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Content

General resources/news

Scottish Government (Scotland) Improving maternity and neonatal care (Last Accessed July 2026)

Scottish Government (Scotland) Women's Health Plan: Phase 2, 2026-2029 (Last Accessed July 2026)

NICE updated their guideline for Postnatal Care (Last Accessed June 2026)

Health Improvement Scotland (Scotland 2026) Maternity Care Standards (Last Accessed July 2026)

Access to care

1. Brennan-Tovey, Kerry, Kausiki Sarma, Dafni Lima, et al. Professional perspectives on barriers to accessing maternity care in England: a qualitative study. BMC Pregnancy Childbirth. 2026.Vol.26(1), pp334. Background Women living on low income in England are at an increased risk of experiencing stillbirth, neonatal death, preterm birth, low birth weight and maternal mortality. Women with poor access to financial, educational, and social and health resources engage less with health and care services throughout their pregnancy, due to social stressors, low health literacy, digital exclusion, lack of support, language barriers, transport difficulties, and stigma and judgement from healthcare professionals. Existing evidence documents the experiences of women facing socioeconomic disadvantage, little is known about how healthcare professionals understand and respond to these barriers. The aim of this qualitative study was to explore professionals' perceptions of the barriers pregnant women living on low income face when accessing maternity care. Methods Data were collected through one-to-one semi-structured interviews with professionals (i.e., midwives, health visitors, Voluntary, Community and Social Enterprise (VCSE) practitioner) working in the NHS, local authority or VCSE organisations in the North East of England. Purposive snowballing sampling was used to recruit participants. Anonymised interview data was thematically analysed and incorporated Ecological Systems Theory (EST). Results Seventeen participants were interviewed (NHS maternity services n = 6; local authority n = 3 and VCSE n = 8). Data highlighted three interlinked levels of barriers that professionals perceived pregnant women living on low income experience accessing maternity care: structural, interactional and individual. Structural barriers included digital exclusion, language-related difficulties and service delivery challenges related to staffing shortages. Interactional barriers included limited social networks, lack of partner involvement, and experiences of racism and discrimination. Lastly, individual level challenges included cost of travel and other pregnancy-related costs, fear of professionals and unfamiliarity with services. Conclusions Findings from this study present professionals' perspectives of the different challenges pregnant women living on low income face when accessing maternity care. These include language and communication, a lack of social support network, the cost and time of travel and the fear of professionals and unfamiliarity of service. Recommendations to improve access

to maternity services include the implementation of recycled smart phones, the use of digital translation apps within appointments and the use of pre-paid travel vouchers.

Audit

2. Bolarinwa, Obasanjo. **Advancing maternal health equity: the need for cultural awareness and inclusivity in maternity service delivery in the UK: anchored in the MBRRACE-UK 2025 findings.** Int J Equity Health. 2026.Vol.25(1), pp177. Despite ongoing national efforts to improve health outcomes, the UK continues to experience entrenched inequalities in maternal mortality, disproportionately affecting Black, Asian, and migrant women. The MBRRACE-UK 2025 report reaffirms that these disparities are not random but rooted in structural deficiencies within the maternity service delivery system. This commentary argues that achieving maternal health equity requires a fundamental shift in how maternity care is commissioned, delivered, and evaluated. Cultural awareness and inclusivity should be recognised as an important integral to the provision of safe and effective maternity care, rather than treated as supplementary considerations. Embedding these principles into national clinical guidelines, service contracts, commissioning frameworks, and mandatory workforce training will reduce barriers to access, promote equity, improve the quality of maternity care, and rebuild trust among underserved populations. The paper calls for bold and decisive leadership, targeted policy reforms, and genuine co-production with affected women and communities to ensure that maternity services reflect diverse needs. Without such decisive actions, inequalities will persist, undermining the credibility and safety of the UK's maternity care system. The paper also offers actionable policy and system-level recommendations to guide measurable transition towards equitable, culturally responsive maternity services in the UK.

Breastfeeding/feeding support

3. Bird, Amelia Grace, Hazel Inskip, Keith M. Godfrey, Nicholas C. Harvey, Sarah Crozier and Janis Baird. **The Association Between Maternal Adiposity and Breastfeeding Initiation and Duration: Evidence from the Southampton Women's Survey** Maternal & Child Health Journal. 2026. 01/01. Vol.30(1), pp16–23. Background: Most mothers in the UK are not meeting the breastfeeding recommendations set by the World Health Organisation (WHO, Breastfeeding - Maternal obesity has variably been associated with lower initiation and shorter duration of breastfeeding, but few studies have examined the impact of maternal adiposity estimated from skinfold thicknesses. Aim: To investigate the relationship between maternal adiposity and breastfeeding initiation and duration. Methods: Data from 2,873 mother-offspring pairs in the Southampton Women's Survey (SWS) mother-offspring cohort study were used to assess the relationship between a mother's adiposity and breastfeeding initiation and duration. The exposure variables were body mass index (BMI) and body fat percentage, calculated from 4-site skinfold thickness measurements measured prior to conception. The outcome variables were breastfeeding initiation and duration. All analyses were adjusted for confounders identified using a Directed Acyclic Graph. Results: After adjustment for confounders, no associations were found between maternal BMI (RR 0.99 per 5 kg/m^2, 95% CI 0.97, 1.01) or body fat percentage (RR 0.99 per 5%, 95% CI 0.97, 1.00) and initiation of breastfeeding. After adjustment for confounders, amongst women who initiated breastfeeding, higher maternal BMI (β −0.09 SDs per 5 kg/m^2,

95% CI −0.13, −0.04) and body fat percentage (β −0.10 SDs per 5%, 95% CI −0.16, −0.04) were associated with shorter breastfeeding duration. Conclusions: In this study maternal adiposity had little impact on breastfeeding initiation but higher maternal adiposity was associated with shorter breastfeeding duration. This study suggests that more support should be given to mothers with overweight and obesity to promote longer duration of breastfeeding. Significance: What Is Already Known on This Subject?: Currently, the evidence base surrounding this topic is conflicted. Some evidence suggests there is no association between maternal adiposity and breastfeeding, whilst other studies suggest that there is an association between maternal adiposity and breastfeeding. One possible explanation for the discrepancy is related to multiple adiposity measures used across the evidence base. What This Study Adds?: This study uses a large mother-offspring cohort study based in England and is one of the few to recruit women prior to pregnancy. Two of the most commonly used methods for measuring adiposity were used to test for an association, addressing one of the current challenges within this topic area.

4. Blanch, Bianca, Amanda R. Cooklin, Nicole Bridges and Lisa H. Amir. **How do Australian workplaces support breastfeeding mothers in 2025? A content analysis to develop a 'Supportive Workplace Checklist'**. Health Promot. Internation. 2026.Vol.41(2),Abstract Few studies have described uptake and implementation of breastfeeding friendly workplace initiatives from employers' perspectives in Australia. Our aim was to describe how Australian breastfeeding friendly workplaces report supporting breastfeeding mothers in paid employment. We explored the characteristics and/or workplace profiles of Australian BFWs listed on a publicly available Australian Breastfeeding Association (ABA) website. Each BFW provides: a lactation space, lactation breaks and a supportive workplace culture. Based on these profiles, systematic reviews, published literature, and information on the ABA website, we created a 46-item inventory of supportive workplace factors and counted the number of factors present per profile. On 1 October 2025, we identified 138 BFWs on the ABA website, most commonly from federal government and government agencies (n = 30; 22%) and hospitals and health care service industries (18; 13%). Fifty-seven (41%) organizations published a workplace profile. Of a possible 46, the median number of supportive factors or workplace benefits was 13 (IQR: 10–17.5). Three frequently reported factors: supportive workplace culture (93%), flexible work conditions (74%), and work–life balance (70%). Workplaces demonstrated many ways to support breastfeeding mothers. Future studies should focus on better understanding employers' perspectives of providing workplace supports and whether the lived experiences of mothers returning to work match the purpose of each workplace initiative.

5. Bruckner, Bailey, Rachael Taylor, Carmen Parata, et al. **Maternal perception vs actual breast milk supply: is there a difference? protocol for an observational study**. Proc.Nutr.Soc. 2026.Vol.85It is well known that breastfeeding provides favourable health outcomes for both mother and baby. However, many mothers struggle to meet global breastfeeding recommendations, with Perceived Insufficient Milk Supply (PIMS) being a leading reason for early cessation(1). Currently, little is known about the relationship between PIMS, actual milk insufficiency, and human milk nutrient composition. The primary aims of the Māmā (mother) and Baby Breastfeeding Study

are to describe human milk volumes produced by a diverse sample of breastfeeding mothers at 3 months postpartum with differing perceptions of milk supply, and to compare human milk composition in relation to milk volume. In this observational study in Dunedin, Aotearoa New Zealand, a sample of 150 mother-infant dyads will be recruited. A diverse range of participants in terms of ethnicity and socio-economic status will be included, with an aim of recruiting as close to 20% Māori as possible. Targeted recruitment through networks within the maternity and healthcare sector as well as through Māori researchers will be utilised. Human milk volume (milk supply) will be assessed using the 'dose-to-mother' stable isotope (deuterium oxide) technique. Mother participants will consume an accurate dose (30 g) of deuterium oxide after baseline saliva samples are collected from both mother and infant. Subsequent post-dose samples will be collected over 3 time-points to determine deuterium enrichment over a 14 day period using Fourier-Transform Infrared Spectrometry. Human milk macronutrient (energy, fat, carbohydrate, and crude and true protein) and mineral and trace element (sodium, magnesium, phosphorus, potassium, calcium, iron, copper, zinc, selenium, and iodine) composition of one full milk expression from one breast will be analysed using the MIRIS Human Milk Analyzer and ICP-MS, respectively. Potential predictors and maternal perception of milk supply will be assessed via questionnaire. Infant body mass index (BMI) will be calculated from measures of weight and length at three different time points over four weeks, using standard techniques. These, alongside anthropometric measurements collected at the infant's Well Child Tamariki Ora (WCTO) visits, will be used to assess infant growth trajectory over time. Regression models will be used to assess the associations between maternal perception of milk supply, human milk volumes, and composition. Recruitment for this study began in February 2025 and is anticipated to conclude in June 2026 with analysis expected to be completed by February 2027. As of 25 August, 56 participants have been enrolled. Progress with recruitment, and the initial demographic profile of participants, will be presented. This research will provide new knowledge on whether maternal perception of milk supply aligns with actual human milk volume or nutrient composition. Such information will be beneficial to health professionals working with breastfeeding mothers with milk supply concerns and inform the design of breastfeeding support programmes and resources.

6. James, Eilish, Gary Hoang, Daniel Lange, Kate Jolly and Joanne Clarke. **Mothers' Experiences of Formula Feeding Support in the UK: A Qualitative Systematic Review**. Maternal & Child Nutrition. 2026. 04/01. Vol.22(2), pp1–12. Most babies in the UK and Ireland receive formula milk in their first 6 months of life. Understanding mothers' perceptions of formula feeding support is crucial in shaping practical guidelines, research-based strategies and future policies to support formula feeding decisions. This review aimed to synthesise qualitative evidence on mothers' experiences of formula feeding support in the UK and Ireland. The Cochrane Handbook guidance for systematic reviews was followed and MEDLINE, CINAHL, PsycINFO, Web of Science and ASSIA (ProQuest) databases were searched. Ten included papers were assessed for methodological quality using a CASP checklist. The Thomas and Harden three-stage approach was used to thematically synthesise the data. The synthesised findings include: (1) Limited support for formula feeding, (2) Withheld or conflicting healthcare professional support, and (3) Emotional health and wellbeing impact on mothers.

Mothers who formula feed require empathetic, formal guidance from HCPs as they navigate their feeding journey. This review highlights predominantly negative experiences due to inadequate support received. Formula feeding support should be recognised as an essential element in perinatal care. Future research could investigate effective interventions for formula feeding support strategies. Summary: HCPs should provide tailored, non-judgemental support for all infant feeding methods, including formula feeding, to build maternal confidence and reduce stigma.HCPs should provide clear, consistent, evidence-based feeding advice to reduce mothers' reliance on informal sources of formula milk marketing.Further research should be conducted to understand HCPs' perspectives on providing formula feeding support, their awareness of guidance and how to operationalise it.

7. Lunny, Emily, Helen Gray, Elen Davies, Amy Brown and Catrin Griffiths. **The Impact of International Board Certified Lactation Consultant (IBCLC) Support on Breastfeeding in the UK and Ireland—A Scoping Review**. Maternal & Child Nutrition. 2026. 04/01. Vol.22(2), pp1–16. Breastfeeding is important for infant and maternal physical and mental health. Despite this, the United Kingdom (UK) and Ireland have the lowest breastfeeding rates in the world with between 34% and 52% of women breastfeeding partially or exclusively at 6–8 weeks across the nations. This is driven by complex biological, social, psychological and economic factors. However, a significant body of evidence shows that mothers who receive skilled breastfeeding support are more likely to breastfeed for longer. Effective breastfeeding support can be delivered by a range of trained professionals and peer supporters depending on need. The highest specialist support is provided by International Board Certified Lactation Consultants (IBCLCs). Research from the USA has shown the positive impact of IBCLC support upon breastfeeding duration and experience. However, there is limited data on this topic from the UK and Ireland. Given significant differences in IBCLC access and health care systems, this review therefore aimed to explore the impact of IBCLCs in the UK and Ireland. Of 5169 papers retrieved, only four studies met the eligibility criteria. Four themes were identified; breast milk feeding rates increased, breastfeeding duration increased, lack of specialised IBCLC support available outside of study and format of support delivery, including group based or 1-1 support. The findings show increased access to IBCLC support may increase breastfeeding rates in the UK and Ireland. However, the findings are limited due to poor quality studies and recruitment bias. The paucity of evidence highlights the need for further research on this topic. Summary: There is limited published evidence on the impact or outcomes of IBCLC support in the United Kingdom and Ireland, despite established evidence base elsewhere.IBCLC support in the UK and Ireland is associated with increased breastfeeding duration and increased rates of mothers' own milk feeding.Access to IBCLC support in the United Kingdom and Ireland was limited, as IBCLCs are not often available within universal healthcare services.

8. Makwana, Nick, Lauren Arpe, Aneta Ivanova, et al. **The Role of Hydrolysed Rice Formula in the Dietary Management of Infants with Cow's Milk Allergy: A UK Healthcare Perspective**. Nutrients. 2026. 04/15. Vol.18(8), pp1225. Cow's milk allergy (CMA) remains one of the most common food allergies in infancy, requiring the avoidance of cow's milk and its derivatives. Breast milk is the best source of nutrition

for infants. For those infants with CMA whose mothers are unable to breastfeed or choose not to, extensively hydrolysed formulas (eHFs) are widely recommended as first-line milk substitutes, whereas hydrolysed rice formulas (HRFs) are increasingly recognised as a viable alternative. This concept paper provides a healthcare professional (HCP) perspective on HRF, drawing on expert consensus from two meetings convened in 2025. Discussions noted the long history of safe and effective HRF use in Europe, its nutritional adequacy, and the evolving international guidelines supporting HRF as an alternative first-line option. A key meeting outcome was the development of a practical decision tree to help UK clinicians decide when HRF should be the preferred choice. Key considerations for its use in non-breastfed infants include the following: parental/caregiver stress related to persistent symptoms; ongoing symptoms despite multiple interventions; cultural and lifestyle choices; religious dietary requirements; and specialists' recommendations. Secondary considerations highlighted by HCPs include the following: proven reactions whilst infants are breast-milk-fed together with parental request for formula; faltering growth; multiple symptoms; taste acceptance (older infants); and parental preference based on experience. The role of functional components, such as prebiotics and human milk oligosaccharides (HMOs), was noted in regard to the emerging evidence of benefits to the microbiome and immune development. The experts emphasised the importance of engaging HCPs across all levels of CMA care and addressing challenges in translating current guidance into treatment practice. It was concluded that, overall, HRF represents a nutritionally complete, plant-based alternative that has been shown to be well tolerated (taste, symptoms) in clinical studies. It can be used to broaden therapeutic options for infants with CMA in the UK who are not exclusively fed breast milk.

9. Uijtewaal, Renate. **Long-term breastfeeding mothers' perspectives on the warm chain's support.** BMC Pregnancy Childbirth. 2026.Vol.26(1), pp492. Background Although breastfeeding provides many benefits for infants as well as mothers, the UK has one of the lowest breastfeeding rates worldwide. While 54.3% of mothers start breastfeeding after birth, only 1% exclusively breastfeed for the first six months and less than 0.5% continue for up to two years as recommended by the World Health Organization and UNICEF. This study aimed to understand what encourages mothers to initiate and sustain breastfeeding, and how society can support them in their breastfeeding journey despite the obstacles they face. Methods A qualitative study using reflexive thematic analysis explored the experiences and attitudes of breastfeeding mothers regarding the support they received. Eight interviews were conducted with mothers aged 38–52 who breastfed for at least twelve months of their lives. Participants had diverse ethnic backgrounds but similar educations levels, partnership statuses while breastfeeding, and lived in East London at the time of the study. Results Four themes emerged from the data: "Breastfeeding is hard", "Breastfeeding is magical", "Breastfeeding is an emotional rollercoaster", and "Support is everything". Participants described physical challenges, social stigma, and exhaustion, while simultaneously experiencing deep bonding, pride, and fulfilment. Conclusion Support from healthcare professionals, family, and peers is essential for breastfeeding success. Interventions should focus on building self-efficacy and providing consistent, accessible support, for example via video conference. Education about realistic expectations and practical aspects of breastfeeding better prepares mothers and

reduces anxiety related to perceived insufficient milk supply. At a policy level, strengthening implementation of the warm chain may support longer breastfeeding duration and reduce avoidable early cessation. These findings align with WHO and UNICEF recommendations supported through the Baby-Friendly Hospital Initiative and community-based peer support networks. Limitations The small, homogeneous sample (highly educated, middle-class mothers in East London) and recruitment through convenience sampling limit generalisability. Findings may differ among younger mothers, lower socioeconomic groups, or more diverse populations.

10. Patel, Ronak, Alona Courtney, Natasha Elysha Jiwa, et al. **Mastitis and Mammary Abscess Management Audit (MAMMA): A Survey of Patients' Perspective on the Management of Mammary Abscesses in the UK**. Breast J. 2026. 02/17. Vol.2026 pp1–10. Background: The recent Mastitis and Mammary Abscess Management Audit demonstrated widespread variation in the management of breast abscesses across the United Kingdom (UK), with up to one-fifth undergoing surgical drainage rather than image-guided needle aspiration. The impact of these practices on patient's perspective and quality of life is unclear. This study aimed to assess patients' experiences following breast abscess treatment, focusing on treatment modality, cosmesis, breastfeeding and quality of life. Methods: A cross-sectional online survey was conducted between February and August 2024, aimed at UK-wide adult women with a history of breast abscess. Descriptive and thematic analyses were performed using SPSS and NVivo software, with multiple imputation for missing data. Results: Of 172 participants, half underwent needle aspiration (50.58%), while 23.84% received surgical incision and drainage. Among those undergoing surgery, 68.29% reported prolonged wound healing, 85.37% experienced permanent scarring and a significant negative impact on their breast appearance ($p = 0.029$). Breastfeeding was disrupted in 58.12%, and 40.17% were unable to resume breastfeeding following treatment. Amongst participants who underwent surgery, 36.5% reported negative impacts on sexual well-being, 31.7% on mental health, and 24.4% on self-confidence. Thematic analysis revealed two major themes: repercussions of the treatment and issues with provision of care, highlighting delays in diagnosis, inadequate breastfeeding support, and negative cosmetic outcomes. Discussion: This study is the first to investigate patients' experiences of breast abscess management, highlighting significant variability in practice and the association of worse cosmetic and breastfeeding outcomes with surgical treatment. Standardisation of care and improved patient counselling may improve patient experience and outcomes.

Clinical practice

11. Bennett-Weston, Amber, Andrew Ward, Danielle Burnett, Julie Hogg, Rheo Knight and Jeremy Howick. **Complex intervention to improve empathy within maternity services: a mixed methods feasibility study with pilot evaluation**. BMJ Open Qual. 2026.Vol.15(2), ppe004013. Lack of empathy in National Health Service maternity services contributes to adverse outcomes for women, babies and practitioners. While empathy training can improve individual communication, sustainable improvement in empathy requires system-level change. We conducted a mixed-methods feasibility study with pilot implementation and evaluation of an initiative to improve system-level empathy within a maternity unit. The initiative was a complex intervention that

included empathy training for practitioners, training in empathic teamwork and a system-level empathy workshop. The mixed-methods evaluation was conducted in two phases. Phase 1 included questionnaires assessing participant satisfaction and intention to change behaviour. Phase 2 included questionnaires assessing perceived change in empathy, staff satisfaction and patient satisfaction. System-level changes generated by healthcare leaders were also recorded. Quantitative data were summarised using descriptive statistics and free text comments were analysed using thematic analysis informed by the Consolidated Framework for Implementation Research. Of the 177 maternity services staff who took part, 123 completed the first evaluation phase. 89% of these rated their satisfaction with the workshops as 8 or higher and 86% rated the likelihood that the training would improve empathy as 8 or higher on 10-point scales. Thematic analysis of free-text comments generated four themes: (1) appreciation for intraprofessional and interprofessional interaction, (2) value of creating a supportive environment, (3) enhanced ability to identify practical approaches to empathy and (4) desire for additional workshops. Twenty-one participants completed the second evaluation phase. Most (76%) agreed that the work had led to greater empathy. System-level changes included the introduction of free coffee for staff, weekly 'gratitude pledges' and a fortnightly community newsletter. This mixed-methods feasibility study demonstrated that implementation of the intervention is feasible and acceptable and generated pilot data to inform future evaluation. Early data suggest positive trends in empathy and patient satisfaction, supporting the need for sustained implementation and longitudinal evaluation

12. Carter, Jenny, Dilly Anumba, Christy Burden, et al. **Does the Tommy's Pathway: Clinical Decision Support Tool have the potential to reduce disparities in UK maternity care? Findings from an early adopter implementation evaluation study**. BMC Digit Health. 2026.Vol.4(1), pp18. Background Tommy's Pathway: Clinical Decision Support Tool (the Tool/the Tommy's Pathway), a web-based application for assessing risk of preterm birth and placental dysfunction, is provided as a dual-interface web-application, used by maternity care providers and maternity service users. The Tool utilises validated algorithms and rule engines to offer a more sophisticated assessment of risk than traditional checklist methods and offers instantaneous decision support by providing care recommendations according to risk and in line with evidenced-based clinical guidance. This novel intervention has the potential to reduce variation in care that could contribute to the higher rates of preterm birth and stillbirth seen in those from ethnic minority and socially deprived groups. We evaluated implementation of the Tommy's Tool in five early-adopter NHS hospitals to inform a cluster randomised controlled trial. Methods We used online surveys, semi-structured interviews and focus groups to investigate: maternity service user and healthcare professional (HCP) experience; barriers and facilitators to implementation; reach (whether particular groups are excluded and why), fidelity (degree to which the intervention is delivered as intended), and unintended consequences. The NASSS framework (Non-adoption or Abandonment of technology by individuals and difficulties achieving Scale-up, Spread and Sustainability) informed analysis. Results 1181 women and 112 HCPs participated, completing 1260 online surveys, 8 focus groups and 29 semi-structured interviews. Findings highlighted the importance of ensuring the Tool was used in routine care management for all eligible service users. This informed development of an additional

functionality to ensure that HCPs were able to create profiles for those who were unable or unwilling to sign up and create a profile themselves. Before this feature was introduced the proportion of service users registered on the Tool, was ~ 70%, compared to ~ 90% afterwards. Proportions of women from Asian and black ethnic groups, and those from the most deprived areas (IMD quintiles 1 & 2), also increased after the change, from 14.6%, 5.8% and 40.9% (of all maternity service users), to 16.9%, 14.2% and 52.4%, respectively. Further refinements will include translation into non-English languages. Conclusions The Tommy's Tool has the potential to make the provision of optimal maternity care easier for healthcare professionals, which could reduce variation in care and ultimately improve outcomes. This study gave us the opportunity to evaluate early adopter implementation in order to optimise the Tool and its implementation strategy ahead of a cluster randomised controlled trial. Trial registration This study was prospectively registered on ISRCTN: ID13498237, on 31/01/2022. A note on inclusivity Within this paper we use the terms 'woman' and 'women's health'. However, it is important to acknowledge that it is not only women for whom it is necessary to access women's health and reproductive services in order to maintain their gynaecological health and reproductive wellbeing. Gynaecological and obstetric services and delivery of care must therefore be appropriate, inclusive and sensitive to the needs of those individuals whose gender identity does not align with the sex they were assigned at birth.

13. Elkashif, Mirfat Mohamed Labib, Doaa Mostafa Sheashaa, Mohamed Sayed Abdellatif, Darelglal Ahmed Gassmelseed, Shimaa Mohamed Mohamed Koabar and Sally Abd-Elrahman Mohamed. **Advancing Sustainable Healthcare in Obstetric and Maternity Nursing: Nurses' Knowledge, Awareness, and Clinical Practice-A Cross-Sectional Study.** International journal of environmental research and public health. 2026.Vol.23(6), pp734. Sustainable healthcare in obstetric and maternity nursing emphasizes the provision of high-quality, safe, and environmentally responsible care for women and newborns. Nurses' knowledge, awareness, and clinical practices are central to the implementation of sustainable approaches, including efficient resource management, evidence-based interventions, and patient education. Evaluating these dimensions is essential for identifying gaps, informing targeted training, and supporting sustainable and effective maternal care aligned with global health goals. Accordingly, this study aimed to assess obstetric and maternity nurses' knowledge, awareness, and clinical practices related to sustainable healthcare. A cross-sectional study design was employed. A convenience sampling technique was used to recruit obstetric and maternity nurses working in the selected study settings during the data collection period. A total sample of 120 participants was targeted. The study was conducted at Al-Azhar University Hospital in New Damietta and selected Family Medicine Centers in Damietta Governorate, Egypt. Data were collected using a structured, self-administered questionnaire developed specifically for this study to assess eco-conscious nursing practices in obstetrics and gynecology units. The questionnaire included sections addressing demographic and professional characteristics, knowledge and awareness of sustainable healthcare, eco-conscious clinical practices in maternity settings, perceived barriers and institutional support, attitudes and advocacy toward environmental sustainability, procedure- and material-related environmental concerns, and energy and water conservation behaviors. Responses were measured using standardized 5-point

Likert and frequency scales, with composite scores calculated to categorize levels of knowledge, practices, and attitudes toward sustainability; higher scores indicated greater knowledge, awareness, and engagement in sustainable practices. Overall, among the 120 nurses, of whom 62 (51.7%) had reported having heard about sustainability and received training about it, whereas 58 (48.3%) had not. Most participants held a bachelor's degree (= 54, 45.0%), nearly half had more than 10 years of nursing experience (= 58, 48.3%), and the largest proportion worked in delivery rooms (= 53, 44.2%). Regarding knowledge, attitude, and practice, good knowledge was observed in 61 participants (50.8%), good practice in 46 participants (38.3%), and positive attitudes in 108 participants (90.0%). The findings also showed that trained nurses in obstetrics and gynecology units demonstrated significantly higher knowledge, more positive attitudes, and better eco-conscious practices compared to untrained nurses across all domains (< 0.001). The study demonstrates that maternity nurses showed moderate to high awareness and positive attitudes toward sustainability, while environmentally sustainable practices were less consistently implemented, indicating a clear knowledge-attitude-practice gap. Nurses who received sustainability-related training consistently achieved significantly higher knowledge, attitude, and practice scores than untrained nurses.

14. Foster, Mary Eileen, Nancy Sakaya Stephen Raj, Manish Das, Olivia Ray, Paul Clarke and Harsha Gowda. **Delivery room cuddles for preterm infants in maternity centres of the UK: a national survey of practice**. bmjpo. 2026.Vol.10(1), ppe003782. AimThis national survey aimed to evaluate the adoption and implementation of delivery room cuddles (DRC) for preterm infants (<32 weeks' gestation) in neonatal units across the UK. We sought to determine the extent of the practice, and understand the consistency and challenges associated with DRC, with the goal of enhancing care for preterm infants.MethodsBetween January and March 2024, all UK level 2 and 3 neonatal units were invited to complete a structured survey on DRC practices. We collected data on the existence, frequency and facilitation of DRC, as well as any institutional guidelines and barriers for its practice.ResultsWe received complete responses from all 131 centres invited (100% response rate). Among these, 60 centres (45.8%) reported routinely practising DRC, 66 (50.4%) did so occasionally and 5 (3.8%) reported not practising DRC at all. Notably, 81 centres (61.8%) practised DRC without formal institutional guidelines. Main barriers to practice included equipment limitations, varying staff attitudes, and concerns about the clinical condition of preterm infants.ConclusionThis survey demonstrates an encouraging high uptake of DRC in recent years, typically offered after initial stabilisation (within 30–60 min post-birth). Despite the recognised benefits of DRC to parents and in enhancing neonatal outcomes, considerable variability remains in its implementation underscoring the need for comprehensive guidelines and professional training. These could standardise DRC practices across the UK, promoting more consistent and effective care for preterm infants.

15. Hu, Yanan, Valerie Slavin, Joanne Enticott and Emily Callander. **Beyond evidence hierarchies: Leveraging randomized controlled trials and real-world data to advance the value of maternity care.** Acta Obstet.Gynecol.Scand. 2026.Vol.105(3), pp395–402. While existing literature has compared the methodological strengths and limitations of

randomized controlled trials (RCTs) and real-world data (RWD) in general medical research, two critical gaps remain unaddressed: (1) no prior communication papers have specifically examined this comparison in the context of maternity care where unique ethical and practical considerations exist, and (2) no studies have systematically compared cost-effectiveness analyses derived from RCTs versus RWD approaches—a crucial dimension for value-based maternity care decisions. This article examines how both approaches can strengthen the evidence base and support the delivery of value-based maternity care. We argue that neither RCTs nor RWD should be regarded as inherently superior in guiding decision-making. Each study design offers valuable insights, and their findings must be critically appraised in light of methodological rigor, context, and relevance, particularly when their results diverge.

16. Whybrow, R., G. Robert, J. Dagustun, et al. **Improving maternity and neonatal care in England: protocol for a formative evaluation of the implementation of the core competency framework to enhance multi-professional practice**. BMC Pregnancy Childbirth. 2026.Vol.26(1), pp465. Background Concern exists about the variation in maternity services across England, highlighted by various high-profile investigations into care failures. In response, NHS England developed the Core Competency Framework (CCF) to standardise training and reduce unwarranted discrepancies in maternity and neonatal care. The current version of the framework (CCFv2) outlines minimum training requirements, targets key areas of harm, and supports multi-professional education while allowing local adaptation. This study aims to explore and enhance the rollout and impact of the CCFv2 and to strengthen its implementation and impact across England. Methods We will conduct a mixed-methods formative evaluation across four work packages. WP1: a national survey of maternity units to assess adoption and variation in CCFv2 implementation. WP2: ethnographic research in seven purposively selected maternity units to explore variations in local implementation. WP3: retrospective analysis of routinely collected outcome data from these sites to assess effects on practice and patient safety. WP4: Joint Interpretive Forums with stakeholders at each study site and nationally to support shared understanding and inform the development of an implementation toolkit for CCFv3. Discussion This study will generate practical insights into how the CCF is embedded across diverse settings. Through a collaborative, multi-disciplinary design - including input from service users, NHS staff, and academics - it will identify enablers and barriers to implementation and inform future improvements. Findings will guide the development of CCFv3 and support national efforts to improve care quality and reduce variation, particularly for vulnerable populations.

Emergency care/safety

17. Beecham, Emma, Gráinne Brady, Paulina Bondaronek, et al. **Beyond the report: a qualitative exploration of safety incidents in maternity services**. BMJ Open Qual. 2026.Vol.15(1), ppe004020. Background Maternal and neonatal mortality in the UK remains high, underscoring safety concerns in maternity care. Incident reporting remains a key mechanism for identifying risks and driving improvement, yet challenges, including underreporting and limited organisational learning, persist. Aim The primary aim of the study was to explore clinicians' preferences and behaviours in maternity patient safety reporting within a tertiary hospital. Methods We conducted a two-phase

qualitative study in a UK tertiary teaching hospital maternity service. Phase 1 involved AI-supported Big Qualitative (Big Qual) thematic analysis (using Caplena and Infranodus) of the first 400 patient safety incident reports submitted via the local electronic reporting system over a 5-month period (June–November 2024). Phase 2 comprised semistructured interviews with 14 maternity clinicians conducted between April and June 2025 and informed by phase 1 findings. Interview data were analysed using a Rapid Assessment Procedure and framework-based thematic analysis. Findings from both phases were integrated at the interpretation stage to examine reporting practices, barriers and enablers and opportunities for organisational learning, drawing on sociotechnical systems and safety-II-informed concepts. Results Thematic analysis of incident reports identified ten recurrent topics including staffing capacity, documentation discrepancies and communication issues. Interviews highlighted barriers such as psychological safety, form complexity and limited feedback, alongside enablers including visible learning and supportive leadership. Inconsistencies in reporting behaviours, feedback mechanisms and system integration were evident, with underreporting of near misses and staff conduct identified as key gaps. ConclusionsT his study offers a nuanced view on how incident reporting is enacted in practice within maternity care. By combining interview data with Big Qual incident analysis, it identifies actionable insights for improving safety and organisational learning. Recommendations include simplifying reporting systems, embedding psychological safety, standardising processes and enhancing feedback and cross-professional learning.

18. Mandalou, Angeliki. **What happens when no one really knows what happened? Rethinking maternity emergencies through a "black box" lens**. Midwifery. 2026.Vol.160 pp104880.

19. Melamed, Anna, Kirsten Small, Christine McCourt, et al. **Antenatal risk assessment and classification in maternity care: An integrative review**. Midwifery. 2026.Vol.158 pp104789. Antenatal risk assessment and classification dominates midwifery care but may not be improving outcomes and may introduce iatrogenic harm. Midwifery-led care and birth settings promote good birth outcomes and women's experiences. In the United Kingdom increasing numbers of women are classified as having high-risk pregnancies and therefore recommended to have obstetric-led care and birth settings, restricting the number of women accessing midwife-led care. Evaluate and integrate literature on the effectiveness, justification and impact of antenatal risk assessment and classification as performed in the UK. Integrative literature review of 16 articles from 2000 to 2025, from midwifery and obstetric perspectives. Many antenatal risk assessments did not improve outcomes due to inconclusive tests, lack of treatment options and difficulties balancing risks. The assessments and proposed treatments were not clearly communicated to women and assumed benefit and acquiescence in the absence of evidence. Risk assessment processes could create physical and emotional iatrogenic harm to women. Reductive medical-model risk assessments and subsequent care pathways are not compatible with women-centred care and lead to known benefits of midwifery care being under-utilised. Biopsychosocial risk assessment could be culturally and value sensitive, better address social determinants and inequalities, offer genuine choice and control for women and increase the use of women-centred midwifery services while enhancing safety. UK antenatal risk assessment lacks efficacy

in improving outcomes, risks iatrogenic harm and can negatively affect women's experiences. A shift to relational models of midwifery antenatal risk assessment could be more women-centred, personalised and culturally specific, possibly leading to better outcomes overall.

20. Titcombe J. **To improve maternity services we must confront the damaging ideology that prizes "normal childbirth" over safe care**. BMJ: British Medical Journal (Online). 2026;393:e100094.

Home Birth/freebirth

21. Galera-Barbero, Trinidad, Vanesa Gutierrez-Puertas, Helder Jaime Fernandes, Blanca Ortiz-Rodriguez, Alba Sola-Martinez and Lorena Gutierrez-Puertas. **Experiences of Women Who Opt for a Planned Home Birth After a Previous Hospital Birth: A Qualitative Study**. Nursing reports (Pavia, Italy). 2026.Vol.16(4), pp147. Background/Objective: In Spain, 99% of births occur in hospital settings, and planned home birth is neither funded nor regulated by the Public Health System. Despite growing interest in this birth option, qualitative evidence exploring the experiences of women who opt for a planned home birth after a previous hospital birth remains scarce, particularly in contexts where this practice is not integrated into the healthcare system. This study aimed to explore the perceptions and experiences of Spanish women who opted for a planned home birth following a previous hospital birth, focusing on the reasons that motivated this decision and the care received during the process. Methods: A qualitative descriptive design was employed. Semi-structured interviews were conducted between July and December 2025 with 19 women who had experienced a planned home birth in Spain after a previous hospital birth. Data were analysed using inductive thematic analysis following Braun and Clarke's approach. The study adhered to the Standards for Reporting Qualitative Research (SRQR). Results: Three main themes emerged: (1) motives related to choosing a planned home birth, including negative hospital experiences characterised by loss of autonomy, medicalisation of birth without consent, and fragmented care; (2) seeking a physiological and humanised birth, reflecting women's desire for empowerment, control, and a transformative experience, alongside barriers such as lack of professional support and financial burden; and (3) the need to increase visibility and establish regulation, highlighting demands for professional training, dissemination strategies, and integration of planned home birth into the Public Health System to ensure equitable access. Conclusions: Women who opted for a planned home birth after a hospital experience reported highly positive and empowering outcomes. However, the absence of regulation, professional support, and public funding creates significant inequalities. Integrating planned home birth into the Public Health System, educating healthcare professionals, and developing strategies to increase the visibility of planned home births are essential to guarantee women's right to choose where they give birth.

22. Grünebaum, Amos and Frank A. Chervenak. **Freebirth and professional responsibility: Respect for autonomy does not justify clinical neutrality on preventable fetal and neonatal harm**. Acta Obstet.Gynecol.Scand. 2026. 08/01. Vol.105(8), pp1417–1419.

23. Gunnarsdóttir, Jóhanna and Hulda Hjartardóttir. **The freebirth debate: Respecting autonomy while reflecting on our own practices.** Acta Obstet.Gynecol.Scand. 2026. 05/01. Vol.105(5), pp768–770.

24. McKenzie, Gemma. **Freebirth: The illusion of freedom**. AIMS Journal. 2026. 04/01. Vol.38(2), pp1–4.

25. Velo, H, M. 2026. **Contribution of the UK Midwives and Freebirth study to the National Maternal and Neonatal Investigation call for evidence.** Hosted on OpenAIR [online].

26. Velo Higueras, Maria. **Declining care as self-protection: What freebirth can tell us about trauma-informed support in the first 1001 days**. International Journal of Birth & Parent Education. 2026. 04/01. Vol.13(3), pp41–46. In recent years, an apparent growing number of women are planning to birth alone without professional attendance, a practice commonly referred as freebirth. While this practice is not new, freebirth has gained recent media visibility and ignited a contentious debate about the boundaries of women's choices and the adequacy of current maternity care provision. This article provides an accessible overview of what freebirth entails, the factors driving families in the United Kingdom (UK) to consider this option, and how practitioners can support them in a trauma-informed manner to promote safety, wellbeing and a positive start to the first 1001 days of parenthood.

27. van den Berg, Lauri M. M., Jens Henrichs, Jeroen van Dillen, Soo Downe, Corine Verhoeven and Ank de Jonge. **Childbirth Experiences in the United Kingdom Compared to the Netherlands: A Cross-Sectional Survey Study**. Birth. 2026.Vol.53(1), pp129–138. This study was performed to compare childbirth experiences in the United Kingdom (UK) and the Netherlands (NL) and identify determinants of positive childbirth experiences in both countries. Women who gave birth in the UK (n = 1303) or the NL (n = 900) between January 2017 and December 2020 who filled in the cross-sectional Babies Born Better survey were included in this study. Fully adjusted logistic regression models were used to assess differences in the odds of a positive childbirth experience between the two countries. Hierarchical logistic regression analyses were performed to identify determinants of a positive childbirth experience, including socio-demographic factors, pregnancy and childbirth outcomes, and care-related determinants. Respondents giving birth in the UK had decreased odds of a positive childbirth experience compared to NL respondents (66% vs. 85%, AOR 0.45, CI 0.35-0.57). Significant determinants for a positive childbirth experience were multiparity, absence of pregnancy complications, a spontaneous vaginal birth, and giving birth at home. UK respondents who had a planned caesarean section had a higher likelihood of reporting a positive childbirth experience when adjusted for confounders. Having a doctor as the primary birth care provider was less likely to be associated with a positive childbirth experience in the UK. Most women in both the NL and the UK reported positive childbirth experiences, but NL respondents were more likely to do so. Determinants of a positive birth experience were mostly factors associated with uncomplicated labor and birth, or linked with fulfilled choices and with being multiparous.

Inequalities

28. Baz, Sarah, Laura Sheard, Rachel E. Rowe, et al. **Safety and personalised care in maternity services of England for women whose preferred language is not English: a critical race theory analysis of interpreter experiences**. bmjph. 2026.Vol.4(1), ppe003859. Introduction Effective communication is central to safe, ethical maternity care. Women with cross-cultural communication needs are more likely to experience intersecting disadvantage, with poor maternal and infant outcomes. A professionally trained interpreter (PTI) can raise the quality of clinical care for patients to approach or equal that for patients without cross-cultural communication needs. The need to improve interpreter services has been recognised at the strategic level of the NHS to improve safety and personalised care. However, evidence for how to achieve this is limited from the UK context.MethodsWe explored the experiences of PTIs working in maternity services in England using qualitative interviews. We analysed the data thematically, informed by Critical Race Theory, which argues that inequality is deeply embedded in policy, law and institutional structures and practices. We discussed interim findings with our lived experience group.ResultsWe interviewed 28 interpreters with a range of qualifications who worked for language agencies or in-house NHS interpreting services. Our analysis constructed three themes: The 'shady' agency; 'You can get anyone and you don't know how experienced they are'; 'you are never part of a team'. We found that institutional practices and outsourcing marginalise interpreters, compromising worker well-being and patient safety.ConclusionTo ensure patient safety, it is essential for the NHS to recognise the professional status of medical interpreters and integrate PTIs into the core clinical team. This will require investment in standardised interpreter training, access to supervision and career development. Embedding interpreters in NHS safety culture is essential for equitable and effective care

29. Burton, Sam, Tisha Dasgupta, Zenab Barry, Abigail Easter, Jane Sandall and Hannah Rayment-Jones. **The role of poverty-related social determinants in maternal and perinatal health inequities: a cross-sectional study using the eLIXIR born in South London, UK maternity-child data linkage**. Int J Equity Health. 2026.Vol.25(1), pp109. Background Evidence on how poverty and social determinants influence adverse maternal and perinatal outcomes in the UK is limited. While ethnicity and area-level deprivation are well described, fewer studies examine the cumulative impact of poverty-related factors such as low income, employment insecurity, housing, and access to social support. Methods We analysed 67,308 pregnancies from the eLIXIR cohort using linked NHS records. Social determinants were defined using the WHO framework as structural (ethnicity, migration status, area deprivation) and intermediary (housing, employment, financial hardship, social support, barriers to care). The primary outcome was a composite adverse perinatal outcome. Binary logistic regression models with random intercepts accounted for repeated pregnancies, and adjusted risk ratios (aRRs) were estimated controlling for key sociodemographic and clinical factors. Conclusions Structural and intermediary social determinants related to poverty have a substantial and cumulative impact on maternal and perinatal outcomes, independent of individual clinical risk. Addressing these inequities requires integrated, cross-sector

strategies that extend beyond healthcare to the wider social conditions influencing maternal and child health. Clinical trial number Not applicable.

30. Hardie, Iain, Kenneth Okelo, Josiah King, et al. **Socioeconomic inequalities in maternal infections during pregnancy: administrative health data evidence from a large UK urban area with high levels of inequality**. BMC Public Health. 2026.Vol.26(1), pp2193. Background Maternal infections during pregnancy (also known as prenatal infections) have been linked to adverse outcomes such as low birthweight, preterm birth, stillbirth and child developmental concerns, all of which have known socioeconomic inequalities. However, there is currently a lack of research into potential links between socioeconomic factors and prevalence of prenatal infections. Methods We utilised linked administrative health data including all children born in a large UK urban area with high levels of inequality, i.e. the National Health Service (NHS) health board of Greater Glasgow & Clyde, Scotland, 2010—2015 (N = 92,094). Logistic regression models were used to examine associations between socioeconomic factors (i.e. area-based Scottish Index of Multiple Deprivation (SIMD) quintiles and household-based UK National Statistics Socioeconomic Classification (NS-SEC)), and odds of prenatal infections, measured as hospital-diagnosed prenatal infections and infection-related prescriptions, with and without controlling for covariates. Results Area-based deprivation was generally associated with greater odds of prenatal infections, particularly for infections diagnosed in hospital. For example, living in a 'most deprived' SIMD quintile area was associated increased odds of both hospital-diagnosed prenatal infections (odds ratio (OR): 1.77; 95% confidence interval (CI): 1.48, 2.11) and infection-related prescriptions during pregnancy (OR: 1.28; 95% CI: 1.21, 1.36), when compared to living in a 'least deprived' SIMD quintile area, after covariate adjustment. Meanwhile, lower NS-SEC was also generally associated with increased odds of hospital-diagnosed prenatal infections, but there was not a clear pattern in associations between NS-SEC and infection-related prescriptions. Conclusions Area-based deprivation, and to a lesser extent, lower household NS-SEC, appear to be associated with increased odds of maternal infections (particularly hospital-diagnosed maternal infections) during pregnancy in NHS Greater Glasgow & Clyde, Scotland. Socioeconomic inequalities in the prevalence of prenatal infections may therefore be a potential contributing factor to wider inequalities.

31. Moukala, Elisha Goma. **IFPHOR0085 Dying to Give Birth: Uncovering the Cost of Inequality in British Maternal Healthcare**. Eur.J.Public Health. 2026.Vol.36Abstract The United Kingdom's healthcare system, though globally recognised for its quality, exhibits stark racial disparities in maternal health outcomes. Black women in the UK are over four times more likely to die during pregnancy or the postnatal period compared to their White counterparts. This narrative review synthesised evidence from MBRRACE-UK reports and peer-reviewed literature identified via PubMed, using search terms related to maternal mortality, racial disparities, and UK maternity care. Evidence was thematically synthesised to examine clinical, structural, and systemic determinants of maternal health inequalities. Findings indicate that maternal mortality disparities cannot be explained by clinical risk factors alone. While conditions such as hypertension and diabetes are more prevalent among Black women, thereby increasing obstetric risk, inequalities persist even after adjustment for these variables. Structural determinants,

including socioeconomic deprivation, barriers to healthcare access, and low health literacy, further compound risk. Systemic issues within healthcare delivery also play a critical role, including implicit bias, delayed escalation of care, communication failures, and a lack of culturally competent services, all contributing to adverse outcomes. An intersectional analysis highlights how overlapping inequalities related to race, class, and gender shape maternal health experiences. Evaluation of current policy frameworks, such as Core20PLUS5, demonstrates progress in recognising disparities; yet significant gaps in implementation remain, limiting their effectiveness. Addressing these disparities requires multi-level interventions, including improved continuity of care, culturally safe maternity services and meaningful integration of community-led perspectives. Ultimately, reducing preventable deaths among Black women represents both a clinical and ethical imperative in achieving equitable maternity care.

32. Rayment-Jones, Hannah, Sam Burton, Laura Bridle, et al. **The Role of Ethnicity and Migration in Perinatal Inequalities: A Retrospective Cohort Study**. BJOG : an international journal of obstetrics and gynaecology. 2026.Vol.133(6), pp1249–1261. To examine ethnic disparities in perinatal outcomes and the role of migration factors. Retrospective cohort. Two maternity services in South London, UK. Women birthing singleton infants between 24 and 43 weeks' gestation (2018-2023). Linked electronic health records were analysed using generalised linear mixed models (GLMMs) with Poisson distribution to estimate adjusted risk ratios (aRR) and 95% confidence intervals (CI) by ethnicity, migration, interpreter need, and country-of-origin income, adjusting for socioeconomic deprivation and medical risk. Emergency caesarean, haemorrhage, preterm birth, low birthweight, low Apgar score, stillbirth or neonatal death. Among 44 634 births, compared with White women, emergency caesarean risk was higher for Asian (aRR 1.22, 95% CI 1.14-1.30, $p < 0.001$) and Black women (1.16, 1.10-1.23, $p < 0.001$). Haemorrhage was higher for Asian women (1.12, 1.02-1.23, $p = 0.021$), those needing interpretation (1.16, 1.06-1.27, $p < 0.001$), and lower for Mixed ethnicity women (0.86, 0.74-0.99, $p = 0.038$). Infants of Black women had elevated risks of preterm birth (1.23, 1.13-1.34, $p < 0.001$), low birthweight (1.74, 1.60-1.89, $p < 0.001$), low Apgar (2.06, 1.71-2.48, $p < 0.001$), and stillbirth/neonatal death (1.57, 1.21-2.05, $p < 0.001$). Asian infants had increased risks of preterm birth (1.19, 1.07-1.33, $p = 0.002$) and low birthweight (1.69, 1.52-1.87, $p < 0.001$). Foreign-born women had lower risks of low birthweight (0.71, 0.62-0.81, $p < 0.001$) but higher risks of low Apgar (1.24, 1.06-1.46, $p = 0.009$) and stillbirth/neonatal death (1.33, 1.07-1.65, $p = 0.011$). Risks were highest for ethnic minority, foreign-born women, though effect sizes were modest. Ethnic minority and foreign-born women, particularly from LMICs or needing interpreters, face elevated risks with modest clinical impact.

Long-term conditions

33. Hanley, Stephanie J., Sharon McCann, Siang Ing Lee, et al. **'It Was a Bit of a Now or Never Situation': Experiences of Preconception Care and Support for Women With Multiple Long-Term Health Conditions**. Health expectations : an international journal of public participation in health care and health policy. 2026.Vol.29(1), ppe70583–n/a. Introduction One in five women enters pregnancy with multiple long-term health conditions, which is associated with increased risks of adverse maternal and child outcomes. There is a lack of research exploring individuals' experiences of

preconception care for these women, which is also reflected in existing guidelines that predominantly focus on single health conditions. This study aimed to explore experiences of preconception care and support among women with multiple long-term health conditions and health professionals. Methods This is a secondary analysis of qualitative data collected by the MuM-PreDiCT consortium. The primary study involved semi-structured interviews between March 2022 and May 2023 with pregnant (> 28 weeks) and postnatal (< 2 years) women with multiple long-term physical and/or mental health conditions in the United Kingdom, and healthcare professionals involved in their care. Data captured within the preconception coding reports were analysed thematically. Results Fifty-seven women and 51 healthcare professionals were interviewed. Six themes were identified from the thematic analysis. Women and professionals described the importance of tailored preconception care and support, incorporating condition-focused counselling (sub-theme 1) and medication planning (sub-theme 2). Sensitive and realistic care and support were considered essential, but women had mixed experiences of involvement and empathy from different professionals. The significance of optimising antenatal care by making every preconception contact count was emphasised by both women and professionals, who valued early referrals, specialist input and integration of services. Although professionals viewed the preconception period as an opportunity to empower women, many women felt they had to self-advocate and seek information due to gaps in professional awareness, knowledge and education. Professionals reported differing views on who, within the care team, should take responsibility for care delivery. Some believed that women should play an active role in managing their health, including initiating conversations around pregnancy intentions. The delivery of preconception care was complicated by a range of challenges, including a lack of service integration, availability, time and funding. Conclusion Women with long-term health conditions can experience substantial gaps in preconception care, characterised by inconsistent guidance and limited access to tailored, reliable support, which frequently leads to feelings of isolation and the need to seek additional information when preparing for pregnancy. These results will inform the co-development of a care bundle for affected women. Patient or Public Contribution Our Patient and Public Involvement group was involved in the design of the study and the analysis and interpretation of the data, and two public study investigators are part of the author group.

34. Hanley, Stephanie, Sharon McCann, Megha Singh, et al. **Maternity care bundle for UK women with multiple long-term health conditions: coproduction workshops.** BMJ Open. 2026.Vol.16(2), ppe103366. ObjectiveThe objective of this study is to co-produce a care bundle for women with multiple long-term health conditions (MLTC) that could be pilot tested and implemented in UK maternity services.DesignOnline co-production workshops each attended by 20–30 key interest holders.SettingUnited Kingdom, October 2023-February 2024.PopulationWomen with experience of pregnancy with MLTC, healthcare professionals and other interest holders involved in commissioning, planning and delivering care for pregnant women with MLTC.MethodsThis study followed a three-step process: (1) a consolidated list of key components of care for pregnant women with MLTC was created through secondary analysis of prior collected qualitative data; (2) the list of care components was explored during four co-production workshops; and (3) findings from (1) and (2) were synthesised to develop a maternity

care bundle of 4–5 key care components for pregnant women with MLTC.Main outcome measuresA maternity care bundle of five key care components for pregnant women with MLTC.ResultsA list of 25 care components was refined to develop a proposed care bundle of five components. These were provisions of early and reliable medication advice and decision support; creation of a ‘goals of care summary’ accessible to women and the care team; provision of continuity of midwifery care throughout pregnancy and postnatal care; provision of a named care coordinator; and a formal postnatal handover of care from the multidisciplinary care team to the General Practitioner (GP) and secondary care team involving the woman. Conclusions This study coproduced an evidence-based care bundle for pregnant women with MLTC to enhance communication and ensure individualised care and support. Further collaborative work with women and professionals is required to refine, implement and evaluate its impact on outcome

Ockenden

35. Abdalla, Mena, Hend Hadawi and Aisha Hameed. **Transforming Maternity Care in England After Ockenden: Reducing Unwarranted Caesarean Birth While Advancing Safety and Equity**. Curr Obstet Gynecol Rep. 2026.Vol.15(1), pp25. Purpose of Review This commentary examines how maternity policy in England has shifted after the Ockenden report and asks how services can improve safety without normalising unwarranted caesarean birth. We integrate the Ockenden reviews (2022 and 2026), MBRRACE-UK 2025, the National Maternity and Perinatal Audit (NMPA) State of the Nation report based on births in 2023, and recent evidence on continuity of carer. Recent Findings The NMPA reports that total caesarean birth reached 39.5% in 2023, with planned and unplanned caesarean rates of 16.4% and 23.1%, respectively, while births without instruments fell to 49.4%. MBRRACE-UK reports a maternal mortality rate of 12.82 per 100,000 women giving birth in 2021-23 and persistent inequalities, with higher mortality among Black women, Asian women, and women living in deprived areas. Recent evidence indicates that midwife continuity of care is associated with fewer caesarean births, more spontaneous vaginal births, and better experiences, while a 2026 UK cohort study found lower preterm birth among women in ethnically diverse and disadvantaged communities exposed to community-based continuity models. Summary The 2022 Ockenden report rightly challenged institutional resistance to clinically indicated caesarean birth. However, this resistance occurred against a backdrop of already escalating national caesarean rates, rather than an overall underuse of the procedure. The next phase of maternity improvement should combine Robson-based audit, strengthened counselling for primary caesarean birth and VBAC, renewed access to continuity of carer, timely booking, and equity-focused service planning, alongside updated recommendations from the 2026 Nottingham review. The goal is not a lower caesarean rate at any cost, but the right birth for the right woman at the right time.

36. Edwards N, Vaughan L, Barach P, Robson S. **UK maternity inquiries: 25 years of the same diagnosis**. bmj. 2026 Jul 28;394.

Partner Violence

37. Kent, Lisa, Claire Kerr, Lorna Lawther, et al. **Intimate partner violence, multiple mental health conditions and risk of small vulnerable newborn births: a maternity population-based data linkage study**. EClinicalMedicine. 2026.Vol.96 pp103997. Small vulnerable newborn birth (SVN) encompasses infants born preterm, small for gestational age, or low birthweight, and accounts for most neonatal deaths worldwide. This maternity population-based administrative data-linkage cohort study aimed to estimate the risk of SVN associated with maternal intimate partner violence (IPV) experience. Records were included for women who accessed maternity services in Northern Ireland and had a singleton pregnancy, with liveborn or stillborn infants born 24–42 weeks' gestation, with an estimated pregnancy start date 01 January 2011–31 December 2021. Pregnancy records were linked to community-dispensed prescriptions and hospital diagnoses data. Data were provided by the Honest Broker Service. IPV, maternal characteristics, and SVN were ascertained through maternity records. Mental health conditions were ascertained via medications or ICD-10 hospital diagnosis codes. Generalised estimating equations were utilised to perform modified Poisson regression with a log link, with clustering to account for women with more than one pregnancy during the study period. The risk of SVN given exposure to IPV was estimated, adjusted for number of mental health conditions and additional maternal characteristics. From 248,645 eligible pregnancies to 157,507 individual women, IPV was disclosed in 11,388 (4.6%) pregnancies (active: n = 3713, 1.5%; historical: n = 7675, 3.1%). The group with highest prevalence of IPV was pregnant adolescents (n = 995, 12.2%). Disparate prevalence estimates were also seen between the most (8.5%) and least (1.9%) deprived areas. Risk of SVN was increased for women reporting both active IPV (RR = 1.21, 95% CI: 1.13–1.31) and historical IPV (RR = 1.18 (95% CI: 1.12–1.25) independent of the number of coexisting mental health conditions and other maternal characteristics. IPV, both active and historical, is associated with an increased risk of birth of babies who are small and vulnerable, and so its detection, even IPV of historical nature, and response should be prioritised through training and creation of referral pathways. UKRI's ADRC NI (ES/W010240/1) & Strategic Priority Fund "Tackling multimorbidity at scale" programme (MR/W014432/1).

Patient views/supporting patients

38. Kokab, Farina, Stephen J. Williams, Niha Hussain and Nicola Gale. **From 'dismissal' to 'medical gaslighting': A literature review of women's experiences of reproductive health services in the UK**. Midwifery. 2026.Vol.159 pp104823. Women in the United Kingdom face noticeable challenges in accessing and receiving reproductive health care. The emotional impact of these challenges is seldom evaluated. Recent research and wider societal discourse suggest that many women experience 'gaslighting', a form of psychological manipulation where their health concerns are not taken seriously, leading to feelings of dismissal and resulting in withdrawal from mainstream healthcare services. This can culminate in delayed diagnoses and poorer health outcomes. A qualitative systematic review of the literature investigating gaslighting and dismissal in women's reproductive health in the UK, with a focus on how these experiences differ across intersecting identities such as ethnicity, sexuality, and socioeconomic status. Search of qualitative literature across key databases including PubMed, PsycInfo,

CINAHL plus, Web of Science, Medline, Scopus, Embase, Science Direct, and HMIC retrieving 25,258 papers. The review identified no papers explicitly addressing gaslighting in women's reproductive health in the UK. However, seven related studies were found containing relevant themes (e.g. dismissal), providing a basis for the review. A thematic summary based on the extracted data resulted in the development of four themes 1) dismissal of symptoms and needs (patients experiences, systemic issues), 2) marginalised experiences (ethnic minority women, LGBTQ+ people), 3) stigma and fear of judgement, and 4) poor communication and limited autonomy. The review highlights the need for more targeted research in this area as the scarcity of literature underscores the importance of exploring the emotional impact and framing of dismissal as gaslighting by women in reproductive healthcare. Better conceptualisation and understanding could inform practice and policy changes aimed at validating women's experiences and improving equity in reproductive healthcare access and outcomes.

39. Lawrence, Rachel, Julie Hartley, Nadia Crellin, et al. **"That's All We Wanted, to Be Heard, Listened to, Just to Be Validated and Believed": Family Experiences of Advocacy Support in Maternity and Neonatal Services.** Health expectations : an international journal of public participation in health care and health policy. 2026.Vol.29(4), ppe70750. Family members with lived experience of maternity services or adverse outcomes (CM, SF) were involved as members of the core project team throughout the study. We also conducted three Patient, Public, Involvement and Engagement (PPIE) workshops with individuals who had experienced adverse outcomes in maternity care to inform key stages (project development, findings and dissemination). The rapid evaluation team has a wider programme of PPIE leadership (RM, PLN), overseeing PPIE involvement across projects.

40. Porter, Aliya. **Supporting Women with Recovery, Breastfeeding and Weight Management the Postnatal Period Through a Cocreated Nutrition Workshop...14th International Festival of Public Health, July 14, 2026, Manchester, United Kingdom.** Eur.J.Public Health. 2026. 07/02. Vol.36 ppiv22. There is currently a lack of nutrition advice in the UK for the postnatal period. Following informal discussions with over 20 pregnant women and new mums, and 5 professionals gaps in the information shared with women, the topics identified as most helpful to women were: nutrition for recovery, breastfeeding and weight management. A workshop was developed and piloted with 2 new mums (10 registered in total), and then adapted to an online format and piloted with 5 pregnant women. Written and verbal feedback was collected. Following this feedback the workshop was delivered multiple times, free and live online in the evening to 28 women in their 3rd trimester to help them prepare for the postnatal period. Excluding the pilot feedback, 21 out of 22 women who responded said they had not covered the information elsewhere in their maternity care. 100% said they would recommend the workshop to a friend. 100% said it worked well over Zoom. Key reported takeaways included focusing on specific nutrients, planning ahead, keeping things simple and supporting wound healing. Requests for permission to have a follow-up after 3 months were not made at the beginning of the study. Of those who gave permission there was limited response. Although the workshop was well received and there is robust evidence of the impact of good nutrition in the postnatal period, uptake

was limited and follow-up data was lacking. Further study is needed to gain a deeper understanding of the long term impact of the workshop on health outcomes.

41. Ridley, Angela, Amy Swift and Amy Cole. **Exploring the inter-professional experiences of student nurses and midwives to facilitate better outcomes for mothers with a learning disability in maternity services: a qualitative case study**. Journal of research in nursing. 2026. pp17449871251328891. The aim of this study is to explore the experiences of student learning disability nurses and student midwives in supporting mothers with an intellectual disability. The Ockenden Report (2022), an independent review into maternity care in the United Kingdom, highlighted workforce challenges and inequalities in maternity services. The report specifically highlighted the need for mothers with intellectual disabilities to have individualised care and support. Public Health England (2021) suggested that continuity of supporting staff is beneficial to mothers with intellectual disabilities. Additionally, specific support is needed for mothers with a learning disability. This case study adopted a qualitative approach by interviewing current student learning disability nurses and student midwives through purposive and convenience sampling. Data were gathered by conducting semi-structured interviews. Data was analysed thematically through Braun and Clarke's (2021) six step process. There were three overarching themes identified from the analysed data: Knowledge and Skills; Curriculum, and Exposure and Support when caring for mothers with an intellectual disability. The findings prompt inter-professional working in maternity services, which in turn can facilitate better outcomes for mothers with an intellectual disability. It may also facilitate the development of materials to raise awareness, reduce stigma, and clarify misconceptions related to supporting mothers with an intellectual disability.

Policy

42. Rowell, Lara, Tisha Dasgupta, Harriet Boulding, et al. **Perceptions of maternity care-seeking and care-giving experiences during a health-system shock: a qualitative study with healthcare professionals and policymakers in the UK, with a focus on care for marginalised groups**. bmjph. 2026.Vol.4(2), ppe004361. Background Healthcare professionals (HCPs) and policymakers had to reorganise and adapt to maternity services rapidly during the pandemic, and as a result, women’s care-seeking and experience within maternity services were affected. Aims This study aims to explore HCPs’ and policymakers’ perspectives of maternity care-seeking and experiences, with a particular focus on marginalised groups. We take a future-focused approach to informing policy to rebuild UK maternity services which remain beleaguered. Method Semi-structured in-depth interviews were undertaken with 21 HCPs and 20 policymakers across the four nations of the UK to discuss their perception of maternity care-seeking and experiences during the pandemic. Data were analysed using Template Analysis, based on an extended version of the Candidacy framework. Results HCPs struggled to navigate reconfiguration of services and implement changes. It was challenging to strike a balance between the need to protect women from the virus while maintaining high-quality care. The transition to virtual care hindered HCPs’ ability to identify patients’ claim to candidacy, affecting the ability to deliver safe and high-quality care. The standardisation of self-monitoring and virtual care, although beneficial for some, adversely affected those with medical and social complexity. Policy had failed

to address inequalities prior to service reconfiguration, making it harder for HCPs to engage with marginalised groups. This included service users with social complexity: lack of social support, mental health problems or belonging to a minority group relating to sexual orientation or gender identity; or medical complexity: those who had to perform self-monitoring of symptoms during pregnancy for any complication, including hypertension, gestational diabetes, additional scans for predisposition to genetic complications, or previous pregnancy loss. A lack of ethnic diversity within leadership roles meant guidelines failed to consider the needs of minority groups who subsequently received substandard maternity care.ConclusionsThis study affirms the negative effects the pandemic had on maternity care-seeking and experience, while highlighting the need for policy to prioritise marginalised groups, patient-centredness and the well-being of HCPs and policymakers to rebuild a resilient maternity service.

43. Wonnacott, Alison, Hazel Powell, Laura Dynan, Helen Thackwray and Tim Draycott. **Meeting the Challenges of Supporting Requests for Maternity Care 'Outside of Guidance'.** The obstetrician & gynaecologist. 2026.Vol.28(2), pp88–92.

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