NCT’s journal on preparing parents for birth and early parenthood

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The passion that NCT practitioners have for helping to improve maternity and infant care for all women and their babies is clearly evident in this Spring issue of Perspective. As we welcome the publication of the National Maternity Review for England, Laura James and Catherine Williams recount their highly rewarding experiences working locally and nationally to improve maternity and newborn care services – a path that other practitioners are warmly encouraged to take. We also bring you research by NCT showing gaps in provision of services for babies with tongue-tie, and look at some of the cultural and other difficulties facing mothers who have recently immigrated to the UK, when trying to access maternity services.

We explore new opportunities for practitioners to learn about the care of babies – and their parents’ experiences - in a neonatal unit and children’s hospice, and the importance of giving special attention to parents of twins and multiples.

Providing further insights into the experiences of new parents, psychology researcher Anna Machin discusses the emotional roller coaster that new fathers can go through as they encounter the reality of fatherhood, while Helen Roy highlights research on assessing postnatal depression in fathers. Anna Hammond contributes a review of the influences on both parents as they negotiate, or not, decisions about work, childcare, and other aspects of family life, in relation to gender. We also review some of the latest Apps that parents may be using, as well as the latest evidence on the important topic of co-sleeping.

Please let us know your views on these articles!

Julie Clayton, Editor, NCT Perspective
Julie.clayton@nct.org.uk
Catherine Williams tells Julie Clayton about how working with parents through pregnancy, and helping to improve local maternity services, led to a national role in the development of new guidelines that will benefit all women and their babies.

How did you become involved with NCT?

When I was expecting my first baby I did NCT antenatal classes. I then became a maternity services user representative in the Midlands in 2004 and joined my local MSLC (Maternity Service Liaison Committee). I became very involved, doing community outreach to Children’s Centres and Sure Start centres. In 2010 I moved to the Thames Valley and became an NCT antenatal teacher — I wanted to work in more depth with expectant parents because I loved going out into the community and listening to women, and their partners when available. I also wanted to learn more about research evidence to help my work and my understanding of the possibilities for women.
Was there anything obviously missing regarding the needs of women and their babies?

When I first started out as a service user rep I had my second baby in my arms and was quite strongly informed by my own experience. One thing I knew was important, though I hadn’t been directly affected, was addressing mental health issues for women and how important it is to be supported both through a network and by a midwife and health visitor who understand how common postnatal depression is, or that for some women going into a new pregnancy there may be important unresolved issues from a first birth. It can be difficult to talk about. We worked on making sure that an excellent service was kept in place.

There was then a review of all maternity services in the area and the MSLC helped the local authority Health Overview Scrutiny Committee to do a survey. We talked to women, took it into community venues, and into our networks. We were looking at the real importance to women and their families — their sense of ownership of the service, knowing what was where, if public transport was poor — how would they get to the clinic? Something that people wouldn’t always be talking about but they do have very strong feelings on.

I really was struck by and valued that experience of a wide range of views and how, if you’re going to have a responsive, effective service, you’re going to have to provide choices. Women are all different and have different needs. Then as now, there was the issue that a home birth service was sometimes so difficult to organise when it ought not to be. The system has to be organised to accommodate choice for women, because it’s the woman who births — my body, my consent.

If you look at the NICE 2014 Intrapartum Care update,¹ it’s very practically focused around planning for birth. It recognises that you need to think about whole system planning and structuring. It looks at healthcare economics for all the recommendations too but that is not the starting point. A NICE guideline starts by looking at the best available evidence, then interpreting that and making recommendations based on the evidence. Then you look at health economics before the recommendations can be finalised.

People often misunderstand that and say ‘ooh that’s being recommended to save money.’ No! It’s recommended because it’s what the best available guidance points to. In this case the recommendation is that healthy women should be offered the choice of all four birth settings, and support for their decision – with evidence-based advice too, to help with their decision. Yes there needs to be some creativity to ensure that choice is provided, but that’s a challenge that people are meeting differently in different areas.
Did your experience of local maternity services help with your work on the NICE Intrapartum Care Guideline Development Group?

Yes it was key. There are two lay members on the guideline and we both have years of experience of working on MSLCs. It’s valuable having people involved at national level who work with women and understand, and are willing to present, their range of views — even if it’s disconcerting sometimes for clinical colleagues to hear you present one view one minute, and then a different view equally strongly five minutes later. Of course clinical colleagues also have a range of experience, so you’re swapping information.

Being part of the networks of MSLC service user reps and NCT practitioners is what is informing me. You’re on the guideline as an individual — you don’t represent an organization. But you’re listening in a directed way in your networks depending on the topics you’re thinking about. Of course, NICE appoints lay members with recent personal experience of services too, but I’m sure they wouldn’t have appointed me if I hadn’t been networked in this way, because my personal experience was not so immediate.

How did your background - including training as a lawyer - contribute to your role?

There are two parts to that — one which concerns me, and one which I hope was beneficial and useful to my colleagues on the NICE guideline.

I come from a privileged professional background (I used to be a lawyer) which is quite often an advantage when it comes to being involved in formal meetings and it helps to be able to read quite complicated documents. However, as an MSLC person, I’m passionate about all MSLC service user reps being supported and — if they wish for it — mentored, so that for people from all backgrounds can participate confidently on MSLCs or in other working groups. NICE supports lay members of all backgrounds really well.

With the NICE guideline I was calling on old skills. I’m not afraid of big documents or daunted by the high volume of work done by email in between meetings. I was asked to lead one of the topic groups — that was huge fun.

I originally did a biology degree in Birmingham and my work as a maternity advocate has brought me back to the science, which I’m really enjoying. As a maternity services user rep I started reading original research papers again. If you want to make an argument for change, you’ve got to look at women’s needs and preferences and views, look at the research evidence, and bring those two together — it makes a more powerful argument.

Of the 10 key recommendations with the intrapartum care update, which ones for you stand out as being most important?

The Planning Place of Birth recommendation and the informed decision-making recommendations that go with it — sharing the research data, the figures, with women, if they choose. So we’ve actually set out the
conversation that you’d expect a midwife to have with a healthy woman about planning place of birth. And that is so exciting. It does happen with some other NICE guidelines but with the maternity guidelines it’s fairly new to have the figures written in.

The second key area is the updated recommendations about interpreting CTG traces and use of CTG machines. Because we’ve taken the recommendations closer to the evidence base for CTG use than the previous ones were — that’s so important. And we’ve also turned the focus very much to the woman rather than to the machine: we’ve emphasized that you look at the woman, ask her questions about her labour at the time, communicating with her rather than simply looking at what the trace is doing.

My third highlight is the two birth culture recommendations put into Planning Place of Birth, around how services, staff and commissioners should provide a compassionate service. This prioritises communication and the provision of unbiased information, so that when consent is given it’s truly informed consent. Women’s choices should be respected and supported.

**How closely do these recommendations match reality?**

It varies from area to area so much because implementing [NICE] guidance is not mandatory. If a problem occurs in a service one of the things that will be looked at is how closely local guidance aligns to the national. Some areas will choose to do things slightly differently. It can often take quite a number of years for new recommendations to be embedded and for people to take them on board. In my local area they have already compared their intrapartum care pathway to the updated guidance, to match the national. But there’s always the question of how the shift is embedded.

**Are you now actively involved in promoting the new guideline?**

Yes, informally. I’m giving some talks and multidisciplinary training sessions with doctors and midwives. I’m talking about it on Twitter and have blogged a little. I’m excited about it. I carried [the guideline], bound into two volumes, all the way to Wakefield to show [a meeting of NCT service user reps and research networkers] the full guideline. That shows really effectively, I hope, that there is a huge amount of research evidence that’s gone into the preparation of the guideline.

I think that’s something that too few people understand. I like to say, ‘We didn’t just sit down and make it up over a cup of coffee!’ This is international standard systematic reviewing. There is a reason that the *Times of India*, the *The New York Times*, *The Sydney Morning Herald* were reporting this as soon as the update was published. It’s like James Bond or cups of tea — it’s a British export. It’s a brand that’s recommended as quality around the world. People are interested in what NICE guidelines say.

**What’s next for you?**

I would always look at opportunities as they come up and consider them one by one. I continue to do all sorts of things that are related. I combine
maternity work with working for a local Healthwatch. I do antenatal teaching and I’m still a service user rep for my MSLC. I do midwifery auditing of Supervisors of Midwives teams, and the RCOG (Royal College of Obstetricians and Gynaecologists) has just appointed me as one of its first cohort of lay co-assessors for invited reviews.

I would like to do more work to promote the public understanding of science, in supporting informed decision-making and informed choice. Where women are offered choices, sometimes sadly they don’t fully have access to the resources, to fully understand. Midwives don’t necessarily have time to spend with women to help and support them to understand the choices. There might be different decision aids and ways of talking about decision-making that could help. A woman may need longer than the 10 minute conversation to really understand and make a choice. I’d like to see the system geared more to supporting women and midwives to make sure that decisions are really informed decisions.

Reference


Get involved!

NCT has a long tradition of user involvement in maternity services and research. We want services and information for parents to be based on high quality evidence, and to be responsive to parents’ needs and preferences. If you’d like to receive news from NCT’s Research & Evaluation department about opportunities and training available for user reps email research@nct.org.uk and we will send you details of how to register.
Why are parents expecting twins or multiples different from those expecting one baby?

NCT tutor and antenatal teacher, Laura Jarman, reveals the answer

It’s a good question – why are parents expecting twins or multiples different from those expecting one baby? In many ways they are not, which is why NCT does not run a specific T&M (Twins and Multiples) Signature antenatal course. T&M parents are travelling the same path as any parent: they often feel unprepared for parenthood,¹ and the skills they require for straightforward birth and feeding and for the transition to parenthood are the same. Many parents of twins say they want to be treated as ‘normal’ expectant parents, especially as they are often singled out as ‘special’ within the maternity services and by family, friends and acquaintances.² As we all know, there are huge variations of needs and wants among the single baby parents we meet and our training enables us to listen and support these parents to make informed decisions about their care and life choices. These are skills we will use for T&M parents too, during our regular antenatal sessions (NCT Signature, Essentials or Refresher course) and within the T&M workshops.

Laura Jarman
Laura Jarman has been an antenatal practitioner in 6D (branch - Solihull and South Birmingham) since 2003 and is now L4 Core Tutor for High Wycombe. She started running Twins and Multiples add-on workshops for parents after trying to establish a Twins and Multiples antenatal course in 2010. She has three children aged 16, 14 and nearly 11. Her closest multiples contact is an NCT friend who has seven year-old twins.
So why are we also offering a ‘bolt-on’ session especially for T&M parents?

If we are already providing for the core needs of all parents through NCT Signature courses, is there something extra that we can offer specifically to T&M parents?

This is a key issue that NCT practitioners can explore in the NCT T&M Facilitation Study Day. The Study Day prepares practitioners to deliver a ‘bolt-on’ three-hour workshop specifically designed for T&M parents who are also attending one of NCT’s regular antenatal courses. Why would parents want (and pay for) a separate T&M session? With most of the workshops that NCT runs, parents attend in order to explore and learn more about a particular topic e.g. Waterbirth or Introducing Solids. They are after information. With the T&M workshop the slant is different. Most parents come to discuss their concerns and anxieties with others in a similar situation. It’s an opportunity to reflect on topics such as how to sleep their babies and how to feed them (breast or bottle; together or separately); to consider strategies to manage life with two or more newborns; how to meet the babies’ needs whilst staying physically and emotionally healthy themselves; and to meet other T&M parents. Several studies report that T&M mothers feel underprepared for complications around birth and the impact of parenting more than one baby. Many feel there is a lack of information and support specifically for their needs. This workshop can help parents to feel more prepared for the birth and parenting of multiple babies. One of the most popular exercises is using dolls to practise picking up two babies, holding and feeding them. It’s usually the dads that participate the most since the mums attending the workshop, pregnant with multiples, often have problems bending! This may sound basic but can be a large hurdle for adults who have had little previous contact with babies. It always reminds me of that scene in Friends when Chandler and Monica cannot work out how to swap babies!

Making connections and developing a group that will work both during the session to explore topics but also as a support network after, helps in the challenging postnatal days. Whilst the couples attending are often separated by distance, they do share experiences and discussions via digital communications and, of course, will also have the more local network established with their regular antenatal course mates.

What about the dads and partners?

A lot is written about the needs of mothers expecting multiples, but what about their partners? There is usually a need for partners to be more involved in baby care when there is more than one baby and yet they are often overlooked by maternity services and NHS provision. Partners benefit from discussions away from the mums: they explore concerns about the safety of mum and the babies, and concerns about complications. These are topics that they will not raise often in front of the mum for fear of worrying her. Partners also need the space to discuss postnatal life –

- how to manage the balance of work and parental responsibilities;
- when to take parental leave if the babies are in SCBU;
- the balance of responsibilities if extended families are involved.
It is also crucial to address expectations regarding work and parental responsibilities in two groups (mums and partners), in order to enable the partners to explore their worries, aspirations and practical arrangements.\(^5\)

**So what does this mean for practitioners working with parents?**

A major challenge for the antenatal teacher who leads the T&M workshop for parents is to facilitate these bonds within three hours. I find it essential for parents to work in small groups and to have opportunities to discuss and explore various topics. I often feel that my role is to throw in pebbles (topics) and let the group investigate the ripples. Resources are also essential: pictures of parenting and feeding twins, and lots of dolls, enable clients to picture themselves with real babies and investigate what is likely to work for them.\(^2\)

You will notice that clients come keen to share concerns, so part of our role is to encourage positive feelings. Many describe the reaction of friends and family when they announce a multiple pregnancy as ‘Well you’ll have your work cut out’; ‘Wow, don’t envy you the lack of sleep’; ‘It will be a caesarean section then’. T&M parents want to share the same excitement and expectation of the pregnancy as any other parents-to-be. Sharing the reasons ‘Why multiples are great’ enables this excitement to build and really lifts the atmosphere of the group. It supports the anticipatory exploration of birth, feeding and parenting during later exercises.

As practitioners, we must also be aware of the need to tread a fine line between acknowledging extra risks and hurdles that T&M parents may face, whilst remembering that multiple birth is a physiologically normal event. Having a firm knowledge base provides us with the confidence to hear about clients’ individual situations whilst recognising that we will not know all the details of each pregnancy or complication. By being aware of the terminology, risk factors and potential hurdles, we are able to listen and prompt, to provide guided reflection to help parents to reach informed decisions. On occasions we can reduce anxieties by knowing the risk factors (‘all twin pregnancies are dangerous’ – really?) and we can support those with complicated pregnancies to be ready for managed births and for the arrival of premature or ill babies in a more focused way than might be possible within a Signature, Essentials or Refresher course. We can help clients to understand the advice (often under the guise of information) that they are being given by professionals and acquaintances and relate their situation to the evidence and research. This knowledge base is addressed by the current T&M Knowledge Study Day including pre-reading and a quiz but an online module is also being developed to support this learning and replace the need to attend a Knowledge Study Day. The knowledge base is essential for those running the T&M workshop, but many have attended as a way of boosting their confidence to support parents in their antenatal courses.

Remember that this workshop is designed as an ‘Add-on’ to a Signature, Essentials or Refresher course. We are not trying to fit an entire course into three hours. Trust your fellow practitioner, who is running their antenatal course, to cover the birth and transition to parenting. Your job in facilitating...
the workshop is to create a support group, help the clients tailor the
knowledge from the course to their situation and provide extra information
on pertinent topics such as hospital protocols for labour with multiples and
care of premature babies. Many practitioners will do this within a course,
but it is rare to have two or more T&M couples to investigate the
ramifications together.

Of course, life is rarely straightforward. With the scheduling of workshops,
it is common for clients not to have finished their regular antenatal course,
or in some cases not to have started it. This means that there can be lots of
signposting to the course content to underpin some of the discussions. For
example, when covering hospital recommendations for the management of
labour, clients may not have covered the skills and hormones that facilitate
birth and bonding.

I don’t want to run T&M workshops. How can I
use the T&M Study Day in my classes?

Even if you are not running specialist T&M workshops for parents,
most practitioners will meet T&M parents within their courses and the
development of a sound knowledge base can boost your confidence so that
you can facilitate appropriate learning. There are techniques that you can use
to help other groups of ‘special’ parents besides specifically those expecting
T&Ms, such as allocating couple discussion time after certain exercises. This
benefits same-sex couples, parents with a disability, mums with pregnancy
complications such as diabetes, low-income couples, older parents, ethnic
minority couples, those who have English as a second language, those living
with parents or with little support etc – in other words, there are very many
circumstances where there are special requirements that can be dealt with in
a more tailored fashion!

I would like to investigate running T&M
workshops – what do I need to do?

ANTs need to be accredited to run T&M workshops. This involves:

• doing the pre-reading and completing the online knowledge module to
demonstrate your knowledge base; and
• attending the Facilitation Study Day.

If you decide not to run the workshops then you will have increased your
knowledge base on T&M and developed facilitation skills for running
workshops and for addressing the needs of diverse couples. The soon-to-
be-available online knowledge module will be open to every practitioner. If
you would like to discuss the knowledge base then you can also attend the
Knowledge Day. NCT breastfeeding counsellors and postnatal leaders also
have access to a Knowledge Study Day aimed at supporting parents with
multiples postnatally.
Tamba and NCT multiple births report

The recent report on multiple births by Tamba (Twins and Multiple Births Association) and NCT\(^1\) was released in November 2015. It highlights the following interesting aspects which are relevant to practitioners:

1. Less than 18% of maternity units fully implemented the NICE guidelines\(^2\) and there is no specific guidance for intrapartum care for multiples (p1). Access to a specialist multiples midwife is a particular issue. Practitioners should be aware of their local hospital’s level of implementation and intrapartum protocols.

2. Over 50% of multiples arrived via elective birth (either induction or caesarean birth) (p3). Whilst 86% of women had discussed the mode and timing of birth with their obstetrician or midwife, some felt that they were not given a choice but pushed into a caesarean or vaginal birth against their wishes (p7).

3. Parents of multiples were unhappy about the advice they received from their obstetrician and midwife on preparing for and actually caring for the babies postnatally, including midwifery advice on feeding. Whilst practitioners would not look to advise parents, this does highlight the desire of parents for antenatal preparation for postnatal life with twins and multiples (p8).

4. Over a third of parents said they were not supported in any way to achieve their feeding preference. Of those who received support, 62% were supported by health professionals, 5.9% by a breastfeeding network, 3.9% by NCT and 2.3% by Tamba peer supporters (p12).

5. Only 42% of respondents said they were given advice about safe sleeping for multiples (p13).

What is the situation in your area?

Can you influence your local Trust to implement the NICE guidelines\(^2\) and provide twins and multiples antenatal workshops?

Can you increase the visibility of NCT services for T&M parents?

References


Tamba Peer Support Line

Tamba’s NCT trained peer supporters group have supported mothers of twins and multiples for over three years. The aim of the scheme is to support mothers across the UK using email, phone, texting and social media, depending on their preference. Initial contact with the group of 14 peer supporters is through a general email tambabreastfeeding@gmail.com which is picked up by the on duty peer supporter and then responded to. Many of the peer supporters also volunteer at local breastfeeding drop-in groups or hospitals, and are active in local twins’ clubs or on Facebook.

Mothers may seek support during pregnancy, wanting information on how to breastfeed two or more. After the babies are born contact may be for a variety of reasons. Often it is the need for someone just to listen - who understands what they might be experiencing - or to help them find a way to make breastfeeding work for their family.

Many of the peer supporters have been part of the group since it began and share the whole team’s enthusiasm and commitment to supporting fellow mothers. Contact between team members happens through email and monthly Skype sessions in which we share experiences and reflect on the support we can offer.

Janet Rimmer
Breastfeeding counsellor, peer support trainer and co-founder of the Tamba Peer Support Line, and mother of 20 year-old triplets.

Sharing and networking

Laura Jarman’s Twins and Multiples workshop has proven extremely useful for Nadine Saunders – who was 22 weeks pregnant with non-identical twin girls when she attended with husband Paul (pictured left) – and for Abi Wood, 34 weeks pregnant with twins, and husband Adrian (pictured right).

They were joined by one other couple, and valued enormously the chance to meet face-to-face with other parents expecting twins. ‘It was the first thing we’d ever done – any antenatal class,’ says Nadine. ‘We didn’t know what to expect.’

For Abi, it was a welcome change to being with friends with single babies. ‘Although you can relate to it all I find that [friends with single babies] don’t want to talk about how hard it is because they’ve only got one, and vice versa, I don’t want to say how tough it is for me going through the pregnancy because every pregnancy is different.’
The workshop provided a forum for sharing a range of concerns. For Abi, this included about tiredness and how to give equal time to each baby, to provide adequate physical care and for bonding. 'It’s nice to see that other people have got similar concerns and to have the reassurance that all you can do is try, and those feelings aren’t abnormal.’

She felt encouraged by Laura’s use of photos of mothers breastfeeding twins. 'It just shows that anything is possible.’

'The exercise we were all given with two dolls – how do you pick them up, hold them, hand them over - it was made to be quite fun but I found that really worthwhile and my husband did too,’ recalls Nadine.

The mums have set up their own What’s App group, as have the dads. 'We’ve had conversations about things like, “what are you going to buy?” and “what are you going to do about feeding?” Hopefully that group will continue,’ says Nadine. 'It’s great to have a support network of other people who know what it’s like.’
Using your BRAIN for Pregnancy Apps

NCT tutors Helen Darlaston and Samantha Havis provide a quick update on what to look for in Apps that many parents are likely to be using.

NCT is moving into the digital age. Without losing the fantastic skills of face-to-face facilitation we have developed over 60 years, exciting new ways of learning are now complementing our more traditional approaches. From volunteer training, to practitioners’ continuous professional development; from ‘NCT Birth and Beyond’ practitioner training to peer support training, flexible, creative ways of using technology for learning are starting to be explored.

Taking our lead from parents, we are also beginning to look at the impact of new technologies on our parent-facing courses and workshops. A new App is now available to provide supporting information for NCT Signature courses. In this article, we are going to look at Apps and their relevance for expectant and new parents, and those who work with them.

A quick search on Google Play or iTunes will reveal hundreds of pregnancy, birth and parenting applications or ‘Apps’. These Apps vary in both quality and content. As educators we need to consider how to support parents and
parents-to-be to use this rich resource to empower their decision making and enhance their perinatal experience.

In our experience as antenatal educators, we have found that parents are coming to classes with high proficiency in using digital information sources. Many people who may not have had the motivation to read a book are readily accessing information through mobile technology. Whereas once we would have asked people to switch off their phones during a class, we now find we are integrating them into our facilitation.

It’s important to remember too that Apps that are useful to parents may not even be specifically birth or parenting Apps. To be able to order your TESCO/Sainsbury’s/Ocado shopping from your phone whilst breastfeeding, to catch up on your favourite programme on iPlayer that you missed because the baby was unsettled, to be able to chat to someone from your NCT group on WhatsApp at 3am, these are invaluable ways technology can benefit new parents.

In classes we often use the acronym BRAIN (benefits, risks, alternatives, instincts and nothing) to help parents ask useful questions and consider various aspects of a situation or course of action. To help educators consider their role in helping parents navigate the world of Apps, we’ve adapted BRAIN.

**Benefits**

- Women use a variety of strategies to find information when pregnant; Apps are just one of them.\(^1\)
- They can answer simple questions easily.
- They can offer social support particularly to isolated women (e.g. Facebook, WhatsApp, Google hangouts).
- They appeal to many learning styles with pictures, videos, in-App games as well as text information.

**Risks**

- They have limitations like most mass media and deal with the usual and common rather than the personal and specific.
- The information given may not be current best practice or country specific due to the global nature of the internet.
- There is a lack of evidence for the effectiveness of Apps (as opposed to traditional ways of giving information).\(^2\)
- Not all parents and parents-to-be have access to smartphones or tablets that can use Apps. An awareness of this and information still available in a variety of formats is essential.

**A few Apps**

Below is a small selection of high quality, evidence-based Apps that meet our evaluation criteria (see box ‘evaluating Apps’).
<table>
<thead>
<tr>
<th>App name</th>
<th>Description</th>
<th>Information and features</th>
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<tbody>
<tr>
<td>Mi-App <a href="http://www.perinatal.org.uk/MiApp/About.aspx">www.perinatal.org.uk/MiApp/About.aspx</a></td>
<td>Developed by the RCM this App offers an electronic copy of a woman's maternity record that fully integrates with existing NHS electronic systems.</td>
<td>-Available from the middle 2016.</td>
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<td></td>
<td></td>
<td>-Holds test results and appointment data.</td>
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<td></td>
<td></td>
<td>-Available in 18 languages.</td>
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<td></td>
<td></td>
<td>-Pregnancy and postnatal information including what to expect in labour.</td>
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<td></td>
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<td>-Women have easier access to their information.</td>
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<td></td>
<td>-Printed versions available still to women with no smartphone access.</td>
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<tr>
<td>Baby Buddy App <a href="http://www.bestbeginnings.org.uk/">http://www.bestbeginnings.org.uk/</a></td>
<td>The Baby Buddy App has been developed by Best Beginnings to support parents and parents-to-be with personalised content approved by doctors and midwives that spans from pregnancy right through to the first six months after birth. Further postnatal content is also being developed up till the child's third birthday.</td>
<td>-Mums and Mums-to-be can create their own 'buddy' who supports her on her perinatal journey.</td>
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<tr>
<td></td>
<td></td>
<td>-Daily information chunks.</td>
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<td></td>
<td></td>
<td>-Simple and easy to use and understand.</td>
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<td></td>
<td></td>
<td>-Useful appointment and question sections.</td>
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<td>NCT Babychange App <a href="http://www.nct.org.uk/parenting/nct-babychange-app">www.nct.org.uk/parenting/nct-babychange-app</a></td>
<td>Babychange is an NCT developed App which helps parents avoid the stress of changing a nappy by showing baby changing facilities nearby. It also allows mums and dads to add new facilities they find and rate them for cleanliness. A new version launched in Autumn 2015 has a refreshed design to make it more user-friendly with increased accuracy and more locations.</td>
<td>-Easy to use and find facilities.</td>
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<td></td>
<td></td>
<td>-Location and map function.</td>
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<td>Pocket Midwife <a href="http://bit.ly/20hUkt4">http://bit.ly/20hUkt4</a></td>
<td>Developed by Nottingham University (NU) Hospitals after asking women what they wanted a pregnancy App to do, the App promises to be everything you need to know about your pregnancy in your pocket.</td>
<td>-A developments calendar that includes a selfie gallery that women can upload pictures of their bump as it grows.</td>
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<td></td>
<td></td>
<td>-Leaflets and links to NHS advice (some of it is NU hospital specific).</td>
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<td></td>
<td></td>
<td>-Contraction counter and ability to send a birth announcement to your phone contact list.</td>
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<tr>
<td>The Lullaby Trust Baby Check <a href="http://www.lullabytrust.org.uk/babycheckapp">www.lullabytrust.org.uk/babycheckapp</a></td>
<td>Developed by the Lullaby Trust this App has 19 checks which test for symptoms and illness in babies.</td>
<td>-Developed from a four year project looking at babies under six months old at home and in hospital to find the most accurate assessment symptoms.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>-Easy to use.</td>
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<tr>
<td></td>
<td></td>
<td>-May help reassure new parents.</td>
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<td></td>
<td></td>
<td>-It recommends you contact a doctor if a parent is still worried or concerned.</td>
</tr>
</tbody>
</table>
Informing
• Ask what parents and parents-to-be are using themselves. What would they recommend to a friend?
• Help parents and parents-to-be to evaluate Apps effectively (see box below).
• Create a list of reliable Apps that you have investigated or had recommended by other practitioners.

Now what?
As the Millennial generation move into parenthood, the majority of the parents and parents-to-be that we now encounter in our different roles are experienced users of technology. Those of us who work with women and their partners during the transition to parenthood cannot bury our heads in the sand and ignore this. By being aware of the most commonly used Apps in pregnancy, birth and parenting and using technology as a teaching aid alongside our more traditional ways of facilitating learning we can hope to further empower parents on their perinatal journey.

Further reading

Evaluating Apps
• Investigate the source of the App. Is who wrote it reliable (healthcare professional, professional organisation, individual)?
• Does it cost anything and what do you get for your money? What does it do with the data it collects from its users?
• Is the information it gives reliable, accurate and non-biased? Is it referenced? Is it applicable to you?
• How easy is it to navigate within the App and access the content?
• Do you like the look and feel of the App?
(Adapted from reference 3)
Cultural awareness and maternity care

Women who have recently migrated to the UK face many challenges when it comes to using maternity services, but training for healthcare workers to develop better intercultural awareness and communication can help alleviate the problems and improve women’s experiences, says Rachel Heathcock

This article introduces two projects in the East of England which provided an insight into the health and social care needs of recently migrated women from outside of the European Union (often termed as third-country nationals*), and supported by the European Integration Fund. The projects revealed not only the challenges for these women and families in accessing maternity care, but also the challenges for healthcare workers dealing with different cultures and traditional practices.

As NCT practitioners, it is important to ensure that we provide services that reach and engage with the needs of all of the diverse and dynamic

Rachel Heathcock
Rachel Heathcock is an antenatal teacher and project worker. She has a degree in third-world studies and a PGCE in secondary education. Rachel has worked in many areas of the public sector including mental health, education, and emergency planning and is now a project worker with the East of England Local Government Organisation. She has two children, Luke aged eight and Lucy aged five.
communities in the UK. Third-country women and their families have a wealth of knowledge that is invaluable and could influence approaches to maternity care in the UK. The opportunity to share experiences and knowledge should be promoted and explored as an example of best practice for all to follow.

When reading this article it is important to remember that every individual is different and will not uniformly share the beliefs or practices of their faith or cultural community. Many customs, rituals, beliefs or practices possibly may not apply or be as important to an individual if they are younger or a second or third generation UK citizen.

The EACH and ACCESS Projects

Embedding Ambassadors in Community Health (EACH) focussed on female migrants who came from beyond the EU’s borders (India, Pakistan, Bangladesh, China and Africa) to the East of England, in order to promote their use of healthcare services.¹

The aims of the project were to develop intercultural awareness for healthcare professionals and to provide culturally-appropriate healthcare for non-EU migrant women. This was achieved by the project team working with local Black, Asian and Minority Ethnic (BAME) community groups who delivered highly interactive workshops to frontline staff on intercultural awareness and also on working effectively with interpreters in healthcare settings.

The Acquiring Cultural Competence, Equalities, Successful Safeguarding (ACCESS) project followed the EACH project. Using the knowledge and findings from the EACH project, ACCESS was similar in delivering cultural awareness training to frontline local government workers and other public sector staff working with new migrant communities from outside Europe.²

What about the migrant women?

Our aim with both projects was to contribute to the health and social care improvement of recently-arrived migrant women. We conducted ‘Open Dialogue Workshops’ (ODWs) — informal facilitated sessions for an invited cross-section of professionals and local migrant women — so as to offer recently-arrived women a unique opportunity to meet health and social care providers in community venues. Through interpreters we helped the women share their positive and negative experiences of accessing health and social care services.

Both the recently-arrived women and health and social care providers commended this face-to-face contact as an invaluable opportunity to share experiences and improve/adapt services. One healthcare professional commented, ‘I never knew how many different cultures we had living in our town, thank you for this opportunity.’

What was learnt from the projects?

The women had difficulties in understanding and/or accessing services and mentioned, for example, the complexity of booking appointments and poor communication systems. Many women had arrived from countries with completely different healthcare systems. Those who became pregnant, for example, did not know that they were entitled to antenatal care and support and often did not meet a midwife until the third trimester of pregnancy.
Interpreting and translation continually caused concerns. Many women spoke little English and depended on their husbands for interpretation. This meant that they struggled to access health services until their husbands returned home from work, often late in the evening or at the weekends, when many of the services had closed. One woman explained that she was unable to access health visitor appointments in the local town as she could not drive and the bus service was very irregular. She had not heard that health visitors would visit her at home.

Without encouragement and support, migrant populations who do not have a good command of English will avoid integrating into local communities, which in turn makes it harder for them to learn English. Some women come to the UK and never leave the house alone. As a result they become isolated and lonely, especially if they become pregnant and have no-one to ask for advice or support apart from their husbands.

The women described how posters, letters and service information leaflets were all provided in English, and even women who could read English found that the language used was too complicated to understand. Aubrey Mason from Translation and Interpreting Provider Ltd (TIP) in Ipswich explained that translators are requested by health professionals to call clients to let them know about their appointment times and venues that use interpreters. ‘It proves very effective as the clients understand what is written in a letter and they are also made aware that an interpreter will be available to translate at their appointment, making them more willing to attend.’

There was a feeling amongst some BAME clients that staff do not understand (or do not necessarily want to understand) other cultures and/or the associated beliefs and practices which may impact on how they use public services. However, I spoke to many health and social professionals who were very interested in developing their knowledge and understanding of different cultural practices and religious beliefs, but lack of time and resources affected their ability to do so effectively.

The workshops highlighted that some third-country national women were arriving in the UK after arranged marriages in their home countries. In some cases, once in the UK, the women realised that they were not happy in their new homes and really struggled to adapt to their new lives.

Often these women are young and speak little English and do not know how to access support outside their new family. The workshops highlighted the importance of making sure that third-country national women knew their rights, and had opportunities to access services and support.

**Recognising and understanding different cultures and traditions**

Information gathered by facilitators who took part in the EACH and ACCESS workshops enabled us to identify many cultural practices and traditions relevant to pregnancy, birth and the postnatal period, which are important to the migrant communities involved. We were then able to refer to these in the training provided to health and social care professionals. The following examples are from the Indian, Chinese and Kenyan communities based in the East of England.
The Indian community
In Ipswich, when a recently-migrated Indian woman’s pregnancy is confirmed, she will often first inform her mother and then her mother-in-law, one of whom then plans to be with her as soon as possible. They constantly advise (instruct) her by phone on how to manage her pregnancy until they arrive from India.

The news of the pregnancy would not be disclosed outside the family for at least three months. The pregnant woman is treated almost like a princess, advised to take a lot of rest, and has her diet supervised remotely. After the baby is born the mother is given a diet rich in proteins, fats and carbohydrates, while the baby’s feeding plan may also differ from what is considered customary in the UK.

When the new mother arrives home after the birth, she can rest as senior family members do all the work and care for the baby, keeping it wrapped up most of the time, and avoiding exposure to the outdoors if cold.

*With thanks to interpreter Prachi Katdari from Ipswich Community Media*

The Chinese community
In the Chinese community, ritual is important. During the first month after the birth (‘sitting month’) the mother will stay at home and do minimal tasks in order to look after herself, including not washing hair for a month, and not having a bath or shower straight after birth. She eats nutritious food, such as chicken and ginger, so as to improve health.

Family also plays an important role. The new mother’s mother will try to help out so that her daughter can rest. A new mother will not return to work until after at least one month. It is very common for women to give the baby a bottle when they return to work.

‘This is our postnatal care, doing minimal task, eating nutritious food and let the body to avoid water during that month.’

*Thanks to Aubrey Mason and Annie Chow from Translating and Interpreting Provider Ltd*

The Kenyan community
In the Kenyan community a child is considered to be raised by the whole community or village. During pregnancy a woman is given light tasks and is well supported by extended family.

‘When the mother returns home she is given special care by family. We have special food, soups that are given to the mother. ‘Njahe’ is from the beans family — it is boiled and mashed with ripe bananas or plantain — it is believed to help the mother produce milk for breastfeeding.’

‘Breastfeeding is a norm; it is equated to motherhood — when one of the midwives in the UK asked me if I will be using the bottle or breastfeeding I thought it was a strange question.’

Traditionally, breastfeeding is encouraged and helped by mothers carrying their babies in a sling. The baby can be rotated round to face the mother’s

Grandmothers and mothers advise their daughters that breastfeeding is the key to all the problems of the baby; it provides contentment, close comfort and reassurance.
chest and feed — wherever they are. Grandmothers and mothers advise their daughters that breastfeeding is the key to all the problems of the baby; it provides contentment, close comfort and reassurance. Women are told to read their babies, as babies are open books.

*Thanks to Rachel Walton from African Families in the UK (AFiUK) CIC for the information provided.*

**The Bangladeshi Community**

Healthcare professionals can be the first people Bangladeshi women get to meet and know outside of their family in the UK. Many women are unaware of their rights in this country and don’t know that when they speak to a health professional the conversation is confidential.

Bangladeshi women regard health professionals as authority figures and it is important that professionals to use this trust and respect to educate and empower women. For example post-natal depression is still not recognised in many communities. Often women are called lazy or are accused of trying to avoid work if they share their feelings with family. Women may also be treated by witch doctors or given herbal remedies to treat post-natal depression.

Health professionals can support these women and their families by offering guidance and advice and explaining what post-natal depression is and how it can be treated. This education is essential to help remove the negative stigma associated with mental health.

*Thanks to Lila Begum from ATA CIC*

**What can cultural awareness teach professionals?**

The EACH and ACCESS projects have led to the following recommendations:

- Be aware that cultures are different and need to be respected. See the ACCESS project cultural diversity guide
- Do not be afraid to ask questions, if you cannot pronounce someone’s name ask them how it is spoken. Ask whether you can shake a person’s hand — do not presume. Asking does not offend, making continuous mistakes will.
- Appreciate that women wear different clothing in different cultures.
- Consider that in many cultures it is not acceptable for women to be alone with men they do not know, so if possible offer a female professional to support the woman.
- Extended families have a very important role during pregnancy and postnatally in many BAME families. It is important to remember that family members travelling from abroad will be constrained by the time limits of travel visas and women may require extra support when their extended support network has to return home.
- Interpreters have an essential role. Ensure that the woman giving birth knows what is happening. Don’t focus on the husband or mother-in-law — use external interpreters if possible. It is important to know what the woman wants in labour, not just other family members.
- Be aware that it can be very lonely for a woman who does not speak English when her birth partner leaves after the birth.

*Postnatal women express symptoms of low mood differently, therefore I am more aware that symptoms of physical pain may also be an indicator of postnatal emotional/ psychological unhappiness.*

NHS staff, December 2013 (Ref.1)
• Consider the dietary needs of different cultures.
• Be aware of female genital mutilation (FGM). Women who have undergone FGM will probably not be familiar with this terminology, but they will require very special care. More information can be found on the Daughters of Eve website: [http://www.dofeve.org/about-us.html](http://www.dofeve.org/about-us.html) and in the Home Office’s FGM multi-agency practice guidelines: [http://bit.ly/1OUm7Bb](http://bit.ly/1OUm7Bb)
• Health professionals will need to consider that pregnant migrant women may have other issues that they need support with such as visas, housing, and specific reasons for leaving their home country. If professionals do not understand all the issues they may not develop a relationship with the mother. This is where they need to work in partnership with organisations that have skills and knowledge of BAME communities.
• Find out about the BAME groups in your area, what work they do and how you can become involved. Many groups welcome speakers — could you go and speak to the group about your work? Or would a representative from the group come and speak at your organisation?
• Be informed: the Race Equality Foundation has produced a wide range of briefings on minority ethnic health and wellbeing which are available to download from [www.better-health.org.uk](http://www.better-health.org.uk/). There are also many reports and studies available to review at the National Institute of Health and Care Excellence (NICE) at [www.evidence.nhs.uk](http://www.evidence.nhs.uk/) and through the NCT at [http://bit.ly/1OUIYh2](http://bit.ly/1OUIYh2)

*Third-country nationals, in migration terminology are those legally living within the EU who are not nationals of any of the current 28 EU member states.

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**References**

Making a difference to maternity care

Voicing the needs of parents to a room full of health professionals and commissioners could be a daunting task but NCT antenatal teacher Laura James relishes her role on her local Maternity Services Liaison Committee – here she explains the huge difference it can make for all parents.

Maternity Service Liaison Committees (MSLCs) were established in 1984 as a way of enabling women to help shape the maternity services they were using. MSLCs are collaborative, meeting at least four times a year, and bringing together health care professionals including midwives, health visitors, obstetricians, neonatologists and anaesthetists, with commissioners, representatives from public health, local Children’s Centres and crucially, the women who use the services and groups which represent them. The NCT has a long history with MSLCs and many NCT practitioners around the country are involved with their local committees.

Some MSLCs were disbanded following changes to NHS commissioning structures in England in 2013, but the majority of NHS trusts in England...
do have an MSLC in place (according to a recent NCT survey of Heads of Midwifery – to be published soon). How active the groups are varies across trusts. The Department of Health is due to publish an updated edition of the 2006 national guidelines for MSLCs, commissioned by NHS England’s Head of Patient Experience, and supported by Julia Cumberlege, chair of the national maternity review. These guidelines underpin the value of MSLCs as independent advisory committees, ensuring that the body that commissions maternity services listens to, and takes account of, the views and experiences of both those who use and provide local services. The recently published National Maternity Review from Baroness Julia Cumberlege, also highlights the role of MSLCs, stating that ‘Maternity Service Liaison Committees (MSLCs) provide a means of ensuring the needs of women and professionals are listened to and we saw how effective they could be when properly supported and led.6

In Autumn 2013 I was approached by consultant midwife Pauline Cross who was planning to set up a new MSLC at the Princess Royal University Hospital (PRUH) in Farnborough, Kent. The hospital was about to be taken under the wing of King’s College Hospital NHS Foundation Trust, after the dissolution of South London Healthcare Trust.

After the first couple of meetings, I was voted in as chair and had a very steep learning curve. Luckily Pauline was on hand to give some guidance and make sure we were off on the right foot. We also benefited hugely from an NCT VOICES workshop in February 2014, facilitated by Gillian Fletcher, who expertly guided us through our aims and achievements to date and helped us form a tangible action plan for the year ahead.3

I had said yes to that initial invitation from Pauline because I had spent the last few years as an antenatal teacher helping to improve maternity experiences for a small number of individuals in each class I facilitated. I recognised that becoming involved with the MSLC would help me ‘widen the net’. Why would you not want to try to reach as many parents as possible in your local area and actively do something to improve those services that your clients are accessing?

Our local MSLC exists in order to plan, monitor, develop and improve maternity care for women, partners and families in Bromley. Our Terms of Reference are based on the Department of Health guidelines which recommend that the committee should have a lay chair and that a third of the committee should be made up of service users or service user representatives, in other words, parents or those who represent parents. We have representatives from different parent voice groups including doula, the Stillbirth and neonatal death charity (SANDS) and the NCT. Several different factors make up a successful, robust MSLC and I’d like to outline why I think our MSLC works so well.

Firstly, we have a cohesive, driven, dynamic team, no hierarchy, and a real sense of everyone working towards one purpose. Having simple icebreakers at the start of each meeting, including asking the group to share something that is not maternity-related, for example, something they do in their spare time when the weather is fine, help to foster this notion of equality. In addition, we have a Development Day once a year during which we vote on
our action plan. Everyone’s views are respected and carry equal weight. This idea of equality can be a difficult line to walk. It can sometimes be challenging for healthcare professionals to listen to the voice of service users and it can likewise be daunting for women who may feel, as they don’t have a medical qualification, that they are not qualified to have an opinion. However, our team of healthcare professionals are exceptionally respectful and actively engage with and listen to the women’s voices.

Secondly, we seem to spend a lot of time on social media. Platforms such as Facebook and Twitter enable us to network with other MSLCs and healthcare professionals nationwide to share ideas, challenges and successes. It is also a good forum for getting feedback from women and publicising the work of the MSLC. Recently we devised a poster thanking the staff on the maternity wards for their hard work, as feedback from our Walk the Patch scheme (see achievements below) has been so positive. We uploaded the poster to Facebook and to date it has been shared 34 times and reached 4837 people, with other MSLCs keen to do something similar (see more examples at www.facebook.com/BromleyMSLC and @bromleymslc on Twitter).

Thirdly, I think our committee was established in the right place at the right time, by someone with a wealth of experience. With the change in hospital trust, it seemed as though support and a willingness for it to succeed were there from the start. We had achievable Terms of Reference that set out clearly how the committee was to be run, funded and maintained by the Clinical Commissioning Group (CCG), members of which have been extremely supportive.

That is not to say that there are not barriers and obstacles to our smooth running. We, along with many other MSLCs, have difficulty recruiting and retaining service users from vulnerable and hard-to-reach groups. We would like our committee to be representative of all women who use local maternity services and we are certainly not there yet.

One of the other obstacles is the sheer amount of volunteer time the committee takes up. It is a constant juggling act, as in many jobs, trying to find the right work/family life balance. In addition to the day-to-day running of the committee, there are always external meetings and some weeks a chair can spend approximately 20 hours working for the committee.

**Achievements**

We are extremely proud of our achievements since we were established, which include:

- designing a poster showing the birthing room which is now on display in all the birthing rooms on Labour Ward;
- implementing Walk the Patch in the hospital: once a month a service user committee member will tour the ward and talk to women about how their experience has been and if there are any improvements they would like to see. This information is then fed back to midwifery managers. We are about to start a similar scheme in the community (at antenatal and postnatal clinics in the local Children and Family Centres);
• helping to shape a new perinatal mental health pathway in Bromley. We provided testimonials from women who had experienced perinatal mental health issues and these testimonials helped to secure the funding from the clinical executive for a new pathway. The service users continue to play a role in advising on the pathway and services should be operational within a few months;

• running a range of consultations and surveys on local maternity services, including one on tongue-tie services;

• improving the birth environment in two rooms on Labour Ward (effectively making them more home-from-home rooms). The MSLC drew up a wish list of items we would like to see in the rooms and the entire list was donated by the baby loss charity 4Louis; and

• creating and displaying these birth affirmations (inset) in birthing rooms on Labour Ward.
Whose Shoes?

In January 2016 our MSLC co-hosted a Whose Shoes?® event at the Princess Royal University Hospital, Bromley. These interactive workshops are the brainchild of Gill Philips and bring together those working in maternity services with service users to discuss maternity issues. Participants make pledges about how their practice will change as a result of the workshop and the MSLC aims to ensure that the action plans are followed over the next year. The Whose Shoes® initiative is closely linked to the #MatExp grassroots Twitter campaign which aims to improve maternity experiences for everyone; service users and healthcare professionals alike.

At the recent babblelive! 2015 NCT conference for practitioners and volunteers, Nick Wilkie, the new CEO of the charity, spoke of his desire to see the NCT reach as many people as possible. This was highlighted by the choice of plenary speakers: single mother Anya Harris, Tim Atkinson, a stay-at-home dad and Emily Slater from the Maternity Mental Health Alliance. All three speakers represent groups that the NCT may not traditionally have reached, but is actively trying to engage with. I passionately believe that the work of NCT practitioners dovetails beautifully with the work of MSLCs and is highly reciprocal. Practitioners already have knowledge of clients’ hopes and fears surrounding birth and can be real advocates for those parents. By becoming involved with an MSLC, I feel as though I am working to improve maternity experiences for all local families, not just the eight couples on a course at any given time. It is my way of reaching groups who might not access NCT classes. Equally, as a practitioner, my work on the MSLC has been so beneficial for my teaching. I now have a thorough understanding and knowledge of how my local unit works, which can only benefit my clients. I also have a great professional working relationship with the healthcare professionals there, so I can ably assist my NCT clients by signposting, and feedback any concerns directly to the midwifery managers. As well as urging anyone with an interest in maternity to join their local MSLC, I would especially recommend NCT practitioners who want to enhance their practice to get involved with their local committee; it is thoroughly rewarding to know you are helping to make a difference to so many families’ lives.

References:

Resources
NCT resources on MSLCs, including the practical guide to MSLCs, consensus statement on MSLCs released by NCT, the Royal College of Midwives and Royal College of Obstetricians and Gynaecologists, case studies and templates:
https://www.nct.org.uk/professional/mslcs

Care Quality Commission ‘Maternity services survey 2015’:
http://www.cqc.org.uk/content/maternity-services-survey-2015

NICE antenatal care pathway:
http://pathways.nice.org.uk/pathways/antenatal-care#content=view-node%3Anodes-women-who-had-problems-in-a-previous-pregnancy

NICE guidance on intrapartum care for healthy women and babies:
http://www.nice.org.uk/guidance/cg190

NICE guidance on the patient experience in adult NHS services: improving the experience of care for people using adult NHS services, February 2012:
https://www.nice.org.uk/guidance/cg138

NHS England maternity review:
https://www.england.nhs.uk/tag/maternity-review/

What other members of MSLC, Bromley, say:

I feel so valued by the team we work with and believe we really make a difference.
As I have no medical background it’s great being able to objectively review situations and be honest about potential improvements without getting caught up in work place policies and opinions. It’s an amazing team of people who really care, and great to see people have a voice.

Service user rep
As both a parent and a professional working in the NHS I have found the MSLC to be a very valuable body, willing and able to provide time, information and qualified perspectives to help improve maternity services for all. I also really like the way they work with us, as a considered, critical friend.

Service user and NHS professional
To me it is local women empowered to improve services for local women. Women ensuring the services we provide are relevant to the changing needs of our community.

Healthcare professional
Like-minded individuals who are in pursuit of compassionate and contextual maternity care and are committed to making a difference to women and their families. A positive driving force. For me personally the MSLC has inspired and motivated me to keep going, and provided me with courage and resilience when times are tough.

Healthcare professional
Huge variation in NHS infant tongue-tie services

Surgery to relieve tongue-tie in babies is simple and effective and yet in many areas there is little or no provision for diagnosis, treatment or support, sometimes resulting in severe feeding difficulties. Patricia Wise, breastfeeding counsellor and NCT tutor, reveals the findings of a recent NCT survey of NHS infant feeding leads

In 2014, following an enquiry from the BBC to NCT about tongue-tie and then a request for parents to write to NCT about their experiences, it became very apparent that some UK parents were very dissatisfied because of a lack of availability of a tongue-tie division service for their baby. The NCT Press Office collected 30 stories from parents and these mentioned a lack of NHS support, no services in some areas and women stopping breastfeeding before they wanted to due to feeding problems. NCT wrote to the then Health Minister, Dan Poulter, and a parliamentary question was also asked. NCT members were encouraged to write to their MPs calling for better services.
It seemed sensible to me to obtain a clearer picture of the actual provision of such services and a small working group led by Senior Policy Adviser, Rosie Dodds, and including Head of Research, Sarah McMullen compiled a set of SurveyMonkey questions to send to infant feeding leads in the NHS.

**Tongue-tie effects on baby and mother**

A tongue-tie occurs when there is tightness in the cord-like membrane (frenulum) under the tongue. This is only significant if it affects how the tongue functions so, if a baby with a tongue-tie is feeding well, no action is needed. Some babies can have a very noticeable tongue-tie (called anterior) yet manage to feed well enough, while others can have a scarcely visible tongue-tie (called posterior) and feeding may be severely affected. In more noticeable cases, where the frenulum is attached at or near the tip of the tongue, the tongue often does not protrude beyond the lower lip and can look heart-shaped. Some babies with a tongue-tie suck more strongly, presumably to compensate for the restricted tongue movement.

Studies indicate that up to one in ten babies has a tongue-tie but maybe half of those manage to feed satisfactorily. Babies who are breastfeeding are more likely to be affected and have difficulty with attaching well to the breast but some struggle with feeding from a bottle; feeds can take a long time, with milk dribbling from the baby’s mouth.

If a mother has painful, damaged nipples it is very likely that the baby is not attached well enough at the breast. A baby who is not obtaining enough milk may need more frequent feeds or better attachment. It is therefore crucial that any mother who is having difficulty with breastfeeding receives skilled help. Sometimes, even with a tongue-tie, improvements to the baby’s attachment at the breast are enough for feeding to become effective. Thus, only if other factors have been addressed and excluded first can a baby be assessed as having a tongue-tie affecting feeding. While there is concern about under-diagnosis of tongue-tie, there is also concern about over-diagnosis, in situations where tongue-tie is assumed to be the cause of difficult breastfeeding without skilled help being given first.

The division procedure is quick — cutting the frenulum with scissors to release the tightness. The risk of not dividing a tongue-tie that has been assessed as affecting breastfeeding is that the mother is more likely to stop breastfeeding early.

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**When Emma’s baby Theodore was born he was unable to attach to the breast, despite help from midwives. He was described as having a severe tongue-tie, which was divided in the hospital at one day old. He then managed to attach but only shallowly so needed top-ups of expressed milk and formula. Emma was convinced he still had a tongue-tie and eventually, when Theodore was six weeks old, his tongue-tie was divided at a community NHS clinic. However, he then refused to attach. After eight days he suddenly did attach and at last he could feed well. Emma was able to have the experience of her baby breastfeeding that she had longed for, although she did then suffer three bouts of engorgement!**
Becky Carter’s newborn son Aidan lost weight and a tongue-tie seemed the likely cause. Becky started expressing breastmilk but needed to top-up with formula. As there was a six to eight week wait for local NHS tongue-tie division she paid for division privately. Straightaway Aidan seemed to attach better. While breastfeeding was still not easy, so Becky continued to express and use some formula, she did find it to be a wonderful experience, and only regrets that the tongue-tie wasn’t snipped earlier.

Becky and local breastfeeding counsellor Kathryn Maintzer report that, early in 2015, NHS Buckinghamshire Trust acknowledged that their ‘NHS tongue-tie referral pathway was becoming increasingly difficult with long waiting times. A new pathway initiated in December 2014 to John Radcliffe Hospital, Oxford, reduced waiting times to under two weeks, with work underway to provide a tongue-tie division clinic at Stoke Mandeville Hospital. The Trust is pleased to announce this is complete, with the service beginning imminently.’ While the waiting time can still be up to two weeks, there has been a marked improvement in the service.

What is the evidence that surgery can help?

Ten years ago, NICE (National Institute for Health and Care Excellence) stated that tongue-tie division is a safe procedure that may help breastfeeding. Since then more studies have been done, including some involving randomising babies to a sham procedure first to try to eliminate the placebo effect. Double-blind randomised trials would be hard to organise as mothers may be reluctant to be in a control group and can often identify whether their baby has had a division.

Edmunds et al reviewed the literature in 2011, confirming that tongue-tie can negatively affect breastfeeding for babies and mothers and that division is a simple, safe and effective procedure. There have been five randomised controlled trials, which all show an improvement in mothers’ experiences of breastfeeding. Hogan et al used single blinding and mothers in the intervention group reported significant improvements in subjective experience compared with the control group. In Dollberg et al’s randomised crossover study, control group participants were initially given a sham procedure. There was a significant reduction in maternal pain scores in the intervention group and a non-significant improvement in latch. Buryk et al’s study involving a sham procedure showed that, although there was a placebo effect, there was a significantly greater reduction in maternal pain and improvement in latch in the frenulotomy group. Berry et al’s 2012 double-blind study found a significant improvement in mothers’ reported experience of breastfeeding following division. Emond et al’s study included only tongue-tie cases assessed as mild or moderate. There was a significant improvement in maternal self-efficacy — in effect confidence in being able to breastfeed. Use of the existing LATCH tool to assess breastfeeding did not show a significant improvement yet the qualitative interviews indicated mothers tended to experience relief from painful feeding. This suggests that the LATCH tool was not sensitive enough.

In all the studies, division was offered for babies in the control group within five days of the intervention group so it is not possible to demonstrate differences in breastfeeding duration between the intervention and control groups. Also, different methods of assessment were used and there is limited evidence about which babies are most likely to benefit from division.
Survey findings
The link to the survey was passed on by Francesca Entwistle, coordinator of NIFN, the National Infant Feeding Network, to the regional infant feeding leads, who in turn sent it to the local leads. Fifty one per cent of NHS Trusts (England and Northern Ireland) and Boards (Scotland and Wales) were represented in the responses, which showed that, in this snapshot, at least 42% of all the Trusts and Boards do have a service and at least 10% do not. The findings confirmed what was suspected — the huge variation in the services provided:
• mainly hospital-based but some community-based
• some commissioned, some not
• some providing a service for bottle-fed babies, some not
• some accepting referrals for posterior tongue-ties, some not
• some accepting out-of-area referrals, some not
• variation in the divisions as a percentage of new births in an area from less than 1% to 7%
• variation in the waiting times for division, with 10% waiting for more than 3 weeks
• variation in the maximum age for referrals from one to two months to no limit
• may be run by midwives, ENT surgeons, maxillofacial surgeons, dentists or paediatricians
• variability in the quality of assessment
• breastfeeding support is not always available immediately after division and follow-up is variable
Several barriers to setting up a service were mentioned, including funding, staffing, lack of training and the need for a suitable venue. In some cases, differences in clinical opinion was mentioned as an issue, despite the 2005 NICE guidance, resulting in disagreement on the need for a service.

Report recommendations
1. All Trusts/ Boards work towards or maintain Baby Friendly status, to provide adequate skilled breastfeeding support.
2. If needed, parents have easy access to a tongue-tie service.
3. Services have sufficient capacity.
4. Identify priorities for further research.
5. Review the training process, particularly for quality control.
6. All who work with mothers and babies recognise tongue-tie division can be beneficial.
7. Agree good practice protocols.
What can practitioners do?

1. Where the opportunity arises, convey accurate messages about infant tongue-tie:
   - no action is needed unless feeding is affected
   - skilled help is needed to assess whether division of a tongue-tie is likely to improve feeding.

2. If a mother’s breastfeeding experience is unsatisfactory, signpost her to skilled breastfeeding help.

3. If there is no assessment and division service locally, or the service is unsatisfactory, raise awareness in a forum such as an MSLC or with the Head of Midwifery or local commissioner.

References


Further Information


Barriers to identifying and dealing with postnatal depression in fathers

I have chosen to highlight a study of how paediatric nurses in Sweden engage with postnatal depression in fathers, with the specific aim to examine recognition of paternal postnatal depression and the barriers to observing these fathers.


Postnatal depression in fathers is now widely recognised and although there is little research in this area compared to postnatal depression in mothers, there is evidence that paternal postnatal depression has a negative effect on child development, the couple relationship and the parent-child relationship. It follows logically then to question how postnatal depression in fathers is identified and the barriers to this.

In Sweden, paediatric nurses visit new families in their homes shortly following birth with the aim of supporting health, and seem to have a similar role to that of health visitors in the UK. The study by Hammarlund and colleagues took a qualitative approach, interviewing a small sample of ten nurses from six health care centres over five geographical areas of western Sweden.

The study identified several themes:

- Difficulties in recognising fathers with depression during the postnatal period; fathers rarely talk about their feelings.
- Establishing contact with the fathers is challenging. Nurses have little regular contact with fathers and fathers rarely put themselves forward. However, first-time fathers were more eager to be present at a nurse visit.
- The indirect route of finding out about the father’s health status through the mother, although perceived to be important, is potentially unreliable as second-hand information and requires follow-up.
• Lack of routines through which to assess the health and wellbeing of fathers. Nurses rely on observation and asking questions to detect depressive symptoms. Nurses perceive postnatal care as focusing on the mother and child rather than on the entire family.

• Different gendered-parenting practices hinder fathers’ engagement. Stereotypes of gender roles in parenting on behalf of both nurses and parents were seen as a barrier to equal care being given to mothers and fathers.

Although the study represents a different health care system and culture to the UK, it highlights problems with postnatal care not being family inclusive. It recommends the development of screening tools for postnatal depression in fathers and highlights the need to involve both parents in postnatal care. Whilst it would be useful to explore these issues from the perspective of both mothers and fathers, this study highlights the importance of postnatal care for fathers. It provides a good starting point for practitioners to reflect on their own attitudes towards gender roles in parenting and supporting fathers in the postnatal period.

Further reading
Evidence made easy

Co-sleeping

1. Where do babies sleep?

Although a cot is generally considered an essential item for a baby, around half of UK parents bring their baby into their bed to sleep, for all or part of the night, at some time in the first three months.¹ This is often not planned but evolves as a way of meeting the family’s need for sleep. Babies may start the evening sleeping in a Moses basket or cot, and move into the parents’ bed when they wake for a feed. Others may be returned to the Moses basket or cot after a feed.

Sharing a bed for sleeping is more common when babies are breastfed. A UK survey found 61% of breastfed babies slept with their mothers at least occasionally compared with 38% that had only formula milk. This means that, on any given night in the UK, around one quarter of infants under six months of age spend part or all of the night sharing a sleep surface with a sleeping parent.² Data for older babies is more limited; one UK study found 21% of babies were bed-sharing on any one particular night.³

Video studies have demonstrated that breastfeeding mothers and babies have relatively consistent behaviours when bed-sharing: facing each other, with babies at breast level and mothers in a ‘C’ shape.³
It is useful to share this information with parents antenatally as, without experience of young babies, they may not realise why parents do co-sleep. It also encourages discussion of ways to enhance practical safety arrangements, wherever babies sleep.

What do we mean by co-sleeping and bed-sharing?

Unfortunately different definitions are used when discussing co-sleeping and bed-sharing. We consider:

- co-sleeping to mean sleeping nearby and sharing a room but not necessarily a bed with a parent, whereas
- bed-sharing means a baby or child sleeping some of the time in the same bed as an adult.

Under these definitions co-sleeping includes babies in a Moses basket or cot next to the parents’ bed and bedside cots which attach to the parents’ bed.

Note that the NICE guideline defines co-sleeping as ‘parents or carers sleeping on a bed or sofa or chair with an infant’.4

2. Why do parents bed-share?

Reports from mothers around the world give the main reasons as ‘ease and convenience of breastfeeding’, comforting, better/more sleep, monitoring their baby, bonding/attachment, reducing crying, tradition, and their own instincts.5,6

Other reasons included the enjoyment of close contact with their baby and a ‘family bed’ parenting philosophy. Some parents know they plan to bed-share for cultural reasons or beliefs,7 others begin bringing their baby into bed in response to tiredness, to settle their baby, or to improve sleeping for the whole family.

3. What are the advantages and disadvantages of bed-sharing?

Research enumerates the potential dangers associated with bed-sharing more clearly than the advantages. Cross-sectional studies indicate that bed-sharing is associated with higher rates of infant death if babies sleep on a sofa or chair with an adult or in bed with adults who smoke, drink alcohol or take other drugs which affect sleep.8 The risk factors are similar whether considering sudden infant deaths (SIDS) or accidental suffocation. Premature or low-birthweight babies are particularly vulnerable to SIDS, and bed-sharing is associated with a higher risk of SIDS in the first three months in several studies.

On the positive side, babies gain comfort and security from closeness to their parents. Advantages put forward include more sleep, facilitating breastfeeding, more stable infant heart rates and breathing patterns, and increased maternal response to infant cues.3 There is limited evidence of
longer-term advantages or differences in attachment, partly because of problems related to controlling for factors which both influence parents to bed-share and other parenting behaviours.

Although it is hard to differentiate cause and effect, there is some indication that co-sleeping enables continued breastfeeding. Breastfed babies who bed-share feed more frequently at night in the early days, which helps milk production. The perception of ‘insufficient milk’ is one of the commonest reasons for stopping breastfeeding early.

4. What does NICE guidance say?

In 2014 NICE reviewed the evidence relating to co-sleeping in the first year. It considered that there was a lack of data related to sofa sharing and therefore defined co-sleeping as ‘parents sleeping on a bed or sofa or chair with an infant’. Neither evidence on bed-sharing as a means of enabling the continuation of breastfeeding, nor the risk of accidental death when sleeping with a baby on a sofa, were considered.

NICE found evidence that, where ‘co-sleeping’ occurs, there may be an increase in the number of cases of SIDS. Because a causative relationship was not proven, the term ‘association’ is instead used to describe the relationship. NICE does recognise that ‘co-sleeping can be intentional or unintentional’ and advises health professionals to:

- discuss this with parents and
- ‘inform them that the association between co-sleeping and SIDS is likely to be greater when they, or their partner, smoke.’

Also the association may be greater with:

- parental or carer recent alcohol consumption, or
- parental or carer drug use, or
- low birth-weight or premature infants.

5. Which factors reduce the risks associated with SIDS and accidental deaths in bed?

- Parents avoiding consumption of alcohol or drugs which affect depth of sleep
- Making the room in which the baby sleeps a smoke-free zone
- Placing babies to sleep on their back, on a firm, flat surface
- Ensuring that babies cannot wriggle under pillows or duvets
- Avoiding overdressing or covering babies with too much bedding (no more than an adult would use)
- Preventing overheating of the room (16-20°C is ideal).

Breastfeeding is also relevant as breastfed babies have a lower risk of SIDS and the effect is stronger for exclusive breastfeeding.

6. Why are sofas a particular risk?

The proportion of baby deaths on sofas increased in recent years, from 24 to 42 deaths a year in England and Wales, during a period when the overall SIDS rate halved. In a detailed study, alcohol or drugs featured in half of these deaths, and in seven cases ‘the parents wanted to feed their infant and...
inadvertently fell asleep’ while sofa sharing. Accidental infant deaths on sofas are usually due to asphyxia from entrapment between an adult and the sofa, overlay, or wedging against the sofa cushions.

Parents need accurate information to understand and balance risk factors. A recent survey of over 700 mothers with babies 0-6 months found that 40% who had slept with their baby had done so on a sofa or armchair, although most had discussed SIDS with their health visitor.

7. What are the advantages of bedside cots?

There are few studies involving bedside cots though it is clearly important that the cot is securely attached to the side of the adult bed and safety factors are adhered to, such as the use of a firm mattress and avoiding pillows. On postnatal wards, mothers preferred using the bedside cot which, after caesarean section, made it easier for them to reach their babies and cope with breastfeeding than it was for women who used a separate cot. In a randomised controlled trial of bed-sharing, bedside cots and separate cots on postnatal wards, babies in separate cots breastfed less frequently than the other two groups. In the absence of further evidence, it is reasonable to assume that removing recognised risks from the sleep environment will reduce risk to the baby. However, it is not clear whether the link between sleeping with an adult smoker and SIDS, for example, is reduced if the baby is in a bedside cot.

References


Resources


What influences gender equality in the home during the transition to parenthood in contemporary Britain?

By Anna Hammond

In many ways contemporary British life is more gender-balanced that at any point: for instance the gender pay gap is closing, albeit slowly, and more women than men are accessing higher education. Although families are reflecting these changes, with fathers becoming increasingly involved with their children, there is also evidence that gendered values become reinforced during the transition to parenthood, with mothers being denied opportunities in the workplace and fathers finding barriers to their being the involved father they often want to be. This article summarises the results of a literature review considering gender balance and parenthood. Evidence suggests that gendered beliefs influence behaviours during the transition to parenthood. Whilst many men and women express non-traditional beliefs, their behaviours demonstrate that involvement in paid work, child care and housework often follow traditionally gendered lines.
Historically, work-life balance policies have been based on beliefs about the division of family roles, reflecting women’s economic dependence on men. The welfare state was created with post-war values on the premise that married women would be responsible for unpaid work in the home, and it can be argued that these values have had a greater impact on the domestic division of labour than policy and legislation.

In contemporary Britain, gender-neutral policies, such as parental leave and requests for flexible working, are designed to support both mothers and fathers to work and be involved in caring for their children. They reflect a recognition that ‘women’s skills are being underused in the workplace and at the same time fathers’ desire to be involved with their children is being frustrated’. However, family-friendly policies and legislation that are designed to be gender-neutral are, in fact, interpreted by many employers and employees as being designed for women with children, with assumptions being made that the mother has responsibility for care and that the father’s involvement is a matter of personal choice. How policies are formed and implemented, how they are taken up by parents and employers, and how mothers and fathers engage in paid work is influenced by gender. The tensions that exist between working and parenting are viewed in terms of mothers’ employment; family-friendly policies are insufficient in addressing this tension.

However, parents’ experiences demonstrate there is a shift in behaviours and a move towards less traditionally gendered views with gendered beliefs and the uptake of policies changing over time. There is a blurring of gender boundaries and an increased desire to challenge gender norms. Where fathers have access to parental leave they are likely to take it and those with access to flexible hours policies make use of them. This in turn has a positive impact on balance in family life.

Despite this evidence of change, and antenatal intentions to challenge gendered norms, the reality is often that postnatal behaviours return to gendered stereotypes. Working practices are said to be incontrovertibly gendered, with the main reason for gender discrepancy in the workplace being parenthood. The dominant British model of full-time male worker and part-time female worker is in itself gendered. Whilst men, particularly in professional roles, are expected to commit to long working hours, mothers are considered to be second-income earners and able to take flexible working patterns to care for their families. The literature would suggest that fathers identify strongly with a breadwinning identity, which both mothers and fathers interpret as a demonstration of his commitment to his family. For some, being a breadwinner may even justify his existence.

Evidence would suggest that British men, who already work amongst the longest hours in Europe, work slightly longer hours when they become fathers, possibly fearing that their career prospects could be damaged by being committed to caring for their family. Fatherhood coincides with a career stage that demands longer working hours, but this does not fully explain the increase, and according to Biggart & O’Brien, becoming a father is a small but significant predictor of working longer hours. In this context it is interesting to revisit Hochschild’s seminal work of the late 20th century, which states that women miss out on working opportunities ‘because men
do not share the raising of their children and the caring of their homes’. Women’s lives are often restricted by parenthood in a way that men’s aren’t. Women are more likely to be influenced by beliefs about child care, with a distrust of formal child care settings. They may, therefore, be more likely to return to work when informal child care arrangements, such as relying on family or friends, can be made. Decisions about returning to work, however, are also gendered. Child care costs play an important part in decisions made, but they are usually taken in the context of the woman’s salary, rather than both salaries, reinforcing the concept of a woman’s income being secondary.

Whilst some fathers identify strongly with a masculine provider identity, and this limits their caring practices, it is widely recognised that fathers’ involvement in caring for their children improves the child’s well-being and family relationships in a range of ways. Attitudes and practices are shown to be changing across the generations and caring for children is becoming more evenly, if not equally, balanced as parents attempt to find ways to be more involved with their children within the constraints of working life.

There is a move towards less traditional views and the increased involvement of fathers, although this does not fundamentally challenge societal beliefs that women are primarily responsible for their families. Not only does the quantity of child care between couples fall into gendered lines, so does the quality, with the belief that men and women care differently: ‘Fathers care about their children whereas mothers care for them’. Women are more likely to spend time on core physical tasks that often rely on some degree of routine and schedule, thereby impacting on their daily lives to a greater extent than fathers who are more likely to spend time playing and talking, activities which are not reliant on timings and are therefore less restricting.

The reality of the practice of caring for infants is explored by Miller. Her research showed that amongst a group of fathers, the antenatal intention to be as fully involved as possible in caring was clear. With an expectation of the mother being the main carer, fathers anticipated that they would be involved with all aspects of child care other than breastfeeding. The reality was different, however, with men describing quickly becoming less skilled in caring. This reinforced their belief that women are more naturally designed to care, and that their own caring role was secondary. Miller’s early interviews with the fathers revealed couples sharing and learning together with the fathers on paternity leave, but a divergence occurring when the fathers returned to work when they changed their earlier attitudes and began to opt in and out of caring and taking responsibility. They increasingly take what could be interpreted as a path of least resistance, an option that is not generally available to women. Fathers describe feeling uneasy caring within this mainly female domain, identifying wariness of perceived social suspicion of men.
Consistently, research demonstrates that women undertake more housework than men, with women doing the majority of the core housework duties described as cooking, cleaning, laundry and ironing. In the UK, women are reported to spend 78% more time on housework than men. An analysis of the literature examining this phenomenon highlights an increase in the amount of housework women undertake when they become mothers, with a pattern being established of mothers taking responsibility for housework and fathers helping out with less core tasks such as DIY. This could be seen as being directly linked to the working practices of women, except for the fact that this

**Implications for NCT Practitioners**

The NCT has a responsibility to consider gender-balance during the transition to parenthood to ensure that the charity achieves its vision to support both mothers and fathers. Many egalitarian couples who attend NCT antenatal classes will find that the reality of parenthood means that the mother’s life becomes restricted in a way that the father’s isn’t. ’I’d known that life with a newborn would be tough but what made it so hard to bear was the disparity that was emerging between my existence and that of my husband. Having a child meant sacrifice in return for a richer existence, but why was the sacrifice all mine?’

How can practitioners support all mothers and fathers to make choices that are right for them?

Often difficulties arise when parents have different expectations of involvement from each other. Whilst acknowledging that antenatal intentions often do not translate into postnatal actions, antenatal teachers can encourage couples to discuss how they envisage sharing work in and out of the home.

Working non-judgmentally to support individual decisions and by exploring expectations of their roles as parents, parents’ values and beliefs both antenatally and postnatally could be valuable.

Practitioners can reflect on their own journey to parenthood: what influenced their choices and decisions regarding work, caring and domestic practices?

Consider what impact gender imbalance may have on clients’ relationship satisfaction and on their mental health.

Consider the impact of language on new parents. For instance although ‘parent’ appears to be a gender-neutral term it is often interpreted subconsciously as being intended for mothers; therefore using the words mother and father may be more balanced. Think about the images and stories that are used: do they reinforce stereotypes or support a more gender equal society?

the father in which the father’s relationship with his child is facilitated by the mother. He may care for his child to please the mother rather than to meet the needs of the child.  

Consistently, research demonstrates that women undertake more housework than men, with women doing the majority of the core housework duties described as cooking, cleaning, laundry and ironing. In the UK, women are reported to spend 78% more time on housework than men. An analysis of the literature examining this phenomenon highlights an increase in the amount of housework women undertake when they become mothers, with a pattern being established of mothers taking responsibility for housework and fathers helping out with less core tasks such as DIY. This could be seen as being directly linked to the working practices of women, except for the fact that this
The pattern is replicated amongst dual income egalitarian relationships. It may be that couples compensate for gender balance in some areas of their lives by returning to gendered norms in others. The NCT is an evidence-based and parent-centred organisation; this means we have to understand the evidence for the experiences that new parents have as well as supporting the choices they make. The evidence would suggest that choices for men and women becoming parents are restricted along gendered lines. Even in egalitarian relationships, heterosexual couples fall into gendered norms that go beyond restrictions placed by biological differences. Gender-neutral policies have not led to a gender-neutral work-life balance, and as a result women in the workplace are underused and men are being denied opportunities to be involved fathers. There is evidence of change over time, but this change sits within the context of fundamental gendered choices with women taking responsibility for the majority of caring and domestic practices and men taking breadwinning and protective roles and to some extent avoiding caring and domestic practices.

References


The transition to fatherhood

Anna Machin

Along with puberty, first love and first loss, becoming a father is one of the most common and profound life experiences a man can have. However, unlike these other key life transitions, we still know relatively little about the experience of new fatherhood, and what is available is locked away in dusty journals in academic libraries. However, what is becoming increasingly evident is that fathers in the UK want to be present in their children's lives to provide care and emotional support; to be co-parents. This change in culture has been driven by a combination of factors including a reduction in health and social care, the decrease in the availability of help from an extended family, economic circumstances that require both parents to work and a growing realisation that fathers have a key and independent role to play in the development of their children. However, as a society we have asked fathers to adopt this evolved role without much knowledge of their needs or experiences, meaning that if support is needed, we can have little idea of the nature of that support. As the growing body of evidence pointing to the existence of pre- and postnatal anxiety and depression in fathers can testify, this can have negative consequences for the man, his family and wider society. However, to begin to formulate ideas around support for fathers we need to return to first principles, to understand at first hand the...
impact that new fatherhood has on the man psychologically, behaviourally and physiologically. The purpose of this article is to summarise the outcomes of my most recent research, which aimed to understand the transition to fatherhood, place my findings within the wider context of research and begin a dialogue about the nature of support needs among men and their families during this life stage.

The study
Funded by the British Academy, the study followed 15 heterosexual, first-time fathers from the point that their partner was seven months pregnant to when their baby was six months old. Fathers resided with their pregnant partner who was the primary caretaker of their baby. Data was collected both quantitatively, via questionnaires, and qualitatively, via an end of study interview. Questionnaires were completed at seven months’ gestation and two weeks, three and six months post birth. The questionnaires comprised questions which were unique to that time point (e.g. questions regarding the birth at two weeks) and repeated measures to assess change over time in personal, social and familial experience, role perceptions, baby development and paternal mental and physical health. Fathers were recruited directly to the study via radio and press interviews, and from NCT antenatal classes in Oxfordshire.

Key findings
Analysis of the qualitative and quantitative data revealed five key themes pertaining to the transition to fatherhood and, in particular, the fathers’ experiences of trying to be ‘involved fathers’. This term was first coined in the 1980s and refers to a new type of father, one who promotes nurturing, practical care and co-parenting above the traditional role of the breadwinner. The five themes were: Father’s role, Experience of the NHS and father’s wellbeing, Bonding and co-parenting, Work life, and Government and society.

Father’s role
Fathers maintained their belief in the idea of involved fathering throughout the study showing consistently strong agreement with statements which characterised the father’s role as equal to that of the mother in terms of care, support, emotional sensitivity and time. However, some fathers felt that, despite their strong wish to be equal, societal norms and structures meant that they were pushed back into traditional roles, particularly while the mother was on maternity leave. This led to a feeling of being the ‘secondary parent’, a belief that is reflected in other studies. Despite this, many fathers felt that they did play a significant role in their child’s development which was categorically different to that of the mother, fostering personality and focusing on moral and ethical development, and felt strongly that to achieve this end they should act as a role model:
'I think there is something about being a role model. I am changing the way I do a lot of things and trying to step up my game. You can do a lot of the big one off gestures...but the thing that is going to make the difference in terms of how he lives his life and who he becomes is actually how I am living my life.' Harry

In focusing upon a role linked to social behaviour and autonomy, study fathers reflected the cross-cultural belief among fathers that they have a role in fostering a sense of agency and independence in their children, in preparing them for success in the adult social world.\textsuperscript{11-13} Recent neuroimaging data has provided physiological evidence for this unique fathering role. On viewing a video of their child, secondary caregiving fathers showed predominant activation of the neocortical areas of the brain associated with social cognition, whereas primary caregiving mothers, on viewing the same video, showed predominant activation in the limbic areas of the brain associated with emotion and nurturing.\textsuperscript{14} Beyond a role in preparing their offspring for the wider social world there is accumulating evidence that this key fathering role also has a critical role to play in reducing the risk of poor mental health in later life.\textsuperscript{1}

This consistent belief in the merits of involved fathering and the special and separate contribution of the father was maintained across the eight months of the study despite the fathers experiencing considerable emotional, physical and practical upheaval:

‘Our lifestyle has changed completely, in ways for the better but it is a massive struggle, it’s like taking on another job almost because it has been very tiring, a lot of hard work, a lot of sleepless nights... the further you go back the worse it was...learning everything, being a dad for the first time everything is brand new.’ Toby

This quote emphasises the emotional and psychological impact of transition. Previous research has found that not only are the factors which predict the ease of transition for fathers different from those associated with mothers, being the quality of the parental relationship and the treatment by healthcare personnel, but that for fathers this period can extend up to the child’s second birthday in comparison to the shorter period of six months in mothers.\textsuperscript{15-16}

**Bonding and co-parenting**

During interview, many fathers commented on the practical, biological and behavioural factors which prevented them from realising their ideal of being an involved father. Issues surrounding the slow development of the baby, the exclusive relationship between mother and baby, the decision to breastfeed and the need to return to work were all highlighted as barriers to co-parenting and the rapid development of a strong bond.
‘I did find it difficult playing with him because he didn’t do much. Now he is actually getting involved and doing a bit more I find it a lot easier, more rewarding. It was all one way streets to start with which is fair enough but that I found difficult.’ Julian

‘...I haven’t experienced feeding until quite recently with solids. I wouldn’t say I was jealous of my wife but I was just I guess resentful in some ways. She was able to calm him when he was hungry and I couldn’t do a thing. So that was a little bit of a challenge for me to deal with.’ Alex

‘After this last week away and seeing him grow and then going back to work and having 15 minutes a day with him…it has made me realise what I am missing and it is hard because you want to be there and you want to see everything...[The bond] has developed but because I don’t get to see him as often as I would like it is a constant worry that it is not developing how I would want it to.’ Ryan

The findings of this study reflect those of previous studies which suggest that the process of father-infant bonding occurs over a period of months and is slowed, in part, by the delay in being able to participate in feeding (e.g.17) and the need to rely on interaction, rather than physiological processes which parallel pregnancy and birth, as a prompt for the neurochemical rewards that underpin the development of a bond. This delay in bonding can cause distress in some fathers as the expected ‘rush of deep love’ at birth does not materialise. One father in my study struggled to develop a bond in the first few weeks, leading him to conclude that his baby ‘didn’t like’ him:

‘For the first week, brilliant, by second week I was starting to get a bit down and by the third week I was really quite...didn’t think I was doing anything right...I was at quite a baby blues stage I think, that’s the only way of putting it.’ James

**Experience of the NHS and father’s wellbeing**

All of the study babies were born in National Health Service (NHS) hospitals and had been the focus of NHS care before and after birth. For the fathers the period of the birth was one of considerable emotional flux; initial feelings of anxiety, concern and powerlessness at the commencement of labour were replaced by relief, pride, joy and happiness following the birth. The majority
felt involved in the birth but the picture before and after the birth is less positive with fathers reporting a lack of support and acknowledgement from NHS staff during the antenatal and postnatal (three and six months) periods. As Mike commented:

‘I think the thing that struck me was you are either treated as a couple having a child or as a mother. There is nothing focused on or no support groups for fathers. There is nothing to help you prepare for your role…’

This lack of father-focused care is of concern because it runs counter to the wishes of expectant parents and can reinforce the father’s sense of being an ‘outsider’ during this period – a recent study found that 7% of fathers experienced high and increasing levels of loneliness during pregnancy and the transition period.18,19 Indeed, while Widarsson and colleagues20 concluded that the mother was the greatest support to a father during pregnancy, they reported that both parents felt that healthcare services should focus on being father-inclusive and make the entire family the focus of care and support. With the father’s experience of healthcare personnel being one of the most significant factors affecting the ease with which he transitions to fatherhood, and the nature of transition influencing the risk of paternal postnatal depression, this perceived lack of support is of considerable concern.15,21,22

While the fathers found the moment of birth overwhelmingly positive, what is clear is that the transition to fatherhood is a time during which fathers experience extreme and rapid changes in emotional state. The joy of a confirmed pregnancy is followed by the anxiety and powerlessness of anticipating the birth while the elation of the birth is rapidly followed by the anxiety and sense of exclusion caused by leaving the partner and baby in hospital. In extreme cases this period of flux combined with a perceived lack of support leads to a negative impact on paternal mental health. Of the 15 study fathers, a third exhibited symptoms of mild to moderate depression at two weeks post birth and one exhibited symptoms of moderately severe depression at six months; precisely the time points at which fathers report the lowest level of professional support. The risk of poor mental health is exacerbated by the impact of the new baby on the established parental relationship:

‘It is difficult. We are very close and have known each other since we were 16....so it is weird suddenly throwing someone else in the mix because we have grown up together.’ Steve

‘[It’s] been almost like our relationship is on holiday for a moment so I wouldn’t say we don’t have a relationship but it is very different in terms of what we talk about every day...I wouldn’t say that’s a bad thing it is just part of the next stage for us.’ Alex
Recent research that has pinpointed the first month post birth as a critical risk period for the development of postnatal depression in both fathers and mothers makes it clear that a lack of support post birth for fathers places the father and his family at considerable risk.\textsuperscript{23} Further, the quality of the parenting or marital relationship is one of the strongest predictors of the ease with which a father transitions to parenthood. As pregnancy affords a period of time in which to begin to protect the partnership against the possible negative consequences of transition it is key that practitioners take the time to handle expectations, normalise concerns and emotions and teach techniques to ease the effect of this life stage on the couple’s relationship.

**Work life**

All the study fathers worked, but many struggled with anxiety and guilt as they tried to balance demanding jobs, the route to family security, with the desire to co-parent and support their partner:

‘I get home and my partner says “I need to do this, take her for a moment”, sometimes I feel guilty because what I am really thinking is I would like to come home and have a bit of time for me to relax from my day but then that is obviously not fair because my partner has had to look after her all day.’ Ben

It is undoubtedly the case that the 14 study fathers that took statutory paternity leave benefited hugely from the opportunity to be fully present for their baby following birth. However, this total immersion in baby-world led to tension when they returned to work as the line between the ideal of involved fatherhood and the reality of the working father became very stark.

‘[My wife was unwell] so I was doing everything and then when I went back to work she was thrown in at the deep end and I was like “where’s my child?” I was used to doing everything and my baby wasn’t there.’ Toby

Fathers reported feeling excluded, anxious, concerned and powerless on their return to work. Previous work has highlighted the tension which exists for fathers between their home and work lives with negative consequences for the father’s mental health and the quality of his parenting behaviour.\textsuperscript{4,24} Indeed, Buist and colleagues\textsuperscript{25} reported that the disparity between the expectation and reality of involved fathering led to significant distress amongst their cohort of fathers.
Government and society

When asked to reflect upon the perception of the father within wider UK society and the impact of the government’s policies, many fathers commented that the attitude to fathers amongst wider society led to their exclusion and relegation to the role of supporter rather than parent. Many felt that society paid ‘lip service’ to the idea of involved fatherhood rather than genuinely investing in its implementation and success:

‘…[the check-up] I did go to, my partner got on the seat and the midwife drew the curtain around me and my partner said “He can watch” and she said “Oh right” and I thought well I am the husband…in a month’s time I am going to be seeing everything. And the midwife was a bit weird as though I shouldn’t be there.’ Steve

‘I couldn’t afford to let my partner go back to work after 6 months and for me to take 6 months, it is just not feasible to do with a mortgage and stuff. And yet this is the time you miss the most, you miss all the little things.’ Ryan

‘I think the government or society thinks that the father is not always needed at home, that is why a system is created with only 14 days leave. We could have done with more…it appears like the father has to be moved out of the house as soon as possible.’ Ajay

Many fathers pointed to their experiences at work and at the hands of health and social care practitioners and the inadequacy of government policies as indicative of a need for considerable cultural change before fathers were afforded parental equality. It was clear that they did not feel facilitated or empowered to decide to be involved in their child’s care. This is unfortunate because the outcome of my and other studies suggest that the changes to healthcare practice that fathers need to feel important and involved are relatively small and centre on the need for fathers to feel that their unique position within the family and relationship with their baby is recognised and that their role sits alongside, rather than subordinate to, that of the mother. Many of these goals can be achieved simply by valuing their contribution, listening to their concerns, questioning their wellbeing and including them in decisions and discussions.’ 26-29,15,30
Conclusions

British fatherhood is in a state of considerable flux. On the one hand there is an increasing focus on the involved father as the ideal, but this is promoted against a societal backdrop which is slow to change its deep-seated conceptions of fatherhood. This means there is a considerable disparity between what fathers expect the transition to fatherhood to be and what it is in reality. Further, initially enthusiastic fathers are not empowered by health and social care to take up the role of involved father in the long term due to a lack of acknowledgement, inclusion and support. However, a growing body of evidence shows that fathers require little in terms of economic investment to underpin their role. Rather, they require an acknowledgement of their potentially very special and different role and their place alongside the mother as an equal in the processes of pregnancy, birth and new parenthood. Pregnancy allows parents the time to anticipate and prepare for this key life transition and practitioners can help fathers to prepare for what lies ahead by handling expectations, identifying points of tension, normalising worries and emotions and stressing the value of the father’s role, not as a ‘male mother’ but as a valuable player in his own right.

Questions for future research

• Gay fathers: The majority of the still relatively small body of research carried out on fathers focuses overwhelmingly on heterosexual couples. However, with the growing number of babies born to gay couples it is important to understand how this cohort of fathers experiences the transition to fatherhood. How does the need for at least one member of the couple to adopt a primary carer role influence his experience of transition? And how do societal attitudes to this still new phenomenon influence the experience of the fathers at the hands of health and social care practitioners and the wider public?

• Fathers and mental health: There is increasing evidence that becoming a father can have a profound effect on a man’s mental health. Research indicates that between 4% and 10% of new fathers experience a form of postnatal depression (PND) and this can have a profound negative influence on the father, his developing child, his partner and wider society. However, it is increasingly evident that the symptomology and causes of this condition differ markedly from that of maternal PND. As a consequence, it is critical that future research focuses on the nature of PND, anxiety and post-traumatic stress disorder in fathers and develops specific new tools to diagnose and treat these debilitating conditions.

• Reaching fathers: With fathers becoming more and more involved in the care of their children it is a critical time in the development of support services for men. However, pressures of work mean that the usual routes of regular healthcare appointments and supportive social networks are not available as methods of accessing fathers. It is important that money is invested in developing and piloting sources of information and support using formats that are inviting, productive and accessible to men.

• Fathers and healthcare: While the inclusion of fathers at the birth is now a regular practice there are still points both pre and post birth when fathers feel excluded from the process of becoming a parent. It is important that we carry out research to identify the source of this perception, including exploring whether a mismatch exists between the father’s understanding of his role and relevance and that of the health and social care practitioners he encounters.
References


Understanding the neonatal unit experience

In order for practitioners to be better prepared and able to support parents of babies treated a neonatal unit, NCT College has launched a new Level 5 stand-alone training module, Understanding the neonatal unit experience, writes Lesley Taylor, NCT antenatal teacher and tutor.

It can be distressing and exhausting for parents whose babies require the special care of a neonatal unit. In the UK, approximately one in ten of all newborns are likely to spend time in a neonatal unit immediately after birth.1 It’s therefore likely that antenatal teachers and breastfeeding counsellors will encounter many parents whose babies require neonatal unit care, particularly if the babies are born prematurely.

The new NCT College module, Understanding the neonatal unit, is open to both students and qualified practitioners, and includes visits to a hospital neonatal unit and a children’s hospice. The module enables both students and qualified practitioners to study in depth the practical and emotional needs of parents and families when their baby needs neonatal unit care.
They gain new skills and understanding which equips them to provide specific support to parents in this situation. Feedback so far shows that both practitioners and NCT have found the module invaluable for beginning to build this level of knowledge within the organisation.

The generous sponsorship of AbbVie has enabled NCT to support the cost for a number of course participants.

**Information about the module**

*Understanding the neonatal unit experience* is a 15-credit Level 5 module designed and delivered by NCT College and accredited by the University of Worcester. It currently consists of four study days: two at the University of Worcester, one at the Leicester Royal Hospital Neonatal Unit and one at the Rainbows Hospice for Children and Young People, Loughborough.

The module enables students to:

- Consider, develop and reflect upon some of their personal feelings surrounding the experience of premature birth
- Develop new insights and further understanding into the experience of premature birth
- Reflect upon the impact of the experience of premature birth upon different members of a family, including mother, father, siblings and grandparents
- Visit a neonatal unit and a children’s hospice, and talk to health professionals and managers directly
- Understand the work of the Neonatal Network within the UK

**A practitioner’s experience**

I’ve just come back from a visit to SCBU to see the parents of Emily* born at 26 weeks. It was so much more emotional than speaking to other parents of premature babies. I think because they have the most premature baby I’ve been aware of and are still in the middle of their journey, she is only four and a half weeks old. The strain and emotion behind the smiles was so evident.

It was wonderful to have the course behind me to back up what I was saying. I mostly let them tell their story but was able to pick up on key points. For example, she is disappointed to only be expressing 30mls at a time despite double pumping every three hours through 24. I was able to point out on her chart how far she’d come... 2.2mls in the beginning... a huge leap up to 30mls, plus her body knowing what Emily needed. We also talked about the importance of not beating yourself up when formula is needed for top ups and how she may be able to help other mums in the class when they face similar issues.

It had not occurred to them that others in their NCT class would not be guaranteed an easy birth either and that with their experience they may be able to provide comfort and support to others in their NCT group when the time comes. They seemed to almost come alive and grow a foot taller at the thought. What an amazing experience to walk this path with them!

* The name of the girl in this case study has been changed to protect her identity
Learning outcomes
On successful completion of the module students should be able to:
1. Demonstrate a critical awareness of the experience of premature birth and the impact it can have on the developing family
2. Recognise and evaluate the theory of family centred care, the rites of passage and the UNICEF Baby Friendly Initiative and other relevant bodies
3. Critically evaluate local neonatal or special care baby units (or other care settings) and relate their observations to the neonatal network within the UK
4. Demonstrate a robust awareness of the skills required by parents to enable them to provide care for their baby
5. Demonstrate empathy and understanding whilst in communication with families and employ practical skills that enable parents, for instance facilitate understanding, increase knowledge, inform their decision making, focus communication with care givers and value them being involved in the care of their baby.

Students
In 2013/2014 only three students started the module, with two students completing.
In 2014/2015, as a result of being able to offer sponsored places, 10 students applied for places on the module (the maximum number possible given the constraints of working with a neonatal unit and hospice). Four students dropped out and six students completed the module.

Jo Sims – Course Leader
(Head of Family Support Services, Rainbows Hospice for Children and Young People)

The emotions that new parents experience can be complex and when faced with their newborn requiring neonatal care, they can soon become overwhelmed.

It could be viewed that supporting these families could be a specialist role; however so often families look to the generic support that is available to all, and to those with whom they have an existing relationship.

This module is essential to enable those accessible practitioners to be equipped with the knowledge to support a new family and enable them to access the services they require elsewhere. This module develops the practitioners’ confidence to welcome parents who face these additional challenges rather than compounding their complex emotions.
Student feedback
Feedback was obtained through the end-of-year evaluation and from individual feedback direct to the tutor:

This module was brilliant!
The module helped me to reflect on many areas of my own life and see things from a totally different view point. I also gained a new understanding and an empathetic stance towards parents with babies in these special situations.

Breastfeeding is also explored in depth within this module and can help assist us when working with parents. Complementary to this, new active listening skills are learned and developed throughout the module.

The neonatal module has given me the confidence to push forward and offer support.

What an amazing experience to walk this path with them (the parents)!

Summary
By developing the Understanding the neonatal unit module, NCT has been able to train practitioners to offer the specialised support needed by parents and families with a baby on a neonatal unit. This is a unique and important area of work and one that NCT is keen to expand on.

Reference