMV AWARENESS MONTH

Congenital cytomegalovirus (cCMV) is the leading infectious cause of deafness and disability in children. Midwives can play a powerful role in reducing the spread by stressing the importance of hygiene practices in early pregnancy – frequent handwashing and avoiding anything that may carry another person's saliva. Go to *b.link/Action-CMVawareness*

PERINATAL MENTAL HEALTH AWARENESS

5-11 May marks Maternal Mental Health Awareness Week. The RCM recognises the unique relationship that maternity professionals have with women during the perinatal period and has set out a series of steps that Governments need to take to ensure specific mental health support is embedded in maternity services. See the Roadmap at *b.link/RCM-roadmap*

INHALE THE TRUTH

A third-year midwifery student cohort at Queen's University Belfast has produced a game to warn about the dangers of smoking and vaping. Scan the QR code to play 'Inhale the Truth':

stand out,

Join us at the RCM conference and exhibition 2025 for a dynamic and joyful celebration of our midwifery community in action

speak up

The RCM conference is *the* event of the midwifery and maternity calendar. Around 1,500 midwives, student midwives and maternity support workers (MSWs) – as well as the wider professional maternity community, policy-makers, commissioners, researchers and midwifery educators – will get together to share learning, insights, experiences, initiatives, support and laughter.

And this year's conference is like no other, because in addition to the impressive line-up of speakers, panel discussions, presentations and exhibitors, there will be workshops, dedicated receptions and hot-topic conversations taking place throughout the two days. These new events are a great way to meet experts and colleagues in an informal way to share your thoughts and experiences.

RCM public affairs advisor Stuart Bonar will be cohosting a workshop in the exhibition hall. He says: "I am running a workshop on how RCM members can exert the influence they have to improve services and their workplace. I am really looking forward to being at RCM conference. It is always a great opportunity to meet and speak with members from every part of the country."

MSW and RCM steward Chrissy Walsh is presenting a hot-topic conversation on MSW careers at the RCM stand. She says: "One thing I love about RCM events is the opportunity to network with colleagues from all over the UK – to share ideas and experiences so we can get the same results without reinventing the wheel.

"Evidence-based practice and reflection is our bread and butter in the NHS, and so being able to support this hot-topic conversation will really help to highlight the professional recognition and career development opportunities of MSWs and start hearty discussions on how we can get Trusts and Boards to invest in them."

For the first time, networking receptions have been set up throughout the two days for different groups. These will host RCM activists and members who are attending conference for the first time, members in Wales, Northern Ireland, Scotland and England, student midwives, educators and researchers.

Throughout the two-day conference you will learn about innovations, findings, ideas and examples of good practice. It is a place to learn from others, connect with a UK-wide professional network and discover career development options. Even more than that, it is an opportunity to feel part of an amazing midwifery community.

ILLUSTRATION: MICHAŁ BEDNARSKI

STREAM A SPEAKERS AND SESSIONS

Trauma-informed care
Listening to lead
Breaking barriers, building bridges
Compassionate bereavement care
Perinatal mental health
Research into practice
Building a midwifery community
International Confederation of Midwives: how midwifery can change the world

STREAM B SPEAKERS AND SESSIONS

Collaborating for safety
Making maternity triage work
Using technology to improve care
Supporting the next generation
Collaborative workforce planning
Identifying and mitigating for group B strep
Research abstracts
Advancing inclusive midwifery practice

STREAM C SPEAKERS AND SESSIONS

Working together for better health, safety and wellbeing
Research abstracts
Smart Start health interventions
Sustainability in maternity
Shaping the future of midwifery research
Making job evaluation work for you

PHOTOGRAPHY: CARMEN VALINO

WORKSHOPS IN THE EXHIBITION HALL

- Writing for publications
- How to have positive and effective conversations about vaccines in pregnancy
- Day in the life of an RCM workplace rep
- How to use your voice to improve the workplace and service
- How to work with language barriers
- Optimising outcomes for preterm birth
- How to support those returning to work after maternity leave

HOT TOPICS AT THE RCM STAND

- Everything you need to know about the MatDAT tool
- Band 7 leadership
- Making the most of midsocs
- Making the most of MSW career paths
- The benefits of journal clubs and literature searches

DON'T MISS OUT!

The RCM conference 2025 takes place at the ICC Birmingham on 30 April and 1 May 2025. It is free to attend for RCM members, so book your place at **b.link/RCMCon25**

For a full list of exhibitors, visit **b.link/RCMCon25-exhibit**

book now

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Voice of a... Student midwife

Second-year student and author Jasmine Fields believes we need to communicate better about our mental health, especially during the perinatal period

Articulating my perinatal mental health experience isn't easy – comparing it to a rollercoaster journey is probably the most accurate. During my pregnancy, I lost a family member to suicide. While I was heartbroken and grieving, I don't think his death really hit me until I was in the postnatal period. My world had already been turned upside down, but it shifted again when I became a mother.

Going from a busy working life and being constantly on the go to just staring at four walls with a little human who demanded my attention every two to three hours sent my brain spiralling into mental torment. I couldn't cope. The anxiety of becoming a mother, the postnatal hormone shift and the ongoing grief became too much, and I sought help.

At first, I was ashamed. I was embarrassed I couldn't be a happy new mum in her baby bubble. I thought everyone would think I was a lousy mother who couldn't cope. However, it was completely the opposite. I look back on my perinatal journey and feel proud of how, even though I experienced poor mental health, I gained the strength to speak up and say I was struggling with postnatal depression and anxiety.

Supporting the vulnerable

Now, as a second-year student midwife, I feel passionate about perinatal mental health and supporting women through one of the most vulnerable experiences they will go through. During pregnancy and up to a year after birth, one in five women will experience mental health issues, ranging from anxiety and depression to more severe illness. Midwives and maternity support workers play a vital role in identifying the signs of poor mental health and supporting women who experience it.

I believe everyone can learn something from someone, no matter their background, career or status. Since being a student midwife, I have learnt that just listening to the anxieties of the women in our care is important and can make such a difference in their mental health outcomes.

I think it's important to normalise these conversations too – to ask how they are feeling rather than just focusing on the antenatal or postnatal checks. I have written a book about my perinatal experience (as well as other life experiences), and I hope that being open and honest about how I felt will help others to speak up too.

We can better support women on their maternity journeys. My hope is that we can offer words of comfort for those going through the same, and raise awareness of these issues that just aren't spoken about enough.

MORE INFO

For a guide on how to better support those experiencing poor perinatal mental health, see RCM i-learn module *Perinatal mental health* (study time: 1 hour): **b.link/RCM-ilearn-mentalhealth**
See the RCM's *Strengthening perinatal mental health roadmap* – a vision for how services can be better supported with training and resources in this area: **b.link/RCM-roadmap**
Order *Fortunate* by JD Fields: **b.link/Amazon-Fortunate**

Money talks

Fair pay and terms and conditions continue to be the RCM's rallying cry. Director of employment relations Alice Sorby and national officer Emma Currer discuss what's next

Q: It seemed that the 2024-25 pay awards showed the start of change for midwives. What are we expecting the news to be this year?

A: The pay rise for 2025-26 is due in April and we have been looking at where we are:

For the 2024-25 pay round in England and Wales:

- 5.5% award implemented in October 2024 (including backpay) in England, and November 2024 in Wales
- interim points at Band 8A and above were implemented in November 2024 in England, and January 2025 in Wales
- a funded mandate for negotiations to begin to resolve outstanding concerns within the Agenda for Change (AfC) pay structure is still outstanding, however.

For the 2024-25 pay round in Northern Ireland:

- a pay circular was issued in December, notifying of the implementation of the pay award for health and social care (HSC) staff. This initiated payment of 10 months of the pay award, which was in wage packets in March. This follows a number

of meetings of the RCM as part of the HSC unions with the Department of Health
- the pay circular confirms that the Department of Health has accepted the recommendations of the NHS Pay Review Body (NHSPRB) as a 5.5% pay award and intermediate pay points at Bands 8A and above (so that staff should progress after two years at the respective band) will also be implemented
- a memorandum of understanding between the HSC staff side and Department of Health has also been agreed and it commits to ongoing full pay parity with England, to guarantee payment of the final two months of the pay award to the 1 April due date. The full backpay has now been approved.

For the 2024-25 pay round in Scotland:

- pay in Scotland is decided by collective bargaining through the Scottish Terms and Conditions Committee (STAC), which is a partnership structure that exists to negotiate for NHS Scotland staff. STAC has a tripartite secretariat, and membership is made up of officials appointed from the Scottish Government Health Workforce Directorate and nominated individuals from the staff and employer side
- in August 2024, negotiations resulted in a final offer of 5.5% across all AfC pay bands effective from 1 April 2024 with no additional pay and reward factors or non-pay elements in the offer. RCM members in Scotland voted to accept, and it was implemented in October 2024 salaries (with backpay in November).

2025-26 pay round

Governments in England, Wales and Northern Ireland have stated that pay will be decided by an NHSPRB process again. The RCM submitted its written evidence to the NHSPRB in November 2024 and attended an oral evidence session in January 2025. The Department of Health and Social Care (DHSC) in England submitted evidence to the NHSPRB that was published in December.

Its evidence stated that 2.8% has been set aside for pay awards, with the NHSPRB asked to advise on how funding for structural adjustments should be balanced against headline awards from within that envelope. Structural adjustment is the funding to negotiate changes to the AfC pay structure, rather than the headline uplift that is applied annually. It looks at things such as small gaps between pay bands – where a promotion leads only to a minimal increase in pay and the length of time it takes to progress through pay bands. Staff Council would then get to negotiate how that structural funding was spent, which means waiting until the NHSPRB reports and the government responds.

A total of 2.8% has been set aside for pay awards

This has been met by anger from the RCM and other AfC trade unions as 2.8% is below the most recent inflation figures (3%) and the recommendation on structural negotiations was accepted by the Westminster Government as part of the 2024/25 pay award.

It is the RCM's position that funding for these negotiations should not be included as part of the 2025-26 pay award and that this should sit with the Staff Council, not the NHSPRB. A funding envelope of 2.8% is not enough for the headline pay award, but a 2.8% funding envelope to cover structural negotiations, headline pay award and the national minimum wage position is unacceptable.

Following the department's evidence, the RCM wrote to the chair of the PRB and the secretary of state to outline our position. Funding envelopes set by the Westminster Government impact across the UK due to the way funding is allocated to devolved administrations. The RCM is urging the PRB to make a recommendation that is independent and fair and that Governments announce the pay award without delay. The RCM will continue to fight alongside its members.

In Scotland, pay for 2025-26 will be negotiated through the STAC. These negotiations commenced with the Cabinet Secretary in March and it is anticipated there will be an offer in the coming weeks.

WHAT RCM IS ASKING OF THE NHSPRB

- **a real-term pay increase that starts to address the pay cuts members have faced**
- **a commitment to the real living wage**
- **a consolidated, across-the-board pay increase**
- **a credible plan to restore the pay lost by NHS staff**
- **ensure banding outcomes reflect job content**
- **limit excess hours and reward additional hours fairly**

MORE INFO

Find out more about Scottish pay negotiations at **b.link/RCM-Scotpayincrease** and **b.link/NHSScot-AfC**

For details on the DHSC (England) evidence to the NHSPRB, see **b.link/NHSPRB-evidence-2025**

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1. Journal of the American College of Nutrition, Vol.18, No.5, 487-489 (1999). **2.** L Brough et al. Effect of multiple-micronutrient supplementation on maternal nutrient status, infant birth weight and gestational age at birth in a low-income, multi-ethnic population. British Journal of Nutrition (2010), 104, 437-45. **3.** Agrawal, R. et al. Prospective randomised trial of multiple micronutrients in women undergoing ovulation induction, Reproductive BioMedicine Online December 2011.

2025-03-12_ADPRGPROFA4_RCM_E_2

Voice of a...
Midwifery clinical research manager

Sarah-Jayne Ambler at Medway NHS Foundation Trust was involved in a pilot of resources to improve maternity care for parents with learning disabilities

I undertook a feasibility study for The Together Project, led by Dr Anna Cox at the University of Surrey. Through engagement with parents with learning disabilities, Anna had developed educational materials and tools for maternity staff, as well as a Maternity Passport to be held by people with learning disabilities containing information needed by the professionals who support them.

Just 1-2% of babies are born to parents with learning disabilities. This is a small number, but we know their outcomes are worse and their mortality rates are higher, and many will have their babies taken into care soon after birth. Over the course of the study, improving care for this cohort was something we all became really passionate about.

One of the first things the study research highlighted was that our digital system could not accurately capture these women. There was one just box labelled 'learning disabilities' – so when a woman disclosed difficulty with reading, for example, there was only one box to try to capture that need. It meant we had a massive overrepresentation, and people were not getting the right support. We worked with our provider, adding separate categories for 'learning disabilities' and 'learning difficulties', with automatic pop-ups with appropriate information and resources for each.

Responsive care

Anna's research identified several important points. Parents with learning disabilities preferred physical leaflets over digital versions. They wanted information that was not patronising – no cartoons, for example – and it was important that it reflected their real concerns, such as whether they would feel overwhelmed or judged.

As well as having a system that allows you to identify and respond to people with learning disabilities, you need midwives who understand the difference between learning disabilities and learning difficulties, and who feel confident in asking the questions and creating a safe space for someone to disclose that information.

IMAGE: CARMEN VALINO

While the resources are brilliant, after one woman involved in the study came into the unit at 36 weeks with her Maternity Passport still completely blank, we realised we needed some infrastructure behind them. We changed our antenatal care policy: if a midwife suspects a woman has a learning disability, they involve the specialist learning disability nurse for a proper assessment, and schedule extra antenatal appointments to discuss her needs and complete the booklet.

From our experience, the four key steps are:

- **review your digital systems**
- **offer training for midwives**
- **provide accessible resources**
- **adapt your policies.**

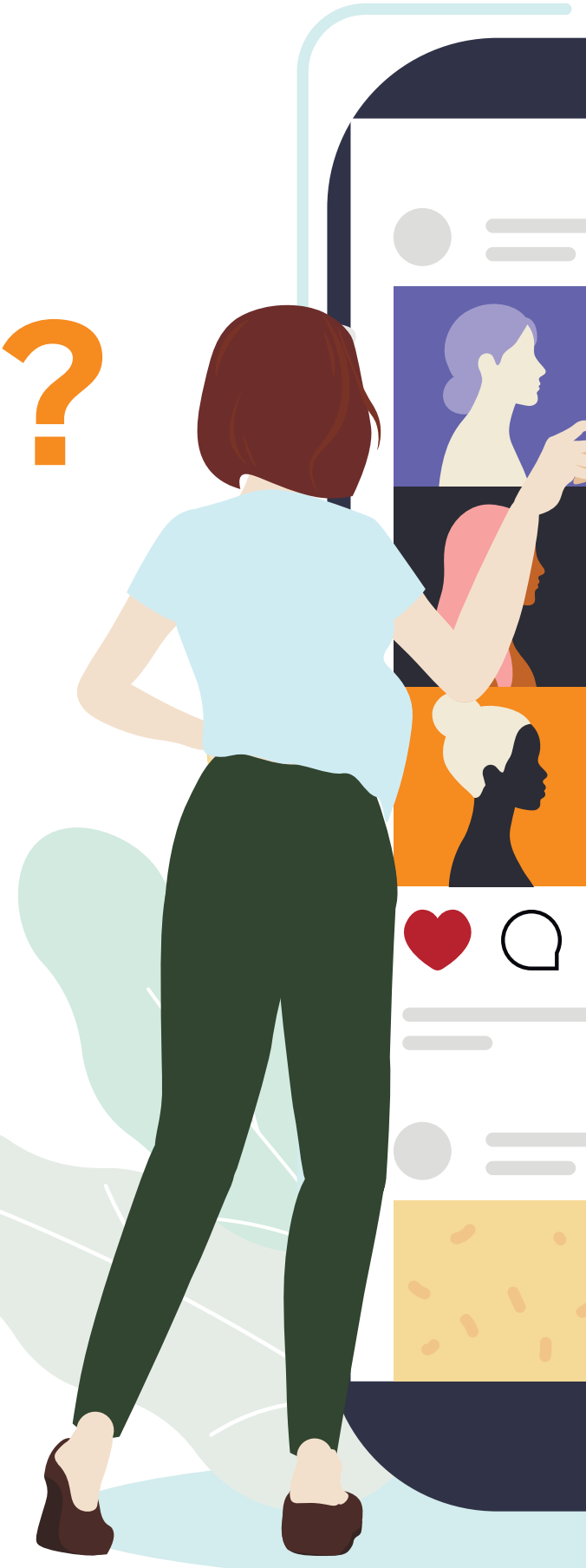
I would urge other services to access The Together Project resources, which are freely available, including a fantastic 30-minute midwifery-specific training video. Making small changes could profoundly improve outcomes for these women and their families.

MORE INFO

The Together Project
b.link/UoS_Together
16-22 June is Learning Disability Week – find out more at
b.link/Mencap-LDW

Force for good?

Social media is rife with negativity and misinformation, but Anna Marsh and Komal Khuti Dullaart have a plan



Whether you use social media every day or stay well away, we all know that social media is affecting the women we care for. Studies show that almost all women use social media for advice and guidance during pregnancy and the postnatal period, and a link has been proposed between social media use and poor maternal mental health.

While some Trusts and Boards have begun using midwife-led social media platforms, such as Instagram or Facebook pages, to communicate with women, these services are few and far between. Moreover, not many of us use social media regularly within our professional roles.

At present, the social media content that pregnant women are exposed to is a largely unknown entity, but the few papers that have looked at this suggest a high proportion of misinformation. Talking to people who use our NHS services, we have found that women often regard social media content about birth as quite shocking, impersonal or scary, with bloody images of 'raw' birth or people reflecting on their negative experience being most common.

As a maternity service, we worry about the effect that this is having on women during pregnancy and birth, when they can feel very vulnerable. We feel strongly that this could be negatively affecting women's thoughts about birth. We thoroughly support women sharing their experiences and acknowledge that maternity services are certainly not perfect, but we feel a positive narrative around birth is really lacking on social media.

Positive view

To overcome this, we [Anna is a perinatal quality improvement midwife at University College London Hospitals NHS Foundation Trust (UCLH) and Komal is the lead of the UCLH Maternity and Neonatal Voices Partnership (MNVP), working together with the midwifery team] collaborated to create our 'Positive Birth Stories' initiative. This social media innovation invites women to share their Positive Birth Stories on the UCLH MNVP

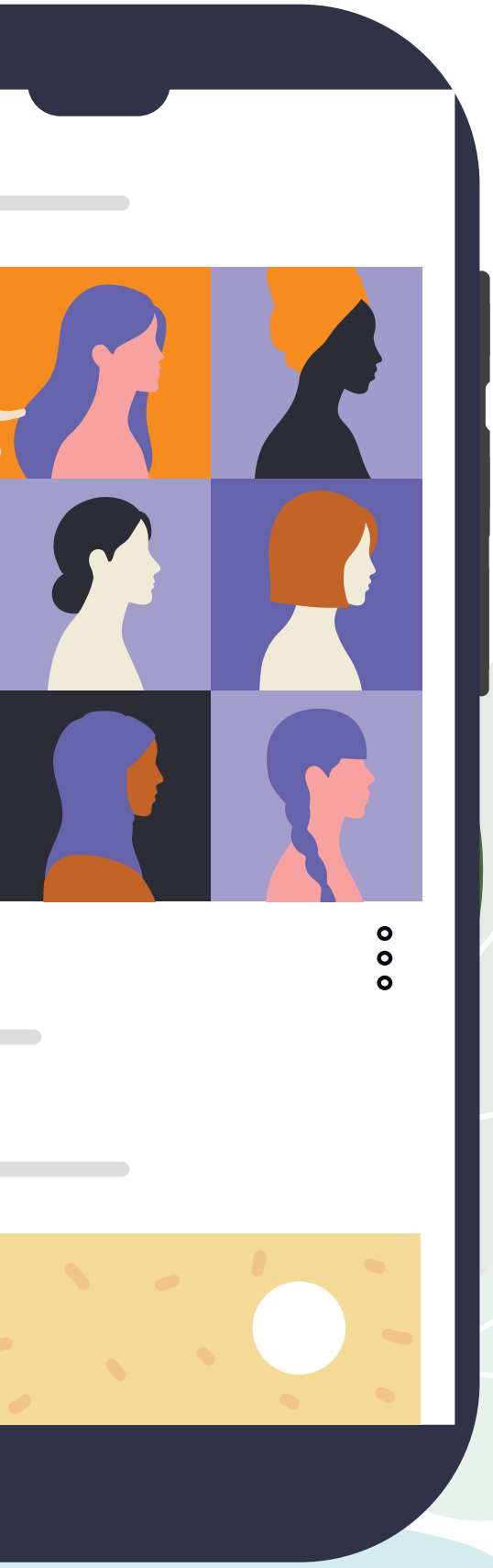


IMAGE: SHUTTERSTOCK/ISTOCK

Instagram page. We collected stories through existing networks such as local WhatsApp groups and placed adverts in Children's Centres. We also used word of mouth among the midwifery and broader hospital teams.

So far, we have collected and shared 10 Positive Birth Stories on the UCLH MNVP Instagram (@UCLHMNVP). These are typically around 100-200 words written by women themselves, usually alongside a photo or image. We felt it was really important to show that 'a positive birth' can mean lots of different things, and we are really pleased that this has been reflected in our stories. These have included elective caesarean births, pool births and inductions.

Honesty is best

It has been really important to avoid censoring stories. Some of the women have shared candid experiences of clinical emergencies, delays in waiting for a bed, anxiety, syntocinon drips and many more complications. The content is entirely their choice. Women were fully aware of the public nature of these posts and that, for authenticity, they could not be anonymous. Framed in the context of positivity, we hope that this has shown that birth is not always a smooth journey, but complications do not have to mean 'failure' or negativity.

We have faced several challenges along the way. Collecting stories from women and families who are busy caring for a newborn can be an understandably difficult job. Women often expressed lots of enthusiasm and commitment to sharing their story, but then – as we completely appreciate – this falls further down the list of competing priorities when managing being a new mum.

Collecting diverse stories

We have worked really hard to collect stories from women from a diverse range of backgrounds, spending lots of time in the community and offering feedback through a range of forums (electronically through email or Microsoft forms, or verbally with our MNVP forms). However, we have still not managed to get an entirely representative picture of the women we care for. We are hoping to improve this by working with communities and making sure that everybody has the opportunity to share their story.

Looking back at our 10 shared stories, we have had such a positive response from women, families and the community. The stories receive lots of likes, comments and shares on the Instagram page, with women saying it is almost like a platform for communication and learning.

We feel a positive narrative around birth is really lacking on social media

We have also found that sharing the stories with the midwifery team directly has been incredibly morale boosting – it has become one of Anna's favourite jobs on a Monday morning to send out an email to all midwives with the most recent Positive Birth Story. We really look forward to continuing to share Positive Birth Stories over the coming months and would encourage other MNVPs and maternity units to do the same. Perhaps this will go some way to counteract the negative narratives that are prevalent on social media and instead spread some much-needed joy.

MORE INFO

See the UCLH MNVP Instagram at **b.link/Insta-uclhmnvp**

RCM Awards 2026

Entries open

1 May 2025

Winners announced

6 February 2026

save the date

The RCM Awards will be back soon, celebrating, rewarding and sharing the outstanding achievements in the midwifery profession across the UK since 2004.

Free to enter for RCM members

@MidwivesRCM | #rcmawards | rcmawards.com

Gentle approach

Alex Clark, a registered nutritionist from Slimming World, continues the second part of compassionate conversations around weight management

Talking about a sensitive topic such as weight can leave health professionals feeling anxious about broaching it – it can feel easier to avoid the subject altogether, especially when you're supporting someone during pregnancy. However, having the conversation at such a key time can have a positive influence on the health of both mother and child.

ILLUSTRATION: ISTOCK

FURTHER INFO

Read Natalie's story **b.link/SW-results**

Healthier You: NHS Diabetes Prevention Programme **b.link/NHS-HYNDPP**

Slimming World and RCM resources **slimmingworld.co.uk/mums**

Besides, not talking about weight can have negative consequences. A research study exploring how women felt during pregnancy identified an important example of when weight should have been discussed but wasn't. Following their ultrasound scan, women in the study reported feeling upset and humiliated when sonographers documented on their notes the difficulties in visualising the fetus, but no explanation was offered to them.

By talking about their weight earlier on, they can feel more informed about the pregnancy, why they may need to attend additional appointments and which birthing options will be available to them. This avoids potential upset, humiliation or anger later in their journey.

Weight is just one piece of the puzzle though. Often when we're talking about it, we're referring to the many lifestyle aspects that affect health, nutrition, physical activity and general wellbeing.

Finding support

"At 34 weeks pregnant, I'd been told by my doctor that I shouldn't have gained any weight during pregnancy. This absolutely shook me and I cried for days."

Natalie's story is sadly familiar – and unnecessary when there is plenty of support available. So, after you have broached the issue (see part one in our January issue), who can you safely signpost pregnant women to for further support?

- registered nutritionists and dietitians, particularly those who specialise in pregnancy
- local NHS services, where available
- for group-based behaviour-change support in the local community, Slimming World is the only national weight loss organisation that offers membership during pregnancy (for healthy weight management, not weight loss)
- for women with gestational diabetes, support is available through the Healthier You: NHS Diabetes Prevention Programme
- Through their alliance partnership, Slimming World and the RCM have created a joint website offering dietary and physical activity advice for before, during and after pregnancy.

A recent Slimming World survey of pregnant members highlighted that they decided to join at this time to 'support the health of themselves and their babies'. Parents naturally want to do their best for their baby, so it can be a moment in time when they're highly motivated to make a change.

Pregnant members in the survey were more likely to eat fruit and vegetables, less likely to consume sugary and fatty foods and more likely to maintain activity levels throughout pregnancy. Improvements in wellbeing such as increased self-confidence, feeling healthier and feeling more in control of food choices in social situations were also reported.

Regardless of the scales, lifestyle changes and improvements in wellbeing can positively affect the health of the mother and baby and improve how mum feels about herself. For you, feeling confident and well-equipped to guide pregnant women through these conversations is key.

Parklife

Julie Dunlop running at Stormont

Spending time in nature and being physically active has been shown to improve mental wellbeing. Now that spring is finally here, it's the perfect time, says the RCM's Kerry Harkin

South West Acute Hospital midwives at Enniskillen parkrun

According to NHS Charities Together "among the top health benefits people reported from getting outdoors were improved mood (75%), immune benefits (36%), sleeping more soundly (28%) and feeling less stressed (38%). When they spend less time in nature, people report feeling sluggish (37%), tired (25%) and irritable (20%), as well as being less inclined to look after their wellbeing."

Research also suggests that exposure to sunlight raises the body's serotonin levels – and we all know what that does.

We also know that moving more is good for us, but sometimes it's difficult to get started. Small steps can make a big difference. Walking is one of the simplest ways to get active and make time for yourself, and it can be a social activity.

Get active with friends

parkrun started in Bushy Park in London 20 years ago. Now, on an average weekend, 137,256 people take part, with 20,772 volunteers and 978 events across the UK. Despite the name, you don't have to run – you can jog or walk at your own pace. It is a positive, welcoming and inclusive experience, where there is no time limit and no one finishes last (because there's always a 'tail runner' to make sure everyone finishes safely).

parkruns are free events run by volunteers. They are very sociable, with all ages and lots of families taking part. The RCM Northern Ireland team has been encouraging members to go along to their local parkrun and even 'took over' the parkrun in Stormont to celebrate International Day of the Midwife in 2024.

The turnout from midwives was amazing – it included activists, midwifery lecturers and students from Queen's University Belfast, plus friends, family, prams and dogs! The midwives got a huge cheer from fellow parkrunners and three Members of the Legislative Assembly took part in RCM T-shirts.

At the same time, RCM members did parkruns at Derry, Omagh and Enniskillen, and the branches provided healthy picnics and drinks. This year, we're planning the same for IDM, on 10 May.

So why not give a parkrun a go? It's a great way to enjoy the outdoors and get active in good company.

MORE INFO

Try to take more steps each day to improve your health and wellbeing. Tips on getting active can be found at Choose to Live Better **b.link/CTLB-active**

To take part in parkrun, just register for free at **parkrun.org.uk/register**

You can build up to a parkrun using a couch to 5k app **b.link/NHS-C25K**

MAIN IMAGE: SHUTTERSTOCK

How will you be celebrating IDM 2025?

From cakes and parkruns to learning events and dance-offs, midwives and MSWs always celebrate in style

International Day of the Midwife (IDM) takes place on 5 May, and it's an opportunity to celebrate your midwifery community and all the amazing things you do every day to support women, birthing people, babies and families.

This year, the theme is 'Midwives: critical in every crisis'. As the International Confederation of Midwives states: "These are challenging times and midwives are trusted first responders who can be ready for any crisis with minimal resources."

You are amazing and we want to celebrate just what midwives around the world are capable of. Branches, midsocs, colleagues – get creative and work together to see IDM 2025 in style. Past events have included: cake-off baking competitions, learning events, charity bike rides, parkruns and even a *Strictly*-style dance competition. What will you do for yours?

MORE INFO

Join the IDM webinar exploring the experiences of two midwives working in Sudan and Ukraine **b.link/RCMwebinar-critical**

#IDM2025

Show us yours on Facebook b.link/RCM-FB X b.link/RCM-X Instagram b.link/RCM-Insta

Team RCM at the Stormont parkrun for IDM 2024

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A different view

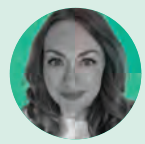
Neurodivergence encompasses a diverse, unique range of strengths and challenges among individuals, which defies any notion of a 'one-size-fits-all' approach. Autism, attention deficit hyperactivity disorder (ADHD), dyscalculia and dyslexia are just a few examples

This highlights the importance of recognising each person's individual needs and capabilities, rather than assuming uniformity in how people think, learn and interact with the world.

And with one in five of us in the UK being neurodivergent (according to the Department for Education's 2024 academic statistics), isn't it about time that neurodivergent individuals were better understood and supported?

MORE INFO

RCM i-learn module *Neurodiversity in the workplace* (study time: 40 minutes). Download the Neurodivergence Acceptance Toolkit at **b.link/RCM-Neurodivergence-Acceptance-Toolkit**



Kayty Richards

KAYTY RICHARDS IS A NEWLY QUALIFIED MIDWIFE AT THE ROTHERHAM NHS FOUNDATION TRUST, AND WINNER OF RCM STUDENT MIDWIFE OF THE YEAR AWARD 2024

I was diagnosed with ADHD in my second year, at the age of 37. Going back into a study environment was difficult. Although I always did well, I had to work incredibly hard and I was becoming really stressed. I needed to understand the 'why' and 'how' behind what I was learning, so when lecturers told me, "You don't need to know that yet," I found that very difficult; I needed the whole picture to process it.

When I got my diagnosis, I cried. After all those times when I had been so harsh

on myself and put myself down, I finally understood why things had been hard.

The university was really supportive. From a practical point of view, I was able to have some extensions, more time in assessments and funded support. I felt empowered. When something didn't work for me, I knew I needed to do it another way – and that that was allowed, without an inner monologue of self-criticism.

For example, I asked to make a slight change in how I approached oral exams – writing down the question before answering gave me the processing time I needed. In my third year, we were due to have back-to-back OSCEs, which I found overwhelming. I raised it with the lecturers, and after they checked in with other students, they separated them into morning and afternoon sessions. Accommodations like that can make things better for everyone, not just neurodivergent people.

Since qualifying, I've noticed new challenges in clinical settings. Wards are very overstimulating, and break rooms can be bright, noisy spaces. Writing up notes in a busy, crowded office is also distracting. I've been working with the head of inclusion and wellbeing to create quieter, more comfortable spaces. Without those basic things, everyone gets tired eventually – but for neurodivergent people, burnout happens much more quickly.

Yes, they might need some support, but I think it is really important to see neurodivergent people for their strengths, not just their challenges. I work really well under pressure, for example. I am good at multitasking, I'm empathetic, I'm extremely driven. The strengths in being neurodivergent don't get talked about enough.

What I would say to neurodivergent midwives and maternity support workers is to be honest – don't be afraid to suggest a change. If you work through an issue, it could actually help support everyone around you to perform better as well.

Emilie Edwards

EMILIE EDWARDS IS A SENIOR LECTURER IN MIDWIFERY AT MIDDLESEX UNIVERSITY AND AN AWARD-WINNING ADVOCATE FOR NEURODIVERSITY ACCEPTANCE AND SUPPORT. SHE CO-LED THE DEVELOPMENT OF THE RCM'S NEURODIVERGENCE ACCEPTANCE TOOLKIT

We've reached the point where it isn't enough to talk the talk – institutions, managers and colleagues have learned about supporting neurodivergent staff, and now they need to actively implement that learning.

I have been very vocal about this, something that does come at a personal cost. I've publicly shared my own lived experiences and found myself in the role of a spokesperson, but that means that people come to me and share their stories – and some are horrifying. Many neurodivergent midwives and students fear disclosing their diagnosis. Others who have disclosed it have experienced everything from disbelief to bullying and harassment, or have been told they shouldn't bother training as a midwife. They feel distressed and abandoned.

The needle isn't moving fast enough. When you consider we're looking at 20% of the workforce or more, institutions are missing a huge opportunity by not supporting their neurodivergent staff to thrive. The NHS is underfunded and overstretched – we can't afford to lose these midwives and students who have so much to bring to the table, if we would only actively support them.

At Middlesex University, we've done a huge amount of work to embed support for students with additional needs from recruitment – how we've built the curriculum, how we assess students and how we ensure they can access a wide range of learning materials. Crucially, we also ensure students are supported on an individual basis.

I would say the first thing to do is to listen to people's lived experience – acknowledge and believe them, then actively do something about it. Most solutions are super simple, such as creating a quiet space, using the professional midwifery advocate network to support colleagues or establishing a 'neurodiversity champion' role. You can always start by just asking the question: "Do you have any reasonable adjustments I should consider?"

We have passionate students being stepped off programmes and told they're "not made for this" when, with very simple steps, they would have been an incredible asset to the profession. As a lecturer, I have seen neurodivergent students who started out completely lacking in confidence emerge as incredible qualified midwives because they had the support to flourish. That is the difference it makes.

IMAGES: SHUTTERSTOCK, ISTOCK

Ruby Handley-Stone
RUBY HANDLEY-STONE, PROFESSIONAL ADVISOR OF EDUCATION AT THE RCM, WAS INVOLVED IN THE DEVELOPMENT OF THE RCM'S NEURODIVERGENCE ACCEPTANCE TOOLKIT

I've always been passionate about inclusivity. After engaging with neurodivergent colleagues and hearing their experiences, it became clear that we needed to actively improve both education and practice to support them better. We know many students with neurodivergent conditions would love to train to become midwives, but may be put off because they fear the course doesn't make allowances for their neurodivergence.

When I joined the RCM two years ago, great work was already being undertaken in this area, including the development of the *Neurodiversity in the workplace* i-learn module. The Neurodivergence Acceptance Toolkit was born out of a recognition that neurodivergent students and qualified midwives are facing barriers that prevent them from thriving in both their education and clinical practice.

Some of the most common challenges include sensory overload in busy environments, difficulties with communication and a lack of awareness among colleagues about neurodivergence, affecting their ability to implement reasonable adjustments. Our toolkit emphasises the importance of creating an inclusive and supportive environment.

Key takeaways include offering reasonable adjustments such as flexible working patterns, ensuring clear and open communication and providing sensory-friendly spaces in maternity units. Additionally, it encourages midwives and educators to adopt a neurodiversity-affirming approach and challenge the stigma that often surrounds neurodivergence.

Progress has certainly been made in maternity services and educational institutions. Many are now offering training on neurodivergence acceptance and there is a growing recognition of the need for reasonable adjustments.

However, more work is needed in many areas. For example, while some universities have begun offering more inclusive recruitment and interview processes and flexible assessment options, there is still a need for greater consistency across the sector.

The RCM plays a crucial role – raising awareness, providing resources such as the toolkit and advocating for systemic change. We continue to present to educators and members, and we've developed a workshop with RCM learning reps that they can share with RCM activists.

The RCM plans to expand resources with more specific guidance relating to clinical practice, engage in further research and work closely with regulatory bodies such as the NMC and NHS Employers to create lasting change.

For midwives themselves, the message is simple: approach neurodivergent colleagues and service users with curiosity, kindness and respect. If you're unsure, ask what support they need rather than assuming. Creating an open, inclusive environment starts with listening and being willing to adapt your practice. In supporting neurodivergent individuals we enrich the profession, creating a more compassionate and diverse workforce.

100-year-old midwife

Albertina 'Tina' Aparicio was born on 31 January 1925 in Trinidad. In 1968, she left its shores to work as a district nurse and midwife in England

At the age of 33, Tina boarded the SS *Colombie* and set sail for England. An orchestra played as the ship left Port of Spain, marking her farewell to her mother and children. Upon arrival in Plymouth, Tina was welcomed by her friend Sybil Batson, a district nurse-midwife in Tilbury, Essex. She recommended Tina for a position at the Tilbury Riverside Hospital.

Following her training at hospitals in London and Berkshire, Tina took on the role of a community midwife in the Thurrock region of Essex. After a promotion to sister, she shared her knowledge and wisdom with aspiring midwives, guiding them through their training and shaping the future of healthcare in the district.

Tina's life as a professional midwife was filled with challenges. "They always seemed to give me the difficult cases," she says. Over the course of her career, Tina brought more than 2,000 babies into the world, with a primary focus on homebirths.

Her reassuring presence made her an indispensable figure in the lives of countless families – indeed, there are many women in the community today with the name Tina.

Tina's career was marked by unforgettable moments. In one case, as she hurried to assist a woman in labour, she caught the attention of the local police, who initially stopped her for speeding. However, they quickly became her escorts, sirens blaring, ensuring Tina arrived without further delay.

In another case, Tina predicted twins for one mother-to-be, only for a doctor to categorically dismiss the possibility. However, Tina ended up supporting the birth of twins, proving a midwife's intuition and expertise.

On one occasion, Tina's young son answered a phone call from an anxious father, saying that "the waters had broken". Misunderstanding the situation, her son innocently replied: "We are not plumbers!"

Tina still lives in Chadwell St Mary, Essex, but at 100 years old her days of being a midwife are now just a happy memory. Her birthday and career were celebrated by several members of the Basildon and Thurrock branch where she practised for 37 years – some of whom remember being student midwives who she trained.

Re:Birth

How we communicate can determine the quality of the care given and received. In 2021, the RCM carried out a collaborative and exploratory project called Re:Birth to understand what language works best.

It found that women and service users wanted descriptive and non-judgemental terms; professionals needed terms that are descriptive and unambiguous about differences in the labour and birth process. Re:Birth developed a system of five As to improve communication.

1

Acknowledge
the woman's previous birth experience, independent of mode of birth, whether this is her first time or if she has had a previous loss.

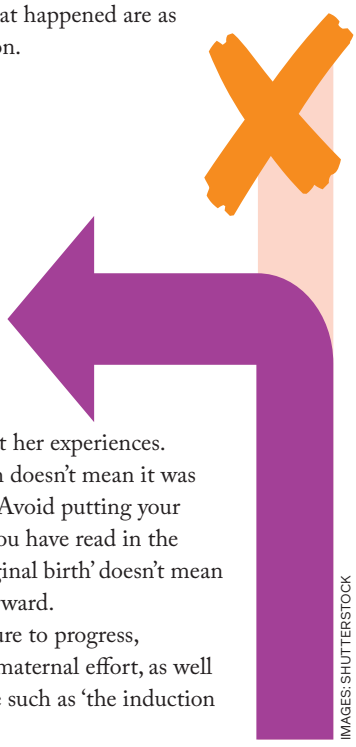
2

Ask
how would they describe the birth(s) they have had or would like to have. Recognise that the woman's feelings about what happened are as important as the description.

3

Affirm
how the birth was described to her and whether those terms feel right and, if not, what she would prefer.

4



Avoid
making assumptions about her experiences. A previous caesarean birth doesn't mean it was very difficult or very easy. Avoid putting your interpretation on things you have read in the notes – a 'spontaneous vaginal birth' doesn't mean everything was straightforward.

Language to avoid: failure to progress, incompetent cervix, poor maternal effort, as well as dehumanising language such as 'the induction in bed 4'.

IMAGES: SHUTTERSTOCK

5

Annotate
Record the woman's own description of her previous experiences and plans. Professionally, the following terms are useful: vaginal birth, caesarean birth, spontaneous vaginal birth, spontaneous labour, induced and/or augmented labour, birth with forceps, birth with ventouse, planned/unplanned caesarean birth.

6

Be mindful
of people who are non-binary or in same-sex partnerships and how the language used affects their care. If in doubt, it's best to ask.

MORE INFO
For more on Re:Birth, visit rcm.org.uk/rebirth

This promotional material has been developed and funded by Pfizer UK and is intended for the UK healthcare professionals.

Prescribing information and adverse event reporting can be found at the end of this article

Protecting Infants from Respiratory Syncytial Virus (RSV): The Critical Role of Midwives in Maternal Immunisation.

Deborah Longe | Lead Midwife for Public Health | London.

The maternal immunisation programme has evolved over the years and is a vital part of antenatal care. In the UK we currently have three vaccines available during pregnancy, namely; pertussis (whooping cough), influenza and respiratory syncytial virus (RSV) vaccine.[1] The use of antenatal vaccines help to prevent and protect against named infectious diseases during pregnancy and the early neonatal period.[1] The maternal immunisation programme includes vaccines that have an acceptable safety profile for use during pregnancy.

The pertussis vaccine was one of the first maternal vaccines to be introduced in 2012.[2] According to the UK Health Security Agency, the pertussis vaccine had a 65.9% coverage of all live births in England in September 2024.[2] Despite the high effectiveness and coverage against pertussis, rates of neonatal mortality have increased in recent months potentially due to low vaccine uptake.[2] This brings up the question of what can be done to raise awareness of the maternal immunisation programme.

In September 2024, the RSV vaccine was introduced to the maternal immunisation programme after extensive consideration by the Joint Committee on Vaccination and Immunisation (JCVI).[3] RSV is a virus which can cause infection of the lungs known as bronchiolitis.[3] The Abrysvo®▼ (Respiratory syncytial virus vaccine [bivalent, recombinant]) vaccine is licensed for use in pregnancy from 28 to 36 weeks across the UK.[4] When vaccination occurs during pregnancy, antibodies are transferred across the placenta to give passive protection to the infant.[1,4] This helps to protect against lower respiratory tract disease (LRTD) caused by RSV from the moment of birth until 6 months of age.[1,4]

RSV causes approximately 26,400 hospitalisations per year in children under 5 years old in England, with around 13,000 of those cases being infants aged less than 6 months.[5] Some of the predisposing clinical risk factors for severe RSV disease amongst infants include congenital heart disease, chronic lung disease, immunodeficiency and prematurity.[6,7] The introduction of this vaccine is key to improving neonatal outcomes in the first 6 months.[4,6] Therefore, similar to the pertussis vaccine, careful consideration is needed in understanding our role as healthcare professionals and ensure the success of the maternal immunisation programme.

Maternal immunisation is vital to our role as midwives where we play a critical role. The invaluable care provided by midwives plays an important role in health promotion which can support women to improve their health and that of neonates.[8] There are several ways that we as midwives can promote the protection against RSV related lower respiratory tract disease and pertussis among neonates, through maternal immunisation.

PP-A1G-GBR-0294. March 2025

Midwives inform women in their care about the different vaccines available during pregnancy and their benefits and risks.[9,10] Where and when to get them is essential because certain vaccines are seasonal (influenza) or may be accessible in hospital or primary care settings.

Answering women's questions about vaccination helps build trust and fosters a sense of autonomy in their decision-making process.[11] Midwives, among other healthcare professionals, should be open to addressing any concerns women may have about vaccination. Open discussions about care not only provide valuable information but also strengthen the women-midwife relationship. Hence, adequate training is also needed for healthcare professionals to feel confident in providing information and care to women.[8]

The World Health Organization (WHO) provides useful recommendations for addressing vaccine hesitancy.[12] This issue is common among pregnant women and healthcare professionals. Vaccine hesitancy can often be due to vaccine-specific factors in addition to individual, group, and contextual factors.[12] As midwives, we are expected to provide women in our care with sufficient information about vaccines for them to make an informed choice.

Midwives also play a role in addressing issues such as access to vaccines and inequalities in vaccine uptake. A holistic approach in promoting the maternal immunisation programme is essential to its success, and as midwives we have a great position of influence to help protect infants from infectious diseases such as RSV and promote overall public health.

Scan the QR code for Prescribing Information.

PP-A1G-GBR-0294. March 2025

Adverse events should be reported. Reporting forms and information can be found at https://yellowcard.mhra.gov.uk or search for MHRA Yellow Card in Google Play or Apple App Store. Adverse events should also be reported to Pfizer Medical Information on 01304 616161.

1. National Health Service (NHS). Vaccinations in Pregnancy. Available at: https://www.nhs.uk/pregnancy/keeping-well/vaccinations/ [Accessed March 2025]
2. UK Health Security Agency. Prenatal pertussis vaccination coverage in England from July to September 2024. Available at: https://www.gov.uk/government/publications/pertussis-immunisation-in-pregnancy-vaccine-coverage-estimates-in-england-october-2013-to-march-2014/prenatal-pertussis-vaccination-coverage-in-england-from-july-to-september-2024 [Accessed March 2025]
3. UK Health Security Agency. RSV Vaccination of Pregnant Women for Infant Protection: Information for Healthcare Practitioners. Available at: https://www.gov.uk/government/publications/respiratory-syncytial-virus-rsv-programme-information-for-healthcare-professionals/rsv-vaccination-of-pregnant-women-for-infant-protection-information-for-healthcare-practitioners [Accessed March 2025]
4. Abrysvo (respiratory syncytial virus vaccine (bivalent, recombinant)). Summary of Product Characteristics United Kingdom. Available at: https://www.medicines.org.uk/emc/ product/15309/smpc [Accessed March 2025]
5. Cromer, D. van Hoek, A. J. Newall, A. T. Pollard, A. J. Jit, M. Burden of paediatric respiratory syncytial virus disease and potential effect of different effect immunisation strategies: a modelling and cost effectiveness analysis for England. Lancet Public Health. 2017. 2(8): e367-e374.
6. UK Health Security Agency. Respiratory Syncytial Virus (RSV): The Green Book, Chapter 27a. Available at: https://assets.publishing.service.gov.uk/media/67a3b62fad556423b636cae2/Green_Book_Chapter__Ch27a_RSV_5_2_25.pdf [Accessed March 2025]
7. UK Health Security Agency. How to protect your baby from RSV Leaflet. Available at: https://assets.publishing.service.gov.uk/media/67a21f7dad556423b636ca18/UKHSA_13180_RSV_Vaccine_and_pregnancy_leaflet_03_WEB.pdf [Accessed March 2025]
8. United Nations. The State of the World's Midwifery 2021. Available at: https://www.unfpa.org/sowmy [Accessed March 2025]
9. Tull, K. Vaccine hesitancy: Guidance and Interventions. The Institute of Development Studies and Partner Organisations. 2019. Report. https://hdl.handle.net/20.500.12413/14747
10. Etti, M. et al. Maternal vaccination: a review of current evidence and recommendations. American Journal of Obstetrics & Gynecology. 2022 Apr;226(4): 459-474.
11. Homer, C. S. E. Javid, N. Wilton, K. Bradfield, Z. Vaccination in Pregnancy: The Role of The Midwife. Frontiers in Global Women's Health. 2022;3:929173
12. World Health Organisation (WHO). Conclusions and recommendations on Vaccine Hesitancy. Available at: https://www.who.int/docs/default-source/immunization/demand/summary-of-sage-vaccinehesitancy-en.pdf?sfvrsn=abbfd5c8_2 [Accessed March 2025]

Tailor made

Over the years, maternity services have rightly placed more emphasis on an ability to serve a diverse community in its entirety. That means understanding the needs of the local community, says Sumayyah Bilal

Nationally published data, from sources such as MBRRACE-UK (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK), has increased awareness that there are stark disparities of maternal outcomes for Black, south Asian and global majority women in the UK. Despite recognition of this health inequality, little has changed.

As a woman of mixed heritage, these numbers are more than statistics as they could have affected the outcomes of my own pregnancies. In 2022, while working as a consultant midwife in a north central London hospital, I established tailored parent education classes for Black women and introduced the role of an equity and equality lead midwife. This article reflects my journey, setting out the learning as a guide for others looking to support local maternity service demographics.

Learning to listen

The Trust's data showed nearly 30% of its maternity service users were from the global majority. A review of the data on serious incidents and cases that were referred to, and met the threshold for, the Healthcare Safety Investigation Branch (now known as Maternity and Newborn Safety Investigations) showed that, even though the global majority accounted for 30% of the local demographic, it accounted for more than half of all reported serious incidents. This reinforced that the work was needed.

All service users are encouraged to share their feedback through surveys or linking in with their Maternity and Neonatal Voices Partnership (MNVP), but there were disproportionately fewer responses from global majority users. So I designed a questionnaire that was sent to those noted to be of Black heritage on their booking forms, with the hope that I could explore their reasons for low engagement and what information would be beneficial to them.

With next to no responses, I then attempted ad hoc phone calls with service users. These were more productive, though there was still hesitancy in giving feedback. Thinking creatively, I then started to approach Black women attending obstetric and diabetic clinics (where there were a high proportion of Black women and birthing people booked in). These corridor conversations were valuable in capturing what was important to them, because face-to-face communication provided greater transparency.

Service users articulated fear of judgement on cultural practice and expressed the desire for a safe space to discuss sensitive matters. They were more likely to engage if the facilitator was also Black.

After consulting the Trust's head of midwifery, I was given the go-ahead to contact Black community midwives to discuss the proposal and incorporated their thoughts and feelings into the model. I established a working group and set up a Trust maternity social media page to promote the classes.

New classes

Based on the useful feedback received, I reviewed the Trust's existing parent education framework and modified the content of the classes. The format was three consecutive face-to-face interactive classes over a three-week period covering antenatal, intrapartum and postnatal.

The first session covered:

- why the classes were created
- icebreaker discussion on their experiences: how do they feel Black women are represented? What challenges or positive experiences have they had? Who are their role models?
- risk factors associated with Black pregnant women
- diet and lifestyle – African and Caribbean Eatwell Guide and food composition
- foods to avoid in pregnancy
- perinatal mental health cultural taboos and local services available
- useful resources
- bonding and getting to know your baby, from pregnancy to birth.

The second session covered:

- preparing for labour
- choices for place of birth
- birth plans and preferences
- what to bring to hospital
- perineal massage and pelvic floor exercises
- signs of labour
- when to come to hospital
- three stages of labour
- what can your birth partner do? – advocating and addressing stereotypes
- pain relief
- activity: what is important to you when being cared for in labour?
- modes of delivery and interventions
- self-advocating and informed choice
- recognising infection on Black skin
- skin-to-skin contact
- activity: physical tour of the unit.

IMAGES: ALAMY, SHUTTERSTOCK

The third session covered:

- how to get involved with the MNVP for better representation
- infant feeding
- benefits and myths of breastfeeding, cultural perceptions of breastfeeding and local support
- positioning and attachment
- hand expressing
- responsive feeding
- nappy changing, bathing baby, and skin and cord care
- cultural practices
- ICON (Infant crying is normal; Comforting methods can help; OK to walk away; Never, ever shake a baby)
- signs of an unwell baby
- identifying jaundice on Black babies
- safer sleeping for babies
- mental health in the postnatal period
- group activity: everyone stand up, then sit down when you feel you would seek professional help
- group discussion: barriers to seeking help? Share who they would ask for help (professional and outside of healthcare)
- how and when to ask for or seek medical help
- feedback/evaluations.

Visual aids demonstrated elements such as recognising presentation of sickness and infection in different skin types, while the face-to-face classes enabled meaningful conversations to take place. This, in turn, helped to develop the structure of the classes and build connections in the community.

Challenges

Despite the classes going well, the process wasn't without its challenges. The proposal of setting up these classes was met with mixed reactions. Some were enthusiastic to try something new in the hope of improving outcomes for an underserved community; some were sceptical that this was, in effect, a form of segregation. Of the original staff approached to support the classes, only four agreed to remain part of the working group and service development.

Additional barriers included clinic space, funding and time. We were forced to be creative with how the classes could be delivered. Weekday clinic capacity was limited, so we held the classes at weekends at hospital sites. Rotas were adapted to factor in staff facilitating the classes and, where this wasn't possible, time was given back in lieu.

Promoting the classes through midwives was inconsistent, as not everyone bought into the model. Because of uncertainty about numbers attending and the initially restricted venue spaces, we put posters around clinics and approached women attending.

Personalised care

Central to Better Births is the principle that maternity care should be personalised and safe. Personalised care means service users have choice and control over the way their care is planned and delivered, based on what matters to them and their individual needs and preferences. Tailoring antenatal classes to meet these seems like a natural step, demonstrating the need to listen to women

IMAGE: SHUTTERSTOCK

and families with compassion. This, in turn, promotes safer care.

Personalised care also has the potential to reduce health inequalities. As MBRRACE-UK has stated: "Maternity outcomes for women are not equal. There remain gaps in mortality rates between women from deprived and affluent areas, women of different ages and women from different ethnic groups."

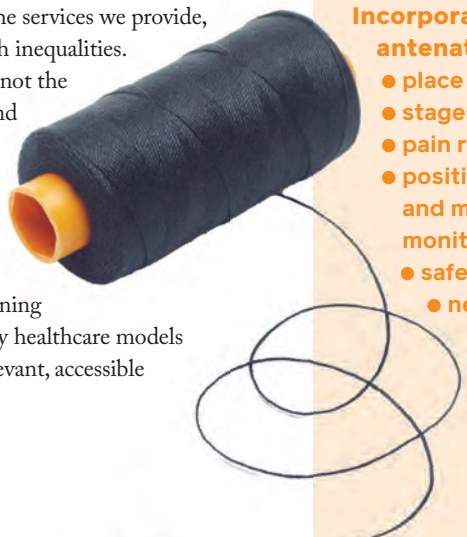
Antenatal education needs to be reviewed and adapted to meet the needs of women and birthing people using the service. A growing body of evidence shows that better outcomes and experiences are possible when people are actively involved and can shape their own care and support.

Results

The feedback was positive and the demand for and attendance of subsequent classes increased. I am proud that, after more than a year of the classes, they have continued to grow and serve the local community. Feedback remains positive and Black women's voices and experiences are being heard, acknowledged and incorporated into care.

My vision was to always scale up the project and offer similar tailored classes to others at risk of poorer outcomes, such as women of Asian heritage. As a midwife, my hope is to continue to empower and better serve our communities, acknowledging individualised risk factors, experiences and voices to improve the services we provide, thus reducing health inequalities.

These classes are not the first of their kind and I hope not the last. We need to think more broadly and increase cultural safety, diversity and awareness, co-designing effective community healthcare models that are flexible, relevant, accessible and welcoming.



FRAMEWORK FOR TARGETED ANTENATAL CLASSES

Trust ethnicity data and reports
- check Trust/Board ethnicity data and reports
- review Trust/Board safety investigation reports – is there a common theme in terms of ethnic groups?

Engagement and listening sessions
- gather views and opinions from members of staff – are they happy to deliver the classes, and to contribute to the content?
- what do service users want to get from the classes – content, online or face-to-face sessions?

Identifying the needs of the ethnic group
- risk factors
- cultural understanding of different aspects of pregnancy, birth and postnatal period
- stereotypes, including mental health stigmas
- local support groups.

Incorporate the generic antenatal classes content
- place of birth options
- stages of labour
- pain relief options
- positions in labour and methods of fetal monitoring
- safe sleeping
- newborn screening tests
- GP check at six weeks.

Tailored content includes:
- risk factors
- diet and exercise
- informed choice and decision-making
- discussion around their own experiences of pregnancy and healthcare – what is important to them?
- cultural practices
- mental health scenarios, when and where to seek help, barriers to seeking help
- contraception
- lifestyle choices (smoking, alcohol use)
- cultural understanding of the postnatal period, including stereotypes, cultural beliefs and choices.

To consider:
- support from local community groups
- engagement of staff (unit meetings, listening sessions for staff)
- members of staff from the target demographic to deliver the classes
- information leaflets in the different languages
- admin resources (e.g. booking management via Eventbrite, sending reminders)
- local venues (easy to access, local to the communities, consider using spaces from local groups to increase engagement)
- include service-user feedback
- bi-annual audit of the classes.

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Waiting game

Things that expectant parents take for granted are out of reach for those seeking asylum and living in temporary accommodation

My husband and I are seeking asylum in the UK; we have three children, including a three-month-old baby. We have been living in hotel accommodation for over two years waiting for our claim to be processed. During my last pregnancy I was anaemic – I regularly felt weak and nauseous, and didn't like to leave the hotel room as I fainted in the street twice. It was really difficult to give my body the nutrition it needed because I'm unable to get fresh healthy foods through the hotel. The foodbank gave me things I have to cook and I don't have access to a kitchen.

In my appointment with the midwife I had a translator, so I was able to tell her I was stressed and weak, and unable to eat a healthy diet. She gave me vitamins and said my situation will be temporary, and that once the baby is born we will be moved to more suitable accommodation. We are still being told three months after the birth that we must continue to wait as there is no housing for us.

My midwife referred me to the charity Newham Nurture, which called me with an interpreter and asked me to visit so they can understand about my situation. I attended their pregnancy classes and received travel money, fresh fruit and a healthy lunch when I attended, which was very good.

Support after birth

At the hotel after the birth, I started to feel unwell with a fever. When I went to A&E I was checked, but they said there was nothing wrong and sent me back home. I felt frustrated and not listened to. My symptoms worsened and I went back to A&E – after an assessment by a doctor they realised that there was placenta remaining that needed to be removed.

I continue to breastfeed my baby, which I'm grateful for as it would be difficult to afford and prepare formula and sterilise the bottles in the hotel room. But soon I will need to make healthy food for my baby, which will be difficult.

Our room doesn't have space for a cot bed or a baby bouncer on the floor, or even space for our baby to crawl. But we have a healthy baby, and we are grateful for this. Newham Nurture has helped us with things for the baby, and the staff are kind and encouraging.

MORE INFO

To find out more about Newham Nurture, visit **b.link/NCT-NewhamNuture**

Watch RCM's 'Pregnant in exile: asylum seeking women's experiences of maternity care' webinar at **rcm.org.uk/on-demand-webinars**

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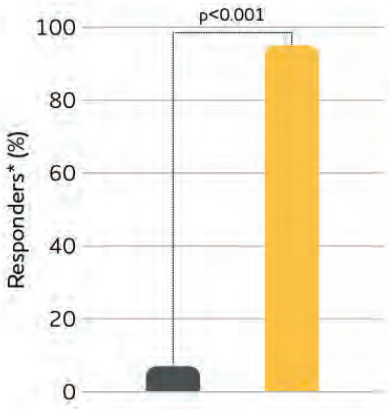
Rate of responders* of *L. reuteri* Protectis versus simeticone



Simeticone (n=42)

L. reuteri Protectis (n=41)

*Infants with 50% or more reduction in daily average crying from baseline

95% successful treatment response

Compared to simeticone, *L. reuteri* Protectis:

- Was superior in reducing daily crying time
- Decreased crying time more than twice as much

Savino F et al. J. Pediatrics 2007;119:124-130

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1 in 10

Around 1 in 10 women develop postnatal depression after birth.

3.1%

3.1% of all vaginal births result in obstetric anal sphincter injuries (OASI).

1 in 4

1 in 4 births in England result in postpartum haemorrhage (PPH).

According to the APPG Birth Trauma Inquiry

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