Interview

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Q1

What led you to undertake a PhD in Maternal Health and Epidemiology and ultimately pursue a career in reproductive health?

I've been interested in reproductive and maternal health since very early on in medical school. As an undergraduate, I did my dissertation on HIV and human rights. Similarly, as a public health registrar, I focussed on maternity- and reproductive health services-related work. There are several aspects of reproductive health that draw me to it but I think the main one is the social injustice aspect. The fact that most maternal deaths are preventable with known interventions leads us to conclude that society does not deem women's lives to be worth saving. It is shocking to me that so many women continue to die because of pregnancy and childbirth, which is a natural process and not a disease. I find it frustrating that we provide sub-standard services to women, where they are not treated with respect or dignity, and then turn around and wonder why women don't access services, which is one of the contributing factors to their morbidity and mortality. From a public health perspective, there are so many societal issues that affect women's health, such as access to education and services, types of employment, gender roles, and cultural and societal expectations. Many of these are outside the control of the individual, yet we place so much responsibility on women's shoulders for their own health and the health of their family. I want to try to bridge some of that gap and empower women to be able to make their own decisions, while shining a light on these structural determinants that also need addressing. A career as a public health academic is the way I hope to do that.

Q2

You were appointed the role of Senior Epidemiologist for Public Health England (PHE) last year as part of the response to COVID-19 pandemic. How has your typical working day changed as a result of the pandemic?

For a while it changed completely! I stepped away from my research and worked full-time for PHE on the day-to-day epidemiology of COVID-19 in the UK for 6 months last year. I am part of the team that produces the daily numbers of cases and deaths, and I oversaw the production of data for the weekly surveillance report. I also worked on specific projects, including HOSTED, which looks at household transmission and produced the first data on the impact of vaccination on transmission from vaccinated cases. This got a lot of media interest. Now, I am mostly back at my usual role of research and teaching at UCL but I still work a day a week for PHE on COVID-19 epidemiology, although not in the field of reproductive health.

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Q3

Your professional experience has involved travel to several destinations, such as Malawi and Myanmar. Where do you believe you gained the most experience and how have your experiences shaped who you are today and the successes that you have achieved?

I have been so lucky to spend time living and working in such diverse settings as Malawi, Myanmar, Honduras, and Chile, and they have all given me different experiences. It's hard to say where I gained the most because I was doing completely different things at different stages of my career. I think the opportunity to spend time living in a different culture is so valuable to help you start to understand how the culture you have grown up in shapes your thinking in ways that you don't realise. As a researcher, this is really important because our own world view shapes if and how we see problems, how we frame our research questions, and how we might answer them. What might seem, from the perspective of an outsider, to be a problem that needs fixing might be a perfectly rationale response when you understand the context.

Q4

You have worked extensively to improve health and social outcomes for women of reproductive age, in the UK and internationally. Could you comment on the on-going topic of socio-economical and racial disparities in reproductive health outcomes? What do you believe the solution to be?

This is such a big issue and, as I said, it is these inequities and the injustice of it that that I find so engaging. I wish I knew the solution! I think we have a lot more work to do to understand why these disparities exist and how to tackle them; however, I do not think that the solution lies solely within the health service. The disparities that we see in reproductive health outcomes have their roots in the wider determinants of health, although that doesn't mean that there aren't improvements that can be made in services. We have to tackle both.

Q5

What does the ongoing P3 (pregnancy planning, preparation, and prevention) study: "Assessing women's feelings and preferences regarding a future pregnancy" entail? What is this study aiming to achieve?

With this study, I am investigating how we can best support women to realise their reproductive goals, whatever they are. I am just as interested in helping women to avoid the pregnancies that they don't want as I am in helping them to

prepare for the pregnancies that they do want. However, our services in England are not set up in a way that healthcare professionals can support this. Not all nurses specialising in contraception feel skilled to discuss preconception health and not all midwives feel confident to have detailed discussions about postnatal contraception. Thus, in health service terms, women either access contraception services or antenatal care and, in the void in the middle, they do or don't get pregnant. This means we are missing a huge opportunity to improve preconception health to increase the chances of a healthy pregnancy for both mum and baby. The more we learn about the importance of the health of women, and men, around conception on the lifelong health and development of their children, the more urgent filling this gap becomes. Consequently, in this study, we are looking at different ways of identifying what women's intentions are for future pregnancies, if and how to incorporate it into primary care, and what the role of digital health, or 'FemTech', could be to support women, and their partners, to realise their reproductive goals. My aim is to see unplanned pregnancies coming down and women and men able to plan and prepare for the pregnancies they do want. I believe that this will have long-term societal benefits, including the reduction of non-communicable diseases.

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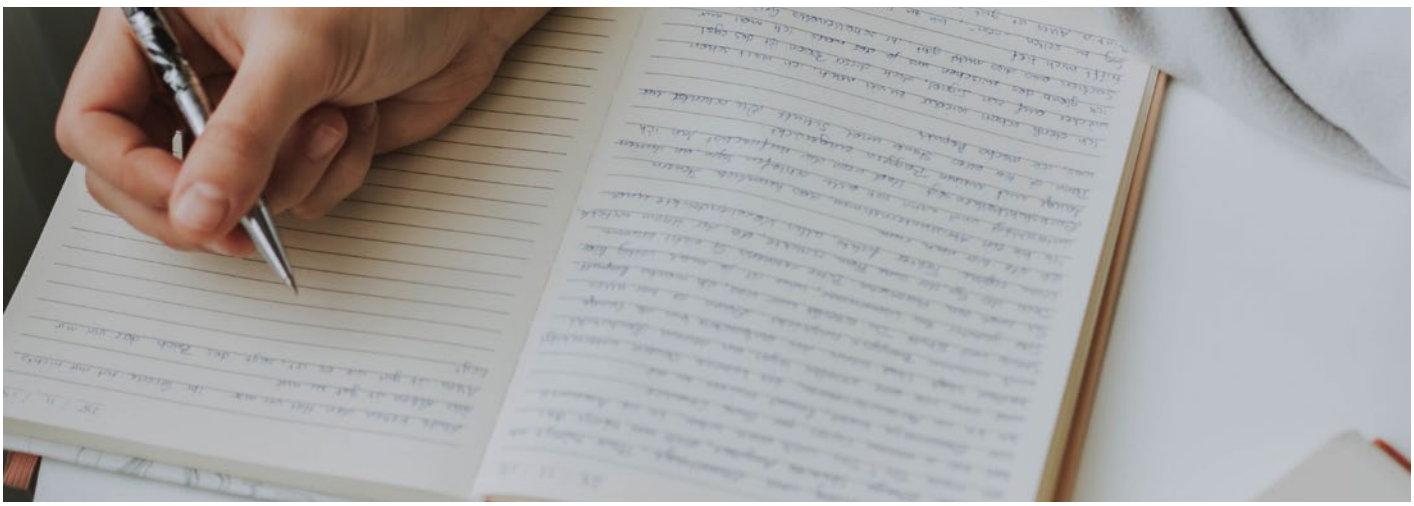
Q6 As a mixed-methods researcher, where can we expect to see your focus lie in the coming years? Are there any advancements on the horizon for the field of reproductive health that you believe will be particularly noteworthy?

There has been a lot of interest in FemTech, with new apps to track periods, fertility, pregnancy, etc., and this has the potential to empower women to take control of their reproductive health. Although it is a little bit odd that, as one journalist found, if you forget to log your period in the app, then Facebook will start showing you adverts for baby clothes! However, this sort of technology is helping to dispel the myth that all women have a regular 28-day cycle, with ovulation occurring on Day 14, because the volume of data collected with these apps is a phenomenal source of information. My focus over the next few years is going to be in normalising conversations about pregnancy planning, both with health professionals and between individuals, because, as participants in our research reflected, why should it be taboo? There are so many hugely important aspects of women's health, like miscarriage or menopause, that are not openly talked about yet have a major impact on women's lives. Clearly, this needs to be addressed.



Q7 What advice would you give to expectant mothers during the COVID-19 pandemic in terms of pregnancy planning and preconception care?

I can only imagine how hard it has been to be pregnant during the uncertainly of the COVID-19 pandemic and for women who haven't had the maternity leave that they had envisaged, or who have had their fertility treatment delayed, or who haven't been able to access contraception services. I'd urge all women (and men) who are thinking about having a baby, pandemic or not, to look at how they can optimise their preconception health (e.g., by taking folic acid, achieving a healthy weight, stopping smoking, or reviewing any medications they are on). This is good for your own health, but also for the chances of a healthy pregnancy and baby. You need to build in time for that before you start trying because one in three couples will get pregnant in the first month of unprotected sex, so make sure you are using effective contraception until you are ready. Everyone should get the vaccine when they are offered it. If you can, I would have it before getting pregnant; however, if you are already pregnant and are offered the vaccine, then discuss with your healthcare provider what your options are and which is the best vaccine for you. Also, if you are pregnant, think ahead to what you would like to use for postnatal contraception because it might be easier to have this sorted at delivery (e.g., have a coil put in) rather than try to access these services later, especially if there are more lockdowns but it can be tricky even just with a newborn baby! Above all, be kind to yourself. Pregnancy and the postnatal period is a tough (and wonderful) time, made all the harder by the pandemic as it has taken away our 'village'. Therefore, make sure you get the support that you need.