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The impact of the pandemic on babies, their families, and the services that work with them

Sally Hogg, Senior Policy Fellow at the Centre for Play in Education, Development and Learning (PEDAL), University of Cambridge

The COVID-19 pandemic, and the measures put in place to control it, have significantly impacted all our lives. Babies and toddlers experienced the pandemic during a particularly pertinent time – a time of rapid development for them and a key transitional period for their families when they would normally rely more on friends, families, and professional services (Reed & Parish, 2021).

In March 2020, when pandemic restrictions were first put in place in the UK, a group of charities with a shared interest in babies' wellbeing and development came together to advocate for the needs of babies, young children and their families to be considered by decision makers. There was particular concern that these needs were not being factored into decision-making around pandemic lockdowns; this later became known as the 'baby blindspot'.

Three charities – the Parent-Infant Foundation, Best Beginnings and Home-Start UK – commissioned research in spring 2020 to shine a spotlight on the experiences of babies and their families during the first lockdown. After that, these charities, and others in the First 1001 Days Movement campaigning alliance, undertook further research to understand the impact of the pandemic on babies born shortly before, during and shortly after the national lockdowns. Continuing to measure and share the impact of the pandemic on these children is important as the effects of early adversity are not always visible immediately but emerge and accumulate over time.

In Summer 2022, a fifth piece of research was undertaken by Sally Hogg and Georgina Mayes (from the Institute of Health Visiting) on behalf of the First 1001 Days Movement. The report of this work, 'Casting Long Shadows' (2022), tells the story of the ongoing impact of the pandemic.

'Casting Long Shadows' (2022) contains findings of an online survey of professionals that took place between June and September 2022 and a brief review of academic papers, wider literature and national data. The survey captured the views of professionals and volunteers working with families in pregnancy and/or with a baby or young child. It had qualitative and quantitative elements and included some of the same questions from previous surveys; it was completed by 555 professionals from across the UK. Survey respondents comprised a range of professionals, with the largest group being health visitors (57.3%).

The research showed clearly that the pandemic and restrictions to contain it had a lasting effect on many babies' and children's wellbeing and development, and on the ability of services to meet their needs. Findings are summarised below, illustrated by quotes from survey respondents. The 'Casting Long Shadows' (2022) report contains a fuller description of the findings, including references for the data and studies captured in the evidence review.

PARENTAL MENTAL HEALTH

The pandemic had widely-reported negative impacts on parental mental health, which were felt more strongly in some families who were already at greater risk of poor outcomes. Whilst the significant deterioration in experience during the first year of the pandemic was reversing after the lockdowns, research found that mental wellbeing across the population had not returned to pre-pandemic levels. This was reinforced by the 'Casting Long Shadows' (2022) survey in which more than four in ten (42.7%) respondents reported that that 'many' of the babies they work with are still affected by increased parental anxiety, stress and depression due to the pandemic.

MALTREATMENT

The pandemic both exacerbated pre-existing safeguarding risks and created new ones. Case reviews of children who experienced abuse and neglect during the pandemic revealed how COVID-19 restrictions hampered the efforts of professionals to safeguard children despite their best efforts. In the 'Casting Long Shadows' (2022) survey, more than four in ten (44.1%) respondents said that 'many' of the babies they worked with were being affected by increased exposure to domestic conflict, child abuse and neglect. Worryingly, this is higher than the proportion of professionals making the same observation in 2020 when only 29% of respondents made this observation. (The 2022 'Casting Long Shadows' survey repeated questions asked of professionals in the 2020 'Working for

PANDEMIC RESEARCH BY FIRST 1001 DAYS CHARITIES

'Babies in Lockdown: Listening to parents to build back better' was published by Home-Start UK, Best Beginnings, and the Parent-Infant Foundation in August 2020. It was based on a survey of over 5,000 parents who were pregnant or had had a new baby during the first lockdown. The research found that many parents were struggling during the first lockdown; for example, six in ten (61%) parents had significant concerns about their mental health. 'Babies in Lockdown' found that the pandemic had affected parents, babies and the services that support them in diverse ways. Some parents struggled enormously and described feeling abandoned, whilst others thrived. Families already at risk of poorer outcomes, such as those with lower incomes, from Black, Asian and minority ethnic communities, and young parents, were hit harder by the pandemic.

'Working for babies: Lockdown lessons from local systems' was written by Jodie Reed and ISOS Partnership for the First 1001 Days Movement and published in January 2021. It described findings from interviews, focus groups, and a survey of professionals which took place in the summer of 2020.
This research showed high levels of professional concern about babies; 98% of professionals interviewed said the babies their organisation works with had been impacted by parental anxiety/stress/depression affecting bonding/responsive care.
'Working for Babies' showed that what was on offer during and after lockdown varied largely between services and between localities and investigated the reasons for this. The national pandemic response, and the 'baby blind spot' in the UK Government's pandemic response, was widely perceived to have made it harder for local decision makers to do the right thing for babies.

'Working for babies: Listening to local voices for a better recovery' by Jodie Reed and Sally Hogg for the First 1001 Days Movement was published in September 2021, summarising key themes from conversations with professionals and local leaders across England. It found that there were still many challenges at this time: the need for support has increased and yet services were still not reaching many families. The picture was also highly variable with enormous inconsistencies in access to services in different areas.

'Babies in Lockdown 2: Nobody wants to see my baby' was published by Home-Start UK, Best Beginnings, and the Parent-Infant Foundation in November 2021. It was based on interviews with parents and a survey of professionals. It found that:

- Families were struggling to access care, particularly from universal health care professionals such as GPs and health visitors, and felt let down. Many routine contacts with health visitors had been missed or delayed.
- Many services were still operating remotely. For example, 28% of respondents reported that health visiting routine checks remained mainly on the phone or online. Parents reported that online delivery of services made interactions difficult and did not provide them with sufficient reassurance.
- Many informal baby and toddler groups had stopped, and parents reported that even if groups were running, restrictions and booking systems make it hard for parents to access them.

Babies' and 2021 'Babies in Lockdown' surveys. We compared findings between the 2020 and 2022 surveys for illustrative purposes, but this comparison is not robust. All three surveys were sent out through the First 1001 Days Movement, although the number and composition of respondents does vary in each study.)

POSITIVE ACTIVITIES

Children's opportunities for play and other positive stimulation at home over the course of the pandemic varied greatly depending on their families' situation, housing, resources, and parents' time and ability to interact with their children. Similarly, access to childcare varied, but was reduced for most children. The number of children accessing childcare dropped significantly in the first year of the pandemic and remained low in 2021, but is now increasing. Engaging in enriching activities and formal childcare not only benefited children during the lockdowns, but also had impacts on later development.

Nearly half (49.4%) of the 'Casting Long Shadows' (2022) survey respondents reported that 'many' babies they worked with were still impacted by more sedentary behaviour and less stimulation and play. This is a similar proportion to 2020, which suggests that changes in children's experiences were persisting despite the easing of pandemic restrictions.

SOCIAL NETWORKS

Lockdowns, social distancing and the closure or restricted use of many groups and facilities affected social contact for parents and their babies. This had varied and pervasive impacts including increased loneliness, reductions in parents' mental health, self-efficacy and knowledge of child development, and on babies' social and language development.

I feel parents are more fearful and have less confidence in their parenting ability which they usually learn from peers as well as professionals. ('Casting Long Shadows' respondent)

Nearly half (45%) of respondents to the 'Casting Long Shadows' (2022) survey stated that family 'self-isolation' was still affecting 'many' of the babies they worked with. This figure is similar to that reported in the 2020 'Working for Babies' survey despite changes in the prevalence and risk of the virus and the ending of national restrictions.

POVERTY

Rising child poverty in the UK, which predates the pandemic, disproportionately affects babies and young children. The pandemic and subsequent cost-of-living crisis have increased financial pressures on families. In the 'Casting Long Shadows' (2022) survey, four in ten respondents (40.4%) reported that many babies had been affected by the loss of family income or increased risk of food poverty.

The terrifying reality is that the residual mental/physical health impact of Covid on the most vulnerable families can only be further compounded by the oncoming cost of living/ fuel crisis. ('Casting Long Shadows' respondent)

CHILDREN'S OUTCOMES

The pandemic has had a negative impact on the health and development of many babies and young children. A range of research and national data shows an increased prevalence of speech and language delays, increased social, emotional and mental health needs, and impacts on physical development and motor skills.

Nearly all (94.8%) of the 'Casting Long Shadows' (2022) survey respondents said that the pandemic was having an ongoing negative or very negative impact on the personal and social skills of young children who were growing up during the pandemic. The majority (92.4%) said the same for communication, speech and language skills, and emotional wellbeing and development. Inequalities in outcomes had also widened as the pandemic had a greater impact on babies and young children from disadvantaged backgrounds.

I find children from deprived families seem to have suffered worse, possibly those who haven't had an outdoor space to use and have been stuck indoors with little stimulation. We are seeing huge developmental delays in these children, particularly communication. ('Casting Long Shadows' respondent)

CHANGES TO SERVICE DELIVERY

The pandemic necessitated many changes to service delivery, including an increase in remote service delivery. The 'Casting Long Shadows' (2022) survey showed that services are not returning to their pre-pandemic ways of working. More than six in ten (65%) respondents reported that services were not yet back to 'normal'. Of these, nearly four in ten (39.2%) reported that they did not think their service would ever return to pre-pandemic ways of working.

Whilst there were many accounts of positive adaptions to services, including new practice innovations and more flexible and online delivery of services, worryingly, nearly six in ten respondents (59.5%) who reported that their service was operating differently said that the changes were not beneficial for families.

More services were operating in a hybrid way, which was seen as positive by some survey respondents, with some benefits for service users including accessibility, flexibility and choice.

Access to free online breastfeeding classes… mums can attend in their PJs! … online breastfeeding support available somewhere in the UK virtually every day of the week – no need to wait for local ones. ('Casting Long Shadows' respondent)

Many pregnant women prefer the video contact as it fits in with working late into pregnancy and not having to travel to appointments or wait around. ('Casting Long Shadows' respondent)

However, other survey respondents, along with research and serious case reviews, noted increased risks inherent in remote delivery, particularly in terms of unidentified needs.

Telephone contact for any development checks relies on parents to spot if somethings is not quite right, and no-one generally likes to admit their child is not doing what they should be as they are afraid of what that means, whereas an eyes-on appointment often shows a Health Visitor issues the parent hasn't noticed, such as deviant squints, leg dragging, and poor speech. ('Casting Long Shadows' respondent)

The digital offer has advanced significantly during the pandemic… However, this has reduced the number of face-to-face visits we are offering and so I feel we are not always offering quality assessments which will impact on our ability to safeguard children. ('Casting Long Shadows' respondent)

Professionals welcomed the benefits they themselves gained from remote working, noting, for example, that it made it easier to come together with other professionals across a local area and to access training opportunities.

LATE IDENTIFICATION AND DELAYS IN SUPPORT

Prior to the pandemic, many services for babies and their families had experienced significant cuts and were already struggling to meet needs. As needs increased and services were restricted during the pandemic, the gaps between needs and service provision widened. Many babies and children were facing long delays in accessing support, which risked delayed treatment and diagnosis. In the survey, several professionals painted a picture of services in 'crisis'. These issues not only affected

babies and their families, they were also impacting on staff wellbeing and retention which further limited the ability of services to work effectively.

A lot of the issues children are experiencing are due to having had to stay at home… I'm not sure this could have been prevented. However, the pressures now on the sector to 'fix' children without any further support from the government is unacceptable. We need more experienced staff than ever, and Brexit and post-pandemic staff shortages put even more pressure on us, driving the remaining workforce out due to exhaustion and feeling devalued. ('Casting Long Shadows' respondent)

CONCLUSION

It is clear from this research that the pandemic cast and is casting long shadows on the lives of many babies and young children, their families and the services that work with them. It will be important for charities and others advocating for our youngest children to continue to monitor this to understand the longer-term impact of the pandemic. Understanding the impact of COVID and the measures put in place to control it can enable policy makers and practitioners to help those children who have experienced harm and perhaps to learn some lessons about child development to inform longer-term policy and practice. The pandemic has accelerated service development and innovation, but this research shows that the ongoing implementation of any changes must be done mindfully, based on evidence, and with children's best interests at heart.

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Happy Baby Community: Perinatal education & support for mothers in the UK asylum system

Jill Benjoya Miller, Perinatal Lead, Happy Baby Community, UK

In their recent position statement on caring for pregnant migrant women, the Royal College of Midwives (2022) cites the 'particular needs of migrant women for compassionate support, effective communication and continuity of care, which are essential to reduce inequality of outcome'.

Happy Baby Community (HBC) is a London-based charity working with nearly 1400 women who are seeking asylum - in other words, who have asked for protection and sanctuary - whilst they are pregnant or with very young children.

In a typical month, we might welcome 35 new members from 18 countries, speaking 16 languages. The profile constantly changes, with women from so many nations, cultures, ethnicities, languages and faiths joining the community. Approximately half of HBC management, staff and volunteers have also lived experience of asylum and motherhood.

The majority of HBC mothers are young, having their first baby and entirely on their own, without partners or any other family. Some are older, some have partners, some have other children. Most fled volatile countries and/or survived and escaped from modern slavery and sexual trafficking. All have made dangerous, frightening journeys. Many are separated from their older children whom they had to leave, or who were taken from them, in their home country. The grief and distress of this situation is with them always.

All mothers who come to HBC have experienced deep traumas, and they continue to live with the physical and emotional effects of these every day. Their lives while in the asylum system are complicated and chaotic, with no money, living in stressful accommodations and navigating legal, medical and societal systems in a foreign language while simultaneously parenting their children without the familiar fabric of family and culture around them. These factors create layer upon layer of disadvantage, impacting their day-to-day lives and their pregnancies.

Our aim is to reduce the isolation created by trauma, asylum, disadvantage and language. The vision is for HBC mothers to feel connected and valued, with opportunities to integrate and ultimately thrive here. Through five weekly drop-in groups plus two 'virtual community' days online, we've created welcoming communities with a range of activities and services that address the challenges of being a new mother, or a mother of very young children, in this new country. The key word is *community*, a place where people feel they belong, where they feel safe and comfortable and can be with others.

A lot of time and resources go toward providing high-quality interpretation so that we can speak with each mother in her own language, freely and authentically. With a combination of community translators and professional interpreters, we do everything from introductory phone calls, health information classes, therapy and welfare sessions, to birth preparation, doula and breastfeeding support.

Most women either join HBC when pregnant or fall pregnant later. A diverse team of 50 doulas, antenatal teachers and infant-feeding specialists supports over 350 mothers each year in our perinatal programme. We provide birth/infant feeding/parenting information and preparation in a variety of ways: via in-person groups, online courses, private phone calls, resources the mother can read or watch, all with interpretation. Each woman chooses what works for her.

We help every woman who wants to write a birth plan to consider and communicate her needs and preferences - which is novel for many who come from places where women have no voice or ability to make choices. The mother has the option to describe her cultural or faith-based practices around birth, plus providing personal information that she wants her care-providers to know so they can care for her sensitively. Very importantly, she can say that she requires interpretation before she can give consent, and she can note which things she doesn't want to discuss, such as the circumstances of her pregnancy, the father of her baby, or past trauma. (It stuns us how many times these things are casually asked about during birth.) The birth plan is transcribed from her words, in her language, into English for her midwives and doctors. This is a significant tool for trauma-informed care. It can also enable women who have survived abuse and exploitation to reclaim their bodily autonomy. Finally, by offering every mother the opportunity to have a doula, we aim to ensure that no one is alone for birth. Over 40% of mothers choose to have an HBC doula.

The Happy Baby Community 2021 pilot study evaluated the positive impact for mothers seeking sanctuary of having a dedicated birth companion:

You didn't leave my side, you were like a mother, you trusted me and didn't doubt me and I'm very thankful. I have no problem with my birth. I am very, very happy. [Mother]

She stayed with me from the first moment of labour until my little girl was born. She was my biggest support in the most beautiful and difficult moments of my life. I never thought that someone would do what she did for me. [Mother]

A strong element of social and peer support runs throughout HBC. In addition to meeting at community groups, some mothers choose to have a perinatal peer support caller (community members trained by HBC to support others) during the months before and after their baby is born. Women who have a partner or friend as their birth companion often choose to have a perinatal caller instead of a doula. This benefits the mothers on both ends of those conversations.

Please keep calling me. It makes me really happy when you ask how I am feeling and how my baby is feeling. [Mother]

This amazing experience filled my soul with joyful moments when I can provide comfort to our lovely moms, being able to draw a smile on their faces by checking on them weekly and providing all the available help by the support of our community… I feel so good that I am also giving my small support to someone, just as I received it in my beginnings in this country! [Peer Supporter]

We are striving to create equity in childbirth so that mothers who have been made vulnerable and disadvantaged can have the same access to maternity care, informed choice, the right to consent and to say 'no' or 'stop' if needed, which we are all entitled to in the UK. Most HBC mothers have no idea of their rights or the spectrum of maternity care options that exist, from birth centres to maternal-choice caesareans. Our medical system is a mystery to them, as is the process of childbirth for many. Through information and discussion, we enable them to better understand what happens in their bodies, what to expect in medical care and what's possible (their rights and options). We know that it's detrimental, and not even possible, to assume what will be best for an individual or what she will want. In all conversations and when providing support, we are led by the mother to tell us what she needs. Moreover, we don't ask questions about women's history, why or how they came here, what may have happened to them along the way. We're extremely careful when talking about previous births and older children, as many have suffered so much loss. We create the space for each mother to discuss what feels safe and appropriate, and we try to listen well so she doesn't have to repeat sensitive information.

Active listening, cultural sensitivity, the principles of dignity and trauma-informed care are the foundation of our work across HBC. Based on the universal assumption of trauma, we've carefully curated and developed many of our own perinatal teaching resources and images to avoid retriggering memories of physical/sexual trauma or powerlessness and to be representative of our diverse community. These resources show the full range of possibilities for labour, birth and infant feeding, including options mothers probably won't have known about which could help immensely, such as:

- using a birthing pool to soothe pain and/or to reduce physical exposure during labour;
- choosing to birth in a birth centre to minimise the number of carers the mother will meet and reduce the likelihood of meeting male practitioners and the chances of needing intrusive interventions;
- using breathing patterns and different positions and movement for working with labour to avoid needing medical pain relief if she's needle-phobic or drug-averse (often a result of abuse);
- breastfeeding without skin-on-skin contact if breastfeeding is too triggering, or expressing milk to bottle/cup feed.

Our teaching is heavily rooted in NCT and Active Birth antenatal education approaches, centring the mother's experience and helping her connect with her unborn baby and realise that she can make choices and be proactive in labour.

The perinatal programme is shaped by what we've learned from the mothers, and we constantly adapt it as we understand more. In addition to language barriers and ever-present trauma, the challenges we navigate include how to help women access and trust our support, advocating for them, sitting with them through pain, and knowing that what is happening for them is almost always beyond our control - we can just keep showing up. We have also learned to expect and respect the unexpected. For example, some mothers feel safe and cared for in a highly medicalised birth, while others want the least medical interference due to fear of others taking control, or of pain, drugs and needles. Unknown mothers might call for the first time requesting support when they're already in labour, or mothers can suddenly be moved away after we've built up a relationship and have prepared to support them through birth and the postnatal period. (This is particularly cruel and not meant to happen in the 'protected

period' from 34 weeks of pregnancy through to six weeks postnatal precisely because it disrupts continuity of care and causes huge distress). Issues around women's partners may come suddenly to the fore when an unexpected trigger occurs; or she remembers her medical history differently from what medical examinations show.

Despite or because of all these challenges, the joys always outweigh the difficulties. At HBC, we feel deeply privileged to meet these women and to be able to offer kindness and respect at such a fraught time in their lives.

It was a pleasure to be part of the IJBPE conference this year in honour of Mary's work. Thank you.

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A career in childbirth and early parenting education: 1985-2022

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Just as we know so much more about the way in which children's experiences shape their future, so it seems likely that the early experiences of childbirth educators might be especially significant in shaping their careers! I was born in the mid 1950s; the Second World War was part of the lived experience of the majority of the country. Women had played an important part in the war effort – working as land girls on the farms, in the munitions factories and as decoders at Bletchley Park, amongst many other activities. When the soldiers came home again in the late 1940s, the cultural expectation that women should be wives and mothers and not seek a career outside the home was being challenged. Many women had enjoyed their time in the workplace; they had proved to themselves, and the nation, that they were equal to jobs previously filled by men. There was a new determination to have their voice heard in every aspect of the nation's life.

And in the course of the 1950s and '60s, women did indeed become increasingly visible in a variety of roles, and not just as nurses and teachers, their traditional occupations. It was notable, however, that their status within maternity services remained one of subservience to a patriarchal, controlling and condescending medical model of care. A 1950s leaflet published by the British Medical Association addressed mothers-to-be as if they would accept and not question whatever was done to them:

You are going to have to answer a lot of questions and be the subject of a lot of examinations. Never worry your head about any of these. They are necessary, they are in the interests of your baby and yourself, and none of them will ever hurt you. (quoted in Katona, 1981:26)

A Sunday Express baby book published in 1950 similarly portrayed women as helpless and incapable of bringing their babies into the world without assistance:

In the delivery room, white with bright lights, you will be taken from the hospital trolley to the delivery table. The nurses will be standing by with the doctor and with their gentle help and encouragement, aided by the science they have studied so long, your baby will be born. (Woodman, 1950)

It is little wonder, therefore, that, arising out of post-War feminism, an organization should be launched specifically to inform women about pregnancy and labour, and prepare them to be active participants in their own care. This was the Natural Childbirth Association, formed in 1956, and shortly afterwards renamed the National Childbirth Trust (today known simply by its initials, 'NCT'). Its first President was Grantly Dick-Read whose highly influential book, 'Childbirth Without Fear', published in 1942, seemed to offer women the means of reclaiming birth as the mother's rather than the doctor's experience. First published in the USA because no British publisher would accept its implicit criticism of the medical profession and its defence of the autonomy of childbearing women, 'Childbirth Without Fear' argued that women had difficult births because they did not understand the process or how they could help themselves, and that education was the way to reduce tension and pain, making medical intervention less likely.

The National Childbirth Trust was a new kind of organization in which the leading women were not experts in the traditional sense of having academic and clinical qualifications, but women who claimed authority from their lived experience of having given birth. The founders set up groups for pregnant women (no men at this point) and taught them basic anatomy and physiology of childbirth and explained Dick-Read's theories of muscular relaxation and breathing control. The organization flourished; women clearly wanted to know more about how their bodies worked, and felt they had a right to a greater say in how their babies were born.

In the meantime, my early childhood experiences were of lots and lots of babies. My mother's two sisters each had ten children; there was scarcely a year when a new cousin wasn't added to my playmates, and in some years, two or more came along. Despite the fact that my own mother had only two children, myself and a brother, later to die in childhood, I internalised the idea that babies were easy to produce and following a fairly short period of dependence, were largely brought up by their siblings! Childbearing and breastfeeding seemed to me simple facts of everyday life, holding no threat and demanding no particular effort (in both of which convictions, I was, of course, hugely mistaken!)

A sense that childbirth could be a frightening

and sometimes dangerous experience didn't grow in me until I started training as a nurse in the early 1980s and was sent on placement to a maternity hospital (which no longer exists) in Cheltenham. There I was struck by how austere, cold and threatening the delivery rooms were, and how many procedures women were subjected to. This was very much not how I had imagined babies coming into the world, and recollections of my aunts simply 'getting on' with having babies challenged what I was seeing at the hospital. As a mere student, my job was primarily to administer enemas, in the mistaken belief that women should empty their bowels in early labour in order to facilitate the passage of the baby. It was some years before this practice ceased on the basis of many women's accounts of diarrhoea at the start of labour – a natural consequence of the early contractions of the uterus – and plea that they were therefore not in need of an enema.

It was important as a student nurse at this period to know your place at the bottom of the hospital hierarchy (with labouring women possibly even lower down). In 1985, John Cleese, in a famous satire from 'The Meaning of Life', portrayed a birth in which the surgeons are focused entirely on the machinery to which they have attached the mother, and on kowtowing to the hospital manager when he explains his devious financial strategy. After the baby is born, it is immediately 'isolated' in an incubator. The mother is told not to ask questions as she is not 'qualified' to participate in the birth. The reason this sketch was so painfully telling was precisely because it magnified the actual experience of many women at this time of being sidelined in the birth their own children.

Because of my very positive and relaxed childhood recollections of babies, this experience of maternity care affected me deeply. When I became pregnant in 1984, I sought out NCT classes, practised 'the breathing' assiduously, and armed myself with arguments to resist unwanted interventions. I wasn't frightened of labour, but I was frightened of being out of control. The result, not perhaps surprisingly, was that I gave birth 'accidentally' at home, in my bedroom, on my own. I remember a feeling of exultation that I had done it all myself. Two years later, my second child also came very close to being born at home; a mad dash to the hospital in late labour resulted in a birth 20 minutes after arrival.

One of the outcomes of these experiences was a newly acquired understanding of the way in which birth experiences critically shape women's feelings about their bodies, their inner strength and their sense of themselves. I felt I had a direction in life now as far as a career was concerned. I wanted to work with childbearing women and their families, but not as a midwife 'within the system' but as an advocate from outside. I therefore decided to train as an NCT teacher. The tuition was exceptional. It opened up to me a world of feminist literature and health care politics that I had been unaware of. I started reading Sheila Kitzinger, Janet Balaskas and Marsden Wagner, and later on, Robbie Davis-Floyd. I became wedded to the need for women to challenge maternity care and insist on being treated as equals in their own care; as Kitzinger (1976:) said in an editorial for 'Mother and Baby' magazine, women needed to make up their own minds:

> *The way we are born, the relations between doctors and nurses and their patients, and the way we die, are matters not only for experts but for all of us…No-one can really decide these things for us. We need to learn about new technological developments, get all the information we can, and make up our own minds.*

I found Marsden Wagner's 1994 book, 'Pursuing the Birth Machine', a revelation. From it, I learned about the limitations of research, and even of the Holy Grail that is the Randomised Controlled Trial, and of the dangers, in Wagner's words, of 'ruthless application of partial knowledge on a vast scale'. These were insights that I took with me into a later phase of my career when I entered the academic world.

From 1985 to 2015, I hugely enjoyed being a childbirth educator and from 1992, a tutor, for the National Childbirth Trust. I taught in villages, towns and cities – from tiny villages in Wiltshire to wealthy towns such as Bath, and huge diverse cities such as Birmingham. I led workshops for midwives, health visitors and educators from the charitable sector in the UK, Australia, New Zealand, Belgium, Holland, Ireland and France. I found that dismissing, or at least under-valuing women's knowledge of their own bodies and their wishes with regards to how they wanted their babies to be born, was not confined to home. The UK had its problems, but the medical model exercised an even greater strangle-hold on women in, for example, Spain and the Republic of Ireland. The need to change this situation inspired me, but there were moments when I felt depressed by how universal the disrespect of women seemed to be.

1993 was a landmark in maternity care in the UK. A Report from the Department of Health, 'Changing Childbirth', chaired by the eminent Julia Cumberlege, was published. On the first page, it stated that women must be at the centre of their care, and that services should seek to provide women with Choice in where and how they wanted their babies to be born, Continuity of midwifery care, and Control over decisions made regarding their and their babies' treatment and welfare. As I write this in 2023, none of what we then called 'the three Cs' has yet been achieved. However, thirty years ago, the report seemed like a glorious new dawn for maternity care, and there

is no doubt that childbirth educators, midwives and many obstetricians and hospital managers worked incredibly hard to realise the aspirations of 'Changing Childbirth'. However, the spark of hope kindled by the report flared up brightly only to quite quickly dim and almost disappear. Why? The answer to this is complex. Suffice it to say that it was partly due to the onwards march of medical technology which lured many women as well as health care professionals into believing that information provided by machines could provide more accurate information about the labouring mother and her baby than the mother herself. It was partly due to fear of litigation so that doctors and midwives felt that if anything went wrong in labour and a malpractice case was brought against them, juries would inevitably convict if every possible gadget and surgical procedure has not been used. And perhaps the failure of 'Changing Childbirth' was also due to uncertainty on the part of women themselves about how much 'control' they actually wanted in childbirth or whether their choice was to hand over decision-making to others.

By the turn of the century, many birth activists and healthcare professionals felt that 'Changing Childbirth' had promised a great deal and delivered little. In any case, the focus as far as antenatal education was concerned was moving away from labour and birth and onto the postnatal period. The 1990s were the 'decade of the brain' when research began to accumulate at an exponential rate to suggest that there are critical periods of development across the life course. One of these – perhaps the most significant of all – was shown to be the first two years of life when the brain was found to translate the effects of experience into permanently altered neural wiring. The message for parents and for those caring for parents was that the quality of early caregiving has a long-lasting impact on how children develop and on their capacity to regulate their emotions and form satisfying relationships.

I found this research compelling because of my own recent experience of adopting a little girl from Romania and the challenges we faced in bringing her up. Attending lectures by such luminaries as T. Berry Brazelton, Peter Fonagy, Vivette Glover and Marian Bakermans-Kranenburg, convinced me that the difficulties our daughter and other Romanian adoptees faced in understanding how relationships work, were probably related to very early experiences of neglect and maltreatment.

My antenatal teaching changed to reflect my new interest – and parents' new interest – in building relationships with their unborn and newborn babies. While I continued to have a focus in my sessions on labour and birth, I also introduced conversations about what makes a good parent, and how babies' brains are influenced by every experience they have. Managing stress became a central topic as research increasingly suggested that unborn babies are deeply affected by stress hormones transmitted to them in the womb. However, I was concerned, as were many other childbirth and early parenting educators, that threatening pregnant women with poor outcomes if they transmitted stress to their babies in the womb, might actually be the best way of creating stress! And indeed, over the last couple of decades, research has become much more nuanced in its efforts to understand the effects of pregnancy stress on mother and baby. Important questions have been raised and remain unanswered: How much stress is too much for unborn babies? Are all babies affected equally by stress? Is acute stress worse than chronic stress, or the other way round? Is some stress actually good for babies, priming them for 'the real world'?

In 2013, I was offered the first ever Chair of Perinatal Education at the University of Worcester. This gave me access to the world of research in a more immediate way than I had previously had as a consumer of studies, looking in from the outside. As a member of research groups exploring, for example, how to help health visitors engage with fathers as part of the Healthy Child Initiative, the impact of military family life on the wellbeing of pre-school children and the influence of giving birth in water on maternal and neonatal morbidity, I gained a much greater respect for the skill, commitment, and sheer persistence of top-class researchers as they combatted multiple obstacles in order to get funding, obtain ethical approval, conduct studies and manage highly complex data. I also became increasingly aware that no study can ever be perfect; participants drop out; study demographics are skewed in favour of 'the usual suspects' (white, educated, affluent, middle class); it proves impossible to interview a sufficient cohort of health professional participants because of service demands; funding runs out so that important aspects of the study cannot be completed. Occasionally, I felt that studies were too 'academic' - far removed from the real concerns and experiences of childbearing families. What I had learned from Marsden Wagner's book a couple of decades previously made me sometimes sceptical of what was being researched and how.

I was never a very good researcher. My passion was for communicating with women and families and with practitioners. This led me to revel in speaking engagements across the world. The most frightening aspect of delivering lectures was, for me, the point at which the Chair asked for questions from the floor! A real adrenalin rush moment. I knew I would be challenged but I also knew I was about to gain an insight into what was truly on people's minds. My audiences never failed to rise to my expectations of their wisdom, experience and enthusiasm.

In 2013, as a further effort to communicate with practitioners, I founded the International Journal of Birth and Parent Education along with my NCT colleague of many years – Shona Gore. We felt that there was a gap in the literature available in the UK to childbirth and early parenting educators. In the United States, the Journal, 'Birth and Parent Education', filled practitioners' needs, but there was no similar publication here. Neither Shona nor I had any experience of managing a Journal, although I had a lot of writing experience and a secure grasp of grammar and punctuation owing to having been taught English at school by my mother who was a stickler for the correct use of the apostrophe! Supported by a remarkable Editorial Board, Shona and I determined that our Journal would include articles by both practitioners and academics. Our mission was to bridge the gap between knowledge and practice, to make the best research accessible to practitioners so that they could apply it in their everyday work with expectant and new parents.

The new Journal met with huge generosity from researchers and practitioners across the world who agreed to write for this unknown publication, because they were in sympathy with what it was trying to achieve. Since October, 2013, when the Journal was launched at a conference at the University of Worcester, we have covered themes as varied as Preparation for Labour and Birth; Fostering and Adoption; Military Families; the Family-Nurse Partnership; Breastfeeding, Sleep and Routines; Home Birth and Free Birth; Early Nutrition; Impact of the Pandemic, and the Cost of Living Crisis for Families with Young Children. The Journal has received hits from across the world including the USA, South Africa, Brazil, Canada, the Pacific Islands, Russia, the Czech Republic, Greece, Finland, Norway, Denmark, Sweden, Germany, Italy, Spain, France, Ireland and all four countries of the United Kingdom. We have also produced supplements which allowed authors to take 'a deep dive' into such areas as perinatal mental health and the ethics and legislative framework of surrogacy.

I retired from the University of Worcester in the summer of last year, 2022, although I remain very much involved with the IJBPE. After so many years of working in the field of preconception, pregnancy, birth and early parenting, I am – sometimes uneasily – aware that there are many key challenges that remain to be tackled. Some of these, as I see them, are:

- How can childbirth educators prepare women for a natural birth when there is little likelihood of their being able to achieve it?
- Do we think that parenting is species-specific or culturally determined? And if the second, how should this influence the education we provide for parents?
- Is online education the way forward or should we be fighting for more not less face-to-face contact with parents?
- How can we reconcile the dictates of neuroscience and developmental psychology, with parents' need for sleep and a respite from babycare in an era where parenting has never been so unsupported by family and so relentlessly demanding?
- Are we sufficiently focused on the preconception and inter-conception agenda?
- Should childbirth and early parenting education be regulated?

Just as eighty years ago, Grantly Dick-Read was adamant that education was the means by which mothers could be helped to overcome their fear of giving birth, so I remain convinced that education is still the means by which we can provide more equal opportunities, from pregnancy onwards, for babies born into very disparate circumstances. Birth and early parenting educators are privileged to have access to women and men at a pivotal moment in their lives – pregnancy – when they are unusually, perhaps uniquely, open to learning about themselves and eager to explore their role as parents. Pregnancy opens a magical window of opportunity when people stop to reflect and ask themselves:– How do I feel about being a parent? How have my ideas about parenting been formed by my childhood experiences? Do I want to parent in the same way as my mother/father? What does a baby really need to grow up happy and healthy? How can I best provide that nurturing environment while looking after my own physical and mental health? Where can I find support on my parenting journey? These are all questions that educators can work through with parents, transmitting information where it is lacking, highlighting and respecting parents' unique abilities, pointing them in the direction of support and always listening, listening, listening……..

To all the amazing childbirth and parenting educators whom I have met and not met, who are still fighting battles to ensure that every baby has the best possible start in life, I send my encouragement and very best wishes.

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Working With Black Parents-To-Be

Lorna Phillip, Founder and CEO of Black Mamas Birth Village

In January, I had the pleasure of speaking at the IJBPE Conference in Worcester; it was the Journal's Manager, Bridget Supple, who invited me to share my work.

When Bridget messaged me, I thought what could I - a mom, grandma, nursery nurse, birth and postpartum doula, doula educator and mentor, hypnobirthing instructor and more recently, founder of Black Mamas Birth Village – what could I possibly speak about at a birth and parent educator conference that they didn't already know about?!

Of course, I didn't have to think too hard and came up with a topic very easily!

Why easy? Well, as the founder of Black Mamas Birth Village, an organisation that provides a safe space and birth education for Black moms-to-be, I know many Black expectant parents don't feel comfortable accessing birth education classes.

This was the case for me when I was expecting my own children in 1989 and 1993. I remember the excitement I felt and how eager I was to book an antenatal course. The antenatal classes leaflet showed pictures of white women and couples; none of the people looked like me. The message I took from the leaflet was that classes were not for people like me. I was not blonde, white and in a couple; I was Black and single. I was also in a well-paid job so there wasn't a financial problem in paying for classes, but I feared that I wouldn't be welcomed and I wasn't prepared to pay good money to be made to feel like an outsider. I'd been in these kinds of spaces many times before – at work, at school, at university, in social situations etc. If there had been something similar to the Birth Village back then, I would have signed up in a heartbeat!

After having my children, I worked in a number of roles, all within the children and families sector. It was when I became a SureStart deputy manager that I encountered new parents who would re-tell their birth stories over and over again. I was a mother of two at the time but hadn't considered or understood the importance of being able to tell a positive and empowering birth story.

It was about this time that I heard about doulas. The seed was planted, I knew I wanted to support parents to have better births but I let seven years pass before I finally started my doula training. As a doula, I served mainly Black and Brown families. This wasn't by design; Black and Brown families sought me out because they wanted a doula who either looked like them or was able to practise in a way that embraced their culture and birth traditions.

I found doula work highly rewarding but also heart-breaking. Not because I witnessed any catastrophic birth outcomes but because of the way the maternity system often works against physiological birth. Equally heart breaking were the racist attitudes of some health care professionals that my clients and I came up against. I witnessed my Black and Brown clients being disrespected, denied care and pain relief and coerced into accepting interventions that they did not want. Birthing whilst Black can often feel like a battle. This maddens me because this is the time when we are supposed to be in our oxytocin-filled birth bubble.

It was as the Covid pandemic was coming to an end that I decided to hang up my doula hat. I'd worked constantly throughout the pandemic; the demand for homebirths was high and doulas were thin on the ground as many had caring responsibilities and stayed home to safeguard vulnerable family members. I knew that I wanted to focus on supporting Black (African/Caribbean and mixed race) women and birthing people, but knew I couldn't physically take on more birth clients.

Lots of note-taking and head scratching ensued. Eventually, Black Mamas Birth Village emerged and was mostly well-received. We started as a private Facebook group where Black pregnant mamas could come to sit and breathe, and share information and experiences. I would facilitate group sessions; some were educational, some were social. The feedback from the mamas was phenomenal and very encouraging. They reported that being part of the Birth Village was like belonging to a sisterhood. Others reported that they had more positive birth and postpartum experiences. Most of the mamas were UK based but we also had US, African, French and Portuguese mamas.

The highlight of our first year was our in-person event – Birth Village Meet and Restore. We'd been holding each other online for all these months and now it was time to meet face to face and enjoy a day of hugging, laughter, conversation, food and African dance. The day was a great success and was made possible thanks to generous donations from the public and numerous organisations who supported with gifts for the mamas' goodie bags.

Year two of the Birth Village brought a significant development. We now have an online membership for the mamas who wish to focus on their birth preparation and feel fully supported until the end of the fourth trimester. By and large, our membership mamas are able to tell really positive birth stories; they feel prepared and well supported. Knowing that I cannot be

everything to everyone, I encourage the mamas to attend hospital and/or private birth education classes and then circle back to the Birth Village to 'colour in the gaps'. I say 'colour in the gaps' as I'm aware that the birth education world is largely white and amongst many birth educators, there is still a lack of experience and understanding of how to work with Black expectant parents and families in a way that is safe and inclusive.

And so to the IJBPE conference. My presentation, 'Working With Black Parents-To-Be', was an invitation to birth educators and other professionals present to reflect on their practice. The main themes were:

Imagery – If educators are wanting to be more inclusive in their practice, it's advisable to start with the images they're using on their websites, social media and any printed promotional material. It's not enough to stick any old picture of a Black family or baby on a flyer. If we are truly seeking to become more inclusive, it's worth putting some thought into the imagery we use to ensure that it reflects the communities that we hope to serve. The language used should also be reviewed.

I choose to centre Black families in the Birth Village's imagery because I want Black expectant parents to know that what I offer is for them and about them.

Inclusivity – When it comes to inclusive practice, my mantra is, 'it should be more of a thread than an add on'. In classes, Black parents-to-be and their babies deserve more than a quick tick box attitude e.g. 'I've mentioned disparities in Black birth outcomes, so that's my EDI box ticked!' I invite educators to be more thoughtful, nuanced and creative. We should be asking ourselves how we can weave inclusivity into our practice so it's seamless and not awkward or forced.

Expansiveness – an invitation for birth educators to be more expansive in their practice. In my experience, white birth professionals tend to close themselves off from others who don't look like them. Work gets passed around within their groups with little or no consideration for reaching out to Black or Brown peers. I asked the educators who or where they would go if a parent in their class asked to be signposted to a Black doula. By refusing to go beyond our 'usual suspects', we're doing ourselves an injustice and not serving Black families in a way that they deserve to be served.

Safety – we hear this word a lot but are sometimes unclear as to how it applies to our practice. I break it down into harmful behaviours and attitudes and offer a more helpful alternative. For example, as a Black doula, I've been put on the spot by a white doula at a meeting of all white doulas asking me about racism. I felt unsafe; the interaction caused me harm. A more helpful approach would have been to address the group as a whole and listen intently to the responses given.

Assumptions - I ended my presentation with a game of 'Simon Says'. I think it's great to introduce games into our practice as they're an opportunity for fun and learning. But not all parents or children will be familiar with the rules of games that we assume are well known. It's always good to check this out before launching into a game and causing embarrassment!

Of course, the game wasn't just about fun!

The rules say players must obey all commands that begin with the words, 'Simon Says'. I had the educators touching their noses, patting their heads etc. All harmless fun. Interestingly, when I said, 'Simon says turn to your neighbour and pinch them so hard that they scream out in pain', everyone chose not to obey the command and when asked why, told me it was because they didn't want to hurt their neighbour. I wanted to demonstrate that as birth and parent educators, we have choices; we can choose not to cause harm - we can choose to practise safely and be inclusive to Black parents and families. We have the power to challenge our own discriminatory attitudes and behaviours and those of our peers.

And lastly, just as we opted out of causing harm to each other in the game of 'Simon Says', birth educators have the power to challenge (or opt out of/leave) the organisations that they trained or work with, and/or their governing bodies, if these organisations do not include cultural safety and inclusive approaches to practice within their curricula. By ignoring the needs of Black families who are birthing in a maternity system that has been found to be systematically racist, such organisations are harmful to Black mothers, birthing people and families.

I feel my presentation was well received and sparked some interesting questions and conversations during lunch. It's clear (to me) that some of the birth educators I spoke to were at the very beginning of their inclusive practice journey. My hope is that they will take further steps to deepen their understanding and knowledge of working with Black families in a way that is inclusive and safe. This will not only enhance their own personal and professional development but also be of benefit to all of the parents and families that they serve.

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