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The Royal College of Midwives' response to the Department of Health and Social Care call for evidence on a women's health strategy

The Royal College of Midwives (RCM) is the trade union and professional organisation that represents the vast majority of practising midwives in the UK. It is the only such organisation run by midwives for midwives. The RCM is the voice of midwifery, providing excellence in representation, professional leadership, education, and influence for and on behalf of midwives. We actively support and campaign for improvements to maternity services and provide professional leadership for one of the most established clinical disciplines.

The RCM welcomes the opportunity to respond to this consultation and our views are set out below.

1. **Placing women's voices at the centre of their health and care**

This section of the response was informed by the RCM Voices Network. which brings together services users, midwives, maternity support workers, and student midwives to support the RCM's work. Many women and birthing people do not feel their voices are being heard, that their views are not seen as important and that services, professionals, and systems do not have the time to hear them. Importantly, many women from seldom-heard groups worry that they will be misunderstood, misinterpreted, viewed as problematic or aggressive when trying to be heard. We need to ensure more funding is available for Maternity Voice Partnerships (MVPs) and other women's voices advocates and organisations; to incentivise organisations to listen; and to ensure midwives and health professionals have adequate time to build trusting relationships and hear from the people they support. Despite the fact that much of the workforce within maternity and women's health are majority female, people felt that women's voices are still not heard within this. There was concern that the 'the majority of the air space' and power was dominated by white males. The RCM Voices Network group reflected on gender and diversity and questioned whether women are equal partners. There is a need to amplify the voices and experiences of seldom-heard women and communities such as those from Black, Asian and minority ethnic backgrounds; women with disabilities; LGBTQ+ parents; young mothers; people who do not speak English fluently; those who face

socio-economic disadvantage; women who have experienced baby loss, terminations, and other difficult experiences which are often stigmatised and result in health inequality. It is also key that fathers, partners, and families' voices are included within this and move toward a more family based maternity system. There is a need to fund, support and enable those with lived experience to be involved in producing, leading, and informing research. The fact that Black and Asian women are more likely to experience baby loss and maternal death highlights a need for health research to address these gaps to ensure that that women and diverse communities are recognised within research and findings are appropriate.

Key recommendations:

- Provide increased and consistent funding for MVPs and other women's voices advocates and organisations aiming to enhance women's voices in health care.
- Improve the way communication of information about women's health occurs and invest in equitable ways of doing this.
- Incentivise the health care system to make sure women's voices are heard.
- Recognise the value of face-to-face consultation, evaluation, and communication.

2. Improving the quality and accessibility of information and education on women's health

This section of the response was informed by the RCM Voices Network which brings together services users, midwives, maternity support workers, and student midwives to support the RCM's work. It is important to open up conversations on and information about women's health to the wider public and ensure education starts earlier and is of a much higher quality. The focus should not just be on young women's education, but also ensuring that older women, boys, and men understand all aspects of women's health, not just sexual health. People's understanding of their own health and bodies is varied, and there is a need for all genders and ages to be better educated on language, contraception, pregnancy, the menstrual cycle, and the menopause. There is a need to end 'toxic positivity' (whereby labour and birth is discussed only in positive terms) and a need to enable people to learn about and communicate harder experiences such as

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baby loss. While many people are increasingly seeking health information online, they also often rely on their midwives and health professionals to understand what much of that information means. Further research is needed to explore where information is accessed, when the 'teachable moments' occur and how information can be transmitted without judgement or blame. Health professionals should be better informed and trained to understand where and how women access information and how they can further support women to understand it. A lot of the information currently provided is written, and the group identified a need for more audible and visual approaches and for the use of existing platforms of communication such as social media. There is a need for public health campaigns to raise education and awareness, and this should be done by reaching people where they already access information, rather than creating a new space. The ability to access information is limited by a lack of knowledge of the correct terms. The group reflected on the power of language and the importance of using the correct terms for women's body parts. They also highlighted the importance of using non-blaming language e.g., 'still birth' rather than 'miscarriage'.

Key recommendations:

- Improve education on women's bodies and health through their lifetime.
- Train health professionals to understand where and how women access information and how they can further support women to understand it, including the correct language.
- Improve the availability of information in audio or visual format.
- Run public health campaigns in partnership with leading organisations and thought leaders on women's health issues such as the menopause, baby loss, and the correct use of language for women's body parts.
- Be aware of and respond to the impact of the new digital barrier when engaging with people and communities.

3. **Ensuring the health and care system understands and is responsive to women's health and care needs across the life course**

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The role of the midwife is a positive and central example of a role that is built around the needs of women and their families, midwives are based both in the community and in hospital settings. The Midwifery Continuity of Carer (MCOC) model that is currently being rolled out across maternity services in the UK enables midwives to follow women from primary into acute care, to continue to provide a seamless experience of care and build meaningful relationships across their maternity journey. This model has been shown to improve care (Sandall et al. 2016) and is a helpful and positive model to consider for the development of women focussed health and care services that reach beyond just maternity care across the whole life course. Globally the role of the midwife is far broader than it is in the UK. In many other countries, midwives provide a longer-term service for women stretching through the preconception period, sexual health, fertility, antenatal, intrapartum, and well beyond the 10-day postnatal period provided by midwives in the UK (see for example World Health Organisation, 2013). Consideration should be given to significantly increasing the number of midwives in order to develop the role further, or to develop primary care-based women's healthcare practitioners who are able to support, advise and provide care to women from puberty to the menopause. We need to further incentivise and develop the influence of women's voices in maternity care (see for example Royal College of Obstetricians and Gynaecologists, 2018). The RCM Voices Network spoke to us about the difficulties they experienced when attempting to access high quality advice and care throughout their maternity journey – and the barriers they faced when needing to share concerns about their care. While the development of the Maternity Voices Partnerships (MVPs) in Trusts across England has meant more women's voices are being heard, more needs to be done to ensure the voices of more seldom heard women are actively sought out and listened to. We need to ensure more funding is available for MVPs and other women's voices advocates and organisations. We also need to incentivise organisations and systems to listen; and to ensure that midwives and health professionals have adequate time to build trusting relationships and hear from the women they support. Across all of women's health, including maternity, there is a need to amplify the voices and experiences of seldom-heard women and communities such as those from Black, Asian and minority ethnic backgrounds; women with disabilities; LGBTQ+ parents; young mothers; people who do not speak English fluently; those that face socio-

economic disadvantage; women that have experienced baby loss, terminations and other difficult experiences which are often stigmatised and result in health inequality. It is also key that fathers, partners, and families' voices are included within this and move toward a more family based maternity system. Communication between systems – maternity/primary care/acute – also needs to be improved. This would facilitate smoother transitions between services. Areas for particular focus and development are pre-conception care, which is currently virtually non-existent; longer term postnatal care to ensure that problems with incontinence and mental health are identified and appropriate advice, care, and treatment is instigated. Many advanced nations have universal postnatal physiotherapy which could identify, prevent and, treat many of the problems that have very long-term effects on women's health.

Key recommendations:

- Develop a truly public health approach to women's health – across the life course, including mental health support and high-quality advice and preventative care.
- Ensure midwifery continuity of care model is rolled out in line with the recommendations contained in the RCM Midwifery Continuity of Carer Position Statement.
- Increase the number of midwives in England to ensure that midwives and health professionals have adequate time to build trusting relationships and hear from the women they support.
- Consider expanding the role of the midwife to provide care prior to and after pregnancy.
- Improve pre-conception care and develop postnatal care to increase prevention and detection of longer-term problems developing – both physical and mental health.
- Ensure that high quality care focussing on women's health needs extends well beyond the childbearing years.
- Improve communication between maternity, primary care, and acute care systems to facilitate smooth transitions.

4. **Maximising women's health in the workplace**

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More than 99% of midwives are women. Midwives are women who at different points in their careers may experience heavy menstrual bleeding, endometriosis, a need access to emergency contraception, abortion, be pregnant, on maternity leave, or experience symptoms of the menopause. However, women are not a homogenous group, and their experiences may vary due to their being trans, non-binary or intersex, disabled or a woman of colour, with some women facing double discrimination at work. Workplace support should be intersectional and sensitive, understanding that some women may be more hesitant to seek support and face additional barriers to doing so. Other health conditions may also impact on the working lives of women including mental health conditions. Long working hours including regular unpaid overtime (during the pandemic almost 40% of RCM members worked three or more hours unpaid overtime each week (RCM, 2020)) and lack of opportunities to work flexibly add to the pressure on midwives and MSWs at work, many of whom are primary caregivers to children, older relatives, and grandchildren. Research by the Equality and Human Rights Commission (EHRC) in 2016 revealed that 54,000 women per year are forced out of their jobs due to pregnancy discrimination and that 77% of women experience negative and potentially discriminatory treatment at work each year due to their pregnancy Equality and Human Rights Commission (2016). This can cause stress, anxiety, and depression, which can have an effect on the health of women and their children. The RCM believes women should be protected from redundancy from when pregnancy begins up until six months after the end of their maternity leave. This protection should be offer to those who experience stillbirth or miscarriage. There are numerous reasons a woman may not want to inform their employer of their pregnancy, for example, she may fear that she will suffer a miscarriage or experience discrimination. If a woman is selected for redundancy, the redundancy decision should be reviewed to ensure that it has not been taken as a result of pregnancy. The Government should adopt the Pregnancy & Maternity (Redundancy Protection) Bill introduced by Maria Miller MP. The health and safety of pregnant women should be a priority. The coronavirus pandemic has highlighted the need to ensure that employers comply with the Management of Health and Safety at Work Regulations 1999 (MHSW). Research has shown that throughout the pandemic many pregnant women have been sent home on sick pay or unpaid leave, put under pressure to use paid holiday, or furloughed at 80% pay (Maternity Action 2020). For many women, this period of lower or no income has fallen within their Statutory

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Maternity Pay earnings assessment period meaning maternity payments were then much lower than expected. Though furlough pay is now disregarded, this is not the case for those who were placed on statutory sick pay or unpaid leave. The RCM supports the Trades Union Congress in calling for the law to require employers to undertake individual written risk assessments when they are informed that a woman who works for them is pregnant, has given birth in the past six months or is breastfeeding. Enforcement of existing legislation is also key, it should be made clear to employers that if the risks facing a pregnant worker cannot be removed, and there is no alternative work available, pregnant women must be suspended from work on full pay. Legislation and enforcement will not improve the experience of pregnant women at work entirely however, a supportive work environment can ensure women feel comfortable to inform their employer of their pregnancy and raise any concerns they may have at an early stage, supporting the health of both the woman and their baby. The menopause generally occurs between 45 and 55 years of age, though it can occur any time up to the mid60s and around 1 in 100 women will experience a premature menopause. Almost one third (29%) of registered midwives in the UK are aged over 50. Many women find it difficult to disclose menopause-related health problems to line managers. Despite being a predominantly female workforce, this is often also the case in the NHS. Workplaces should have standalone menopause policies which link to other relevant policies such as uniform, managing attendance at work, flexible working etc. Line managers should receive training to support their staff, recognise when increased sickness absence or changes in performance may be related to the menopause and understand what workplace adjustments can support staff. For those who do not feel comfortable speaking to their manager other support such as occupational health should be available. Awareness raising across the workforce can also help to ensure women feel more comfortable to speak openly and create a supportive culture at work. Supporting Occupational Health and Wellbeing Professionals (SOM) reported that midwives and nurses are at considerable risk of work-related stress, burnout, and mental health problems (Supporting occupational health and wellbeing professionals, 2020). The King's Fund, in the Courage of Compassion report, found that "staff stress, absenteeism, turnover and intentions to quit had reached alarmingly high levels in 2019, with large numbers of nurse and midwife vacancies across the health and care system" (The King's Fund, 2020). The impact of the pandemic on NHS staff and pressure to implement

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maternity transformation programmes on midwives and MSWs cannot be underestimated, prioritising rest and recovery for NHS staff is key, not only for the staff themselves but to improve care and outcomes for service users. Nursing and midwifery are professions largely dominated by women, employers should not only provide access to support services to care for the mental wellbeing and health of staff but also address the root causes of work-related stress such as increased staffing and improved terms and conditions. Good workplace policies, strengthened legislation, and improved enforcement can support the improved health and retention of women in the workplace. Good work however is key to good health and wellbeing. This means quality work where staff are paid fairly, have opportunities to progress, good working conditions and a positive work life balance. Unionised workplaces where employers work in partnership with trade unions to develop policies and practices and improve workplace cultures can improve the experience of everyone at work. Flexible working can be key to achieving work-life balance, but it also benefits employers by helping to retain women who often have caring responsibilities for children, older relatives, and grandchildren in the workplace. There is currently a shortage of just over 3000 midwives in England alone, a 2016 survey of midwives who had left midwifery or were considering leaving midwifery showed that 76% of midwives who had left would be very likely or quite likely to return if there were opportunities to work flexibly (Royal College of Midwives, 2016).

Key recommendations:

- Encourage employers to ensure workplace support is intersectional and sensitive.
- Protect women from redundancy by adopting the Pregnancy & Maternity (Redundancy Protection) Bill introduced by Maria Miller MP.
- Require employers to undertake individual written risk assessments when they are informed that a woman who works for them is pregnant.
- Ensure employers know that where the risks cannot be removed, and there is no alternative work available, pregnant women must be suspended from work on full pay.

- Ensure workplaces have standalone menopause policies and line managers are trained to support their staff.
- Ensure employers, particularly NHS employers, provide fit for purpose mental wellbeing services.
- Ensure midwives who care for women, and who are predominately women, are paid fairly, have good working conditions and are able to achieve a positive work life balance.

5. Ensuring research, evidence, and data support improvements in women's health

Funding

The RCM is concerned by the lack of research funding allocated to reproductive health and maternity. There is evidence that the spend on this important area of health care falls behind other areas. An analysis of public and charity funded health research in the UK found that less than 2.5% of funding is dedicated solely to reproductive health (UK Clinical Research Collaboration, 2014). There is also evidence that funding for reproductive health falls behind other areas of health care. The Pregnancy Research Review (Guthrie et al, 2020) found that out of £1 spent on pregnancy care, only 1p is spent on research. This compares unfavourably with other areas of health care, such as cancer 12p/£1, heart disease 7p/£1, dementia 6p/£1 and stroke £3p/£1. The report also finds that litigation claims related to pregnancy are around fifty times the current pregnancy research spend, estimated at £2.5bn in 2018–19 (NHS Resolution, 2019). This is despite a recommendation in the annual report of the Chief Medical Officer, that the UK Clinical Research Collaboration work with research funders to review the research needs and spend in the area of pregnancy (Davies, 2015). Midwifery-led research has demonstrated the benefits and safety of midwifery continuity of carer models, water births, continuous one to one support in labour and has helped to bring an end to harmful practices such as routine enemas and episiotomies. Continual improved practice needs to be underpinned by evidence and midwives are key to developing this knowledge. There remain a significant number of areas of midwifery and wider maternity care practice where there is unclear evidence for current routine care, it is important that this is addressed.

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Gender Bias

There are many areas of women's lives and health that have not had a sufficient research focus. Over 30% of women in a Public Health England survey found that women experience severe reproductive health problems but there is a lack of research into these issues, such as premenstrual syndrome, menstruation, endometriosis, the menopause and early puberty for girls (Public Health England, 2018). Women can be labelled "difficult" if they do not find treatment helpful (Young, Fisher and Kirkman, 2019). Collaborative research, with women as participants and researchers, will help to direct research into fruitful areas with useful findings for women and girls. There have been historic inequalities in what gets researched and who has been able to take part in research. Women were excluded as participants in many clinical trials which has led to the understanding of disease and drug treatments based on the male body.

Black and ethnic minority women

Black pregnant women are five times more likely, and Asian women twice as likely, to die during pregnancy and childbirth than white women (Knight et al 2019). Despite these disparities, which have been highlighted over a number of years, little is understood about the reason why and more research should be undertaken as a matter of urgency. The Office for National Statistics has recently released figures on stillbirths and infant mortality and the statistician has suggested that deprivation may explain the higher rates for babies from black and Asian families (ONS, 2021). Work should take place across all government departments to redress these inequalities.

Participation in research

There are also practical reasons women are unable to participate in studies e.g., caring responsibilities. Research design should take this into consideration and provide payments for transport, creche/carer or facilitate participation in the home. There are also some statements within the consent process for research which can be a barrier to women taking part in trials. For instance, 'If you are able to become pregnant you must be willing to practice continuous effective contraception during the first 3 months of the

trial and have negative pregnancy tests on the days of vaccination' (this one from the current national COVID booster vaccination trial). Women's autonomy should be respected, and they should be advised on the risks if they become pregnant and they should be able to decide to whether to enter the trial based on their individual circumstances (single, same sex relationship, abstaining etc.). This will allow women to participate who do not want to discuss the details of their personal lives, reproductive plans, or previous experiences including fertility and pregnancy loss. The COVID-19 vaccination programme omitted pregnant women at the outset. Most pregnant women, who are at risk of complications of COVID-19, have thus been left without vaccine protection until April 2021. This demonstrates how important it is to include women when designing research studies.

Data

The type of routine data that is collected tends to be driven by tradition that has been predominantly influenced by men. For example, the outcomes in HES tend to be hard outcomes, but even then may not cover important areas (as we know in relation to latent phase labour). The experiences of women who access maternity services are important and questions establishing their wishes are not always discovered. Any study should have women's views as part of the data collection, so qualitative data is built into the design of the study.

Female researchers

There have been gender inequalities with regard to those conducting and publishing research, which has been amplified by COVID-19 (Gabster et al., 2020). The structural inequalities need to be addressed by government to provide a level playing field for women doing research and in academia. Research utilisation needs to ensure that all practitioners have dedicated research time within their contracts, and this currently only exists for medicine. Given that midwifery is one of the groups with the greatest impact on women's health, influence in this arena would make a very large impact. The RCM is committed to support midwives to undertake research and is part of the NIHR Nursing and Midwifery Incubator.

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Key recommendations:

- Invest more in promoting and developing women researchers and those from diverse backgrounds so that researchers reflect people and communities.
- Increase researching funding for reproductive health and maternity, including, in particular, midwife led research.
- Ensure research is collaborative and includes women as participants by incentivising researchers to design studies in a way that facilitates women's participation.
- Ensure further research is conducted on disparities in maternal outcomes, as well as still birth and infant mortality.
- Ensure routine data collection in maternity care records qualitative data.

6. Understanding and responding to the impacts of COVID-19 on women's health

The impact of changes to maternity services during the pandemic

During the COVID-19 pandemic, there have been substantial shifts in the way that maternity care is delivered. Care provision has had to be modified and maternity units have faced staffing shortages. The effects of these changes on maternity outcomes have not yet been measured, however it is possible that some shifts have created additional barriers to care which have negatively impacted on outcomes, including in particular for marginalised groups. For example, the increase in virtual appointments is likely to have had some impact on care. While the ability to conduct antenatal appointments virtually has facilitated the delivery of care to women while minimising the risk of transmission of COVID-19, virtual consultations do create some difficulties for maternity staff. Anecdotally, conducting appointments virtually can make it more difficult for midwives to establish a good and trusting relationship with the women in their care. In turn, this can cause women to refrain raising concerns which can cause key issues to be missed. It is our view the while virtual consultations can enhance care and reduce unnecessary travel for women with transport and childcare complications, it will be important to maintain in-person antenatal care. In-person antenatal care is an evidence-based intervention known to

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reduce adverse outcomes including maternal mortality, morbidity and fetal loss (Renfrew, McFadden, Bastos, et al. 2014; NICE Antenatal Guidelines 2010, 2019, RCM, 2020). When developing the Women's Health Strategy, it will be essential for the government to examine the impacts of the COVID-19 pandemic on maternity services and respond accordingly. We urge the government to pay close attention to the outcomes of the Royal College of Obstetricians and Gynaecologists research project which seeks to identify changes to outcomes for women and babies during the pandemic (The Health Foundation, 2021).

The impact of the COVID-19 pandemic on pregnant women and new mother's mental health

Even prior to the COVID-19 pandemic, episodes of mental illness during pregnancy were common, impacting up to 1 in 5 pregnant women. However, this number is likely to have increased as a result of the COVID-19 pandemic, which has created a particularly challenging climate for pregnant and postpartum women. Several studies have highlighted the increase in distress and psychological problems experienced by pregnant women and postpartum women during the pandemic (Durankus F, Aksu E, 2020). This is particularly concerning, given that the increase in virtual appointments has made the identification of women experiencing mental health problems more difficult. Pregnancy and motherhood can be a psychological trigger for many, and the lack of certainty surrounding the COVID-19 situation has caused considerable anxiety. Additional factors impacting on pregnant women and new mother's mental health during the pandemic include loss of income and experience of discrimination in the workplace, (Trades Union Congress, 2020) increasing rates of domestic abuse (Women's Aid, 2020), social isolation, and restricted access to services including the inability to have a partner attend antenatal appointments. If perinatal mental illnesses go untreated, they can have a devastating impact on women and their families and in extreme cases, these illnesses can be life threatening. In addition, according to the London School of Economics, perinatal depression, anxiety, and psychosis carry a total long-term cost to society of about £8.1 billion for each one-year cohort of births in the UK. This is equivalent to a cost of just under £10,000 for every single birth in the country (Bauer A, et al, 2014).

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Midwives and in particular specialist mental health midwives play a crucial role in effective perinatal mental health care. However, there is a severe shortage of both specialist mental health midwives and midwives in the UK. There is also a lack of training for midwives and maternity support workers on addressing mental health concerns. It is absolutely essential that the Women's Health Strategy robustly address support for women's mental health at this crucial time by ensuring all NHS trusts in England employ maternal mental health specialist midwives and reviewing the support and care available for women with maternal mental healthcare needs.

The impact of restrictions on visitors in hospitals

As discussed above, many women have been negatively impacted by the inability to have a partner attend antenatal appointments with them throughout the pandemic. Having a supportive and trusted partner present at key moments during pregnancy and throughout labour is known to have a positive effect on the emotional wellbeing and birth experiences of women and babies. This has been particularly important at a time when many women are experiencing raised stress levels and feelings of fear and loneliness. Sadly, although maternity staff have made every effort to enable women to be accompanied by partners during appointments and scans, the condition and layout of some NHS maternity facilities have made it exceptionally difficult to facilitate this while at the same time maintaining safe services and social distancing. The government should review NHS estates, particularly maternity services, and including bereavement rooms, with a view to upgrading those facilities that have been shown to be not fit for purpose. The need to ensure sufficient footfall, space, and dedicated clinical areas and rooms – including bereavement rooms - should be incorporated into the design of maternity facilities in new hospitals.

The categorisation of pregnant women as vulnerable during the COVID-19 pandemic

During the early stages of the pandemic, the UK government assessed that pregnant women should be included within the list of those 'vulnerable' to COVID-19. However, it did so without consultation with the relevant bodies. The resultant

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disconnect between the advice of the government and the advice of organisations like ours, caused considerable confusion, fear, and stress. It also created conflict between employers and pregnant employees who were receiving conflicting information as to whether it was safe for pregnant women to continue working in frontline roles. In the future, decisions of this nature should be made in consultation with organisations such as ours and the Royal College of Obstetricians and Gynaecologists. In addition, following the categorisation of pregnant women as vulnerable, the government did not proceed to provide adequate protection for those women. For example, many women were placed on unpaid leave or singled out for furlough in contravention of existing health and safety laws. Together with Maternity Action, we urged government to take action to protect pregnant women at work (Petitions Committee, 2020) and ensure employers were aware of their responsibilities. However, the government has refused to take many of our recommended actions (UK Government, 2020).

Key recommendations:

- Be cautious when continuing 'COVID-19 measures', for example virtual appointments, which may have an impact on quality of care.
- Examine the impacts of the COVID-19 pandemic on maternity services, including by examining the outcomes of the Royal College of Obstetricians and Gynaecologists research project.
- Ensure all NHS trusts in England employ maternal mental health specialist midwives, ensure midwives and maternity support workers are supported to undertake training on perinatal mental health and review the support and care available for women with maternal mental health needs.
- Review NHS estates, particularly maternity services with a view to upgrading those facilities that are not fit for purpose.
- Ensure that in future scenarios, proper consultation is undertaken with ourselves and the Royal College of Obstetricians and Gynaecologists on maternity related issues.

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