Danny Lennon:

A very big welcome to the podcast to Dr. Julie Abayomi. Welcome to the podcast. It's great to talk to you today.

Julie Abayomi:

Thanks, Danny. And thanks for inviting me.

Danny Lennon:

Could you maybe outline to people listening a bit about your background, the different roles you've been involved in and why you do think that has been important in informing some of the conclusions that we'll probably talk about a bit later.

Julie Abayomi:

I've been very fortunate, I think, with the positions that I've had. So I worked for about 20 years as an NHS dietitian. And for the last 12 years, I was a senior specialist dietitian in women's health at Liverpool women's hospital. And for most of my time, while I was working at the women's hospital, I was always part also part-time in academia. So I had these dual roles that ran alongside each other and they very much complimented each other. So I'm working in practice and I'm seeing the problems that patients are presenting with. And at the same time, I'm thinking, you know, there must be a better way of dealing with some of these problems. There must be ways that we can improve patient care and prevent so many of these problems. And then had the support of working in a university and having academia to be able to support me to do some research with the patients that I was seeing and in the hospital where I was working, you know, I think at the time as well, it was quite a unique position. There weren't many dietitian working in that field in terms of pregnancy and antinatal care. There's a lot more of us now, but

at the time when I started the role, it was, it was a relatively new speciality. So I've seen it from both sides of the fence.

Danny Lennon:

One of the first topics I wanted to ask you about is in relation to body mass during pregnancy and in particular, how we can best help women who would come in with a classification within class one, class two, class three obesity, and there may be difference between those as well. And particularly when we get towards very high BMIs, because we have a clear challenge, it seems here for both patients and practitioners, because particularly when we look at guidelines around what is an appropriate rate of body mass change across a pregnancy, we see this tends to vary by jurisdiction and some of those guidelines. And I think you've outlined this before, maybe either arbitrary or at least there's disagreement between different groups on what is most appropriate. So as a way to maybe start framing this, and if for the moment we leave aside some of the more complex issues that also come into play here, like weight stigma, or whether even weight losses is possible for someone to adhere to et cetera. If we go purely from a physiological thought experiment perspective, how is your current thinking around these conversations or even debates that are currently going on about potential for weight loss in pregnancy or changes in body mass, across a pregnancy, depending on what classification of BMI a pregnant woman may have.

Julie Abayomi:

Well, as you, as you've suggested, it is a really complex situation. There are no straightforward answers. So we know from research that women with a higher BMI in pregnancy have increased risk of pregnancy complications, but also women who have excessive gestational weight gain during pregnancy have increased risk of complications. And when we look at patterns of weight gain, there, isn't a clear picture emerging. So some of the research that I've been involved in at Liverpool women's hospital, the women with the very high BMIs of 40 or more, when we observed their weight change over time in pregnancy, they didn't really gain much more additional weight. They kind of, their weight stayed very similar throughout the pregnancy. When we looked at some of the women who had lower BMI, they seemed to be the women who were most at risk of excessive gestational weight gain.

Julie Abayomi:

So the women with BMIs early thirties were much more likely to experience excessive gestational weight gain than the women who had BMI of 40 or 50 at the start of their pregnancy. And this is you know, when we look at the guidelines for obesity and pregnancy and referral for specialist, weight management care, most trusts have a cutoff, which is, is to do with resources. So, you know, they would only accept a referral for a woman who's got a BMI of 40 or more, which is purely a resource issue. You know, somebody who with a BMI in the early thirties has probably just as much risk as somebody with a BMI in their early forties. But if we referred everybody with a BMI of 30 or more health service, just couldn't cope, there'd be far too many women being referred. So I think that cut off of 40 as more to do with a resource issue rather than a risk issue. And that, you know, is a cause for concern, because if these women are at increased risk, just as much as the women with a BMI of 40, and they're also at risk of excessive gestational weight gain, but they're not getting anything but standard antinatal care. So that's a group of women that I would be particularly worried about.

Danny Lennon:

Yeah. And that raises itself a number of really important issues. So maybe just to clarify for people who maybe haven't came across some of the guidelines in this area, when you reference their excessive weight gain a across the pregnancy, what type of figures do we deem as appropriate or what is deemed as excessive? How do we tend to define those?

Julie Abayomi:

I mean, that's a really good question because in the UK and Ireland, we don't have any guidelines for gestational weight gain in pregnancy. So a lot of health professionals refer to American guidelines from the Institute of medicine. So their guidelines state that a pre-pregnancy or early pregnancy BMI of 30 women should try and limit their weight gain between five and nine kilos. And again, that raises issues for me. So I've been, when I'm talking about excess weight gain it was the women who had a BMI between 30 and 35 who were more likely to experience weight gain over and above nine kilos, the women with a BMI of 40 or more tended to keep within the IOM guidelines. But, you know, I have a problem with those guidelines as well, because again, it doesn't specify the difference between a BMI of 30 or a BMI of 60, you know, the guideline for five to nine kilos is the same. And I would feel very uncomfortable advising a woman with a BMI in the fifties or sixties that we would still expect it gain an additional five to nine kilos in a pregnancy.

Danny Lennon:

And, and so at this point, and again, this is many of these questions are, are still unanswered. And a lot of the time, I guess it's gonna come down to the individuals involved to be able to make decisions that they feel comfortable making, but are we at then a point of, rather than targeting a specific amount of weight gain based on some of these arbitrary guidelines to some degree that we're, we're taking, as opposed to looking at well, how can we support their overall diet quality and just let body weight do what it's going to do naturally is, is that more in line with how you would typically think someone could start counseling someone on general health eating throughout the pregnancy?

Julie Abayomi:

I think focusing on dietary quality is really important, and I think we should be focusing on dietary quality for all women, regardless of their BMI. For one reason, all women need a healthy, balanced diet for a healthy pregnancy, regardless of their BMI. So we, we should be focusing on dietary quality for all of them. But secondly, I think it helps with some of the issues of weight stigma. You know, if we're singling out groups of women, because they've reached a certain BMI criteria, it does add to that whole issue of weight stigma that they're being treated differently because they've met a certain criteria for BMI. And we know from research as well, that health professionals, including midwives often feel very uncomfortable talking to women about healthy diet and healthy weight gain when they're overweight to start with.

Julie Abayomi:

So if we were having these conversations about a healthy weight gain and a healthy diet with all women, it removes some of that stigma and some of the awkwardness that health professionals might feel, but at the same time, I think, you know, I don't think we can ignore weight. I think weight is still an important issue, and I still think we should still be guiding people about a healthy weight gain, but again, at all, BMIs, you know, a healthy weight gain is important regardless of what the early pregnancy BMI is. You know, if you've got a BMI of 24, but you still gain way over and above what you should be gaining in

pregnancy, that that's still gonna be risky. So I think, you know, regardless of the early pregnancy BMI, there should be advice about a healthy weight gain

Danny Lennon:

On the other side. And I think this is something that we, we just touched on a moment ago, but to maybe go into it a bit more, and it's probably one of the more newer conversations that I've, I've seen popping up in this area with almost two different extreme positions and then a whole bunch of people that are in the middle. And this relates to this idea of if we have an acknowledgement that perhaps someone might be at at higher risk of complications or comorbidities throughout the pregnancy due to excessive body mass, then one group of people are saying, well, look, now we can have a period of time where this person might be more highly motivated to take on advice. They're now gonna be in contact with health professionals more regularly, and now might be a good time where if they did reduce at costly to some degree, we know there might be a physiological benefit to that in terms of cardiometabolic health on the other side, then we have people almost of the opposite position of saying, well, look, no matter what the circumstance, weight losses contraindicate at this time point, and they'll point to a number of theoretical mechanisms by which weight loss can cause problems during pregnancy.

Danny Lennon:

And I'm, I'm I, at least from what I could tell, I'm not sure if there's a clear answer, but I'm just wondering how you've viewed that discussion. And what are your typical thoughts? Because I know there's a lot of nuance to this particular conversation. What are some of the things that typically come to mind when you see these types of discussions? So

Julie Abayomi:

I think the argument that, you know, weight loss in pregnancy is, is a negative thing. If we look at the evidence behind those guidelines, they tend to come from quite old studies. And the studies tend to be looking at extreme examples. So for example you know, studies that have looked at women who've had really bad hyperemesis or vomiting in pregnancy and that's dramatically reduced their food intake as a result of prolonged vomiting or, you know, other examples like the Dutch Famine study from the second world war where women had inadequate food intake because of conflict and poor access to food. But, you know, all of these examples are where really extreme, where women would've been deficient in a whole package of nutrients, not just deficient in energy intake.

Julie Abayomi:

And I think, again, a focus on quality of diet. There's an argument that if women are able to maintain their intake of all the important micronutrients that they need whilst reducing some of the calories that, that from foods that don't particularly provide useful nutrients so that the so-called empty calories galleries you know, if they're maintaining the quality whilst reducing some of the energy and a byproduct of that is that they happen to lose a bit of weight. I wouldn't be too worried. And I've seen lots of examples of this. Most of the women that I looked after when I was working in the hospital had gestational diabetes and they would be referred to me for advice about their diet. And we'd be talking about reducing sugar and Cusing out the sugary snacks and the drinks. And very often as a byproduct product of that, they would lose a bit of weight because they're cussing out all of the calories that they're getting from those sugary drinks and snacks.

Julie Abayomi:

And at the same time, they're maintaining the quality of their diet because I'm advising them about important sources of iron in and calcium and all the other things that are important in pregnancy. And they weren't aiming to lose weight, but very often they did lose a bit of weight. And they actually, you know, felt better for it for some of them, they managed to maintain that change in their dietary intake. And when they'd come back for the second pregnancy, they'd be significantly lighter than when I saw them the first time round, you know, and a lot of them would say, well, you know, it wasn't difficult. What I was doing it, I didn't feel like I was on a diet. So I've just carried on and done what you asked me to do. And here I am two years later and you know, significantly less weight than I was last time I was pregnant. So, you know, they're really positive stories. And if we encourage more of that, I think it will only improve health.

Danny Lennon:

Right. And it would seem strange for someone to say that, that it wouldn't be a positive thing to do, because as you know, it's not like going and encouraging just really a calorie restricted diet and just focus on calories at, like you say, it's a, it's a byproduct of getting people to make shifts to healthier dietary patterns, which in general, considering how the patterns that are common within the general population, that's likely to improve not only overall quality, but is probably gonna lead to a calorie reduction without them even thinking about that. And, and so this becomes a positive byproduct. So, so within that, let's maybe focus on some of those nutrients that you mentioned, cuz you mentioned a couple of important ones and there are some that I think people are quite familiar with in relation to this per pregnancy period, particularly something like folic acid, I'm sure everyone has heard of, but then there's a number of other of not only important nutrients at this time, but also some that maybe there is a high risk of an insufficiency of the average person in the population. So if we could start with an overview level before we get into any of the specifics of any one nutrient, what would you say are some of the key nutrients that you would have most focused on at this time that you know, that people are at risk of maybe not consuming enough of, and that they certainly could benefit from particularly around this per pregnancy period.

Julie Abayomi:

So there's some micronutrients that are really important for fetal development. So they're particularly important in early pregnancy. I mentioned iron and calcium and they're people are probably familiar with those two nutrients, very important for fetal development, but also vitamin D is very important for fetal development. And one of the reasons why we have a recommendation for vitamin D supplements during pregnancy is because pregnant women are unlikely to be getting sufficient vitamin D particularly during the winter months, vitamin B12 is important for fetal development and iodine and omega three fatty acids are really important for brain development and fetal neurological development. And these are probably two of the lesser known supplements in sorry, nutrients in terms of fetal development. But there's lots of evidence at the moment that, you know, these are two nutrients that may be particularly short in UK and Irish diets at the moment because the good sources of these particular foods, which tend to be sea fish for iodine oily fish for omega three fatty acids, you know, people are consuming less fish than they were in previous generations.

Julie Abayomi:

And the other good source of iodine is milk and dairy foods. And we're also consuming a lot less milk and dairy foods at the moment as well. So these are, are two nutrients that we'd be particularly

concerned about for fetal development. And we know from national surveys like the national diet nutrition survey that women of childbearing age are consuming significantly less iron calcium iodine than they should be. So if these women are then gonna go on and become pregnant, that would be a concern that they're not consuming enough of these micronutrients for a healthy pregnancy.

Danny Lennon:

Yeah. And I definitely have a number of questions related to both omega three fatty acids and iodine in particular, but maybe to take a step back just to cover for anyone who maybe has heard about folic acid, but maybe isn't particularly sure why it's so commonly recommended here. Can you, first of all, maybe talk about the role of folate and why it is so important at this time or certainly why, if there's an inadequacy of that, that can be really detrimental. And then second to that, why is folic acid supplementation particularly talked about as opposed to just looking at dietary sources?

Julie Abayomi:

Folic acid is really important for the prevention of neural tube defects in babies. So it's responsible for cell division and cell metabolism. And there's lots of established research showing that low folate intake in pregnancy was very much associated with instance of neural tube defects. So we've had a recommendation for folic acid supplements for about 30 years now, it's quite an established recommendation. So the general population are recommended to take 400 micrograms of folic acid prior to conception and at least up to 12 weeks of gestation to ensure healthy neural tube. However more recently we know that some women are at increased risk. So there are some women who are advised to take a higher dose of folic acid. So this includes women with a previous history of neural tube defects women with a BMI of 30 or more and women with preexisting diabetes before they become pregnant.

Julie Abayomi:

So they've got a higher risk of neural tube defects and they are advised to take a higher dose, which normally needs to be prescribed of five milligrams. And I think this message probably isn't get getting through as well as the 400 microgram message. So we do still see women who are at increased risk who may be only accessed community based care in the early stages of their pregnancy. And they might be on the lower dose rather than the higher dose. And obviously that higher dose is, is important for the first 12 weeks gestation. So very often by the time they're accessing hospital care, we've missed that 12 week window. So it's really important that they know about that higher dose precon, conceptually and in early pregnancy.

Danny Lennon:

And I guess this importance has been underscored in a number of different places where public health interventions have been looked at in terms of fortification. And I think, and you can correct me if I'm wrong, but I think last year there was within the UK, there was an announcement about maybe fortification of folic acid in certain wheat products. And again other regions that may differ, what do you see as the potential role of something like fortification, but given that even whilst folic acid is probably the most well known nutrient in terms of pregnancy, we're still seeing people have suboptimal intakes and still being at risk.

Julie Abayomi:

Yeah, I think fortification is a great idea and I know dietitians have been campaigning for this to be included in wheat products in the UK for a very long time. So I know there are a lot of dietitians really pleased when this announcement was made. I suppose the only downside to it is that it it only includes white flour products. It doesn't include whole meal flour, and it doesn't include gluten-free flour. I think that one's really, you know, a shame because people with celiac disease are only gonna be consuming gluten-free flour and they're not gonna be getting the fortification. So I would've liked to have seen the fortification in all flour products. But I think it's fortification is really helpful because we know about 50% of pregnancies in the UK are unplanned. So if people are consuming extra folic acid through fortification, then that, you know, means they're getting more folic acid, you know, even if they're not taking supplements, I think the supplements are still needed, but the for fortification gives a bit of a safety net for people who have maybe not planned their pregnancy or not planned it as, as much as they might have liked to.

Julie Abayomi:

So it, I do think it's a really good idea. And we know from research in other countries like Canada and the United States, that it has fortification of flour, which they've had for many years has reduced instance of neural tube defects in those countries. So we would like to see a similar effect in the UK.

Danny Lennon:

I, if we turn our attention to the omega three fatty acids, and I suppose to start with DHA in particular, seems to be of key benefit here for brain development and cognitive function. And I suppose just to really zoom in on why this is critical, even during pregnancy around brain development, can you maybe touch on that timeline of why consumption during the pregnancy is gonna have a role here for the brain development of a child even before they're, they're born and the importance of, I suppose, the maternal DHA levels, as opposed to just thinking of early childhood?

Julie Abayomi:

Yeah. So we know that DHA is really important for brain and neurological development in the fetus. So a again, it's the importance of preconception, isn't it's that early pregnancy stage where this is really important. So kind of, you know, looking at quality of diet, precon, conceptually, and early pregnancy is really important to ensure that, you know, women are guessing adequate intakes from the time of conception and in early pregnancy, there are also studies that show that women who are deficient in omega three fatty acids in pregnancy, that there is an increased risk of miscarriage as well. And instance of gestational diabetes can be higher with deficiency of DHI. So really important for maternal and fetal health.

Danny Lennon:

One of the big areas right now, and it's something that we've discussed on the podcast before is the potential importance of a direct dietary source of DHA. And so I suppose this particularly goes to people who either don't consume any fish sources or most notably peak people that would be on a vegan diet, let's say, and they don't supplement, let's say with an algae base form. And so they're may be relying on their omega three intake from ALA and from plant sources. And one of the things that we've touched on is that we know that there's at least some conversion going on from ALA to EPA. The amount converted down to DHA seems so close to negligible that it very rarely changes DHA status. And so whilst there's still a lot of gray area for the average adult in the population, probably one of the real key areas as we've discussed for DHA is in this period of early brain development. And so it would seem that on a

precautionary principle basis, even a direct source of DHA is crucial. I'm wondering what your current take on this situation is how you have typically gone about counseling, a pregnant mothers that may be follow a vegan diet, for example. And if there is indeed a specific recommendation where we can't just rely on ALA and actually getting some sort of direct source of DHA is indeed crucial. How do you think through this and what would is your current position on this topic?

Julie Abayomi:

I think it's a really challenging one. You know, you're absolutely right. That vegans are going to be relying on plant sources that are conversed in the body. And there are good plant sources that would, would provide that. But if they're not conversing to much DHA, then there's still a risk of DHA deficiency there. And there are no suitable plant foods that are going to be provide a direct source of DHA. So I suppose that the only solution in those circumstances would be supplementation or possibly fortification. You know, if there are a vegan foods available that are fortified with DHA, that might be another solution. And I think there's, there's lots of nutrients in a vegan diet. You know, we absolutely, it's possible to have a healthy, balanced, vegan diet for pregnancy, but it needs an awful lot of thought and planning on whether people have the right information to do that amount of thought and planning. I'm not sure there's an awful of misinformation as well. So, so vegan diets and pregnancy are, are a particular concern of mine, not only because of the challenges of providing some of these important micronutrients, but because of the misinformation and people think that they're doing the right things and they're doing the healthy things and that might not necessarily be true.

Danny Lennon:

Yeah. And, and it's unfortunate because it it's one of the things we've discussed before of it's, it's absolutely possible for people to do a well-balanced healthy vegan diet, of course, but you have certain situations where I think people who don't want to talk about the potential for certain nutrients are more at risk or don't admit there's any potential at risk to a certain dietary pattern and are coming from a position more of solely based of activism have to paint it as, as, as no problem whatsoever. Whereas really for something like particularly DHA in pregnancy, we're still very much unknown on that. Right. So I I'd be happy that if in the future we had evidence to say, yes, you can actually get as much as you need from ALA and it's perfectly fine. But for right now, without the evidence seems that we should take precaution. And, and like you say, probably take a supplemental form of this. What of the other nutrients that you mentioned? And I think probably doesn't get as much as attention as it really deserves is, is iodine. Can you maybe talk about this broadly of some of the roles of iodine and particularly why in this pregnancy period, again you brought this nutrient up.

Julie Abayomi:

So iodine is really important for fetal brain development as well. And there are situations... well it used to happen in the UK previously and still happens in low income countries where severe deficiency of ID in pregnancy can result in severe mental poor mental development in children where they're born with a a severe mental disability. We don't see that in the UK anymore, but there is evidence to suggest that even a mild deficiency of ID during pregnancy could affect IQ of offspring and in follow up studies where children were given Optima iodine during childhood, this still didn't correct that deficit. So it's, it's almost like an irreversible effect on IQ caused by inadequate iodine intakes during pregnancy. And we know again from, you know, national surveys that iodine intake in women of childbearing age is far from optimal. There's a high prevalence of poor iodine intake in that particular age group.

Danny Lennon:

Is there an increased need for iodine at this time? Because one of the things that that sometimes gets discussed is changes in thyroid hormone production, does that actually change nutrient requirement or does it just mean that the typical amount we require for the general population, it's just more important to make sure someone is getting that.

Julie Abayomi:

So the dietary reference value is 140 micrograms, which doesn't change for pregnancy. But if we look at European guidelines it's significantly higher. So they, the European guidelines recommend 200 micrograms for pregnancy. And if we look at the, again, looking at a plant-based foods, very few of them are fortified with iodine and the ones that are fortified with I ID, it tends to be quite a low level. So for example, a litter of plant milk might only contain about 120 micrograms. So if your recommendation for pregnancy is 200, you know, you're gonna need to, to be consuming almost two liters of that product a day to get sufficient dine intake. So I've got concerns about plant foods that contain iodine, but also the level of fortification is really inadequate at the moment. And it could definitely do with being improved,

Danny Lennon:

Right? And I suppose one of the big problems there is the massive variance from product to product or brand to brand. Some can have really decent amounts of ID fortified in these alternative milks. Whereas others, like, you know, are, are probably not as, as high as some others and fortification here is a a relatively big story. And as we noted for some of the others earlier, there's differences here based on geography. And so, for example, where we might have certain places where we have iodized salt being so frequent within the food supply that, that has largely taken care of a lot of ID concerns for a number of people that is not something that we have, for example, in the UK, can you maybe touch on again, the potential role of fortification and what could be done differently if you think that some steps that other countries are doing or vice versa would be beneficial.

Julie Abayomi:

So there are lots of countries that have introduced iodized salt. So, so using salt with additional iodine in a lot of low income countries, this has been a really cheap way of increasing iodine intake and has had significant impact on iodine deficiency. The UK's always been very reluctant to use iodized salt because on one hand we have a recommendation that we use too much salt, and we should be using less salt. So it contradicts that recommendation of the event saying, well, use plenty of salt in your diet because it's a source of iodine. So because that advice tends to contradict each other we, we haven't gone down the route of using iodized salt. I was reading recently that a plan of I mean, you're absolutely right. The geography plays a big part. And the, I was reading an article that was suggesting that if we improve the iodine content of the soil, that could improve iodine content in the diet, because plants would be natural, naturally richer in iodine, the animals that always eat those plants would be natural, naturally richer in iodine.

Julie Abayomi:

So I suppose that's, that's one possible solution, but I think, you know, going back to plant alternatives, I think a lot of people who follow a plant based diet presume that they're getting like for like, so, you know, if you are consuming a plant milk, you, you presume it's got the same nutrients as, as if you were buying cows milk and for some nutrients that's largely true. So calcium, for example, a fortification is very similar to cows milk. You would be guessing similar amounts of calcium, but I do think the food

industry could do a lot better with iodine fortification because it is really inadequate in the milks and a lot of other products. So, I mean, you could argue that, you know, it would be a challenge to get sufficient iodine from consuming cows milk and dairy foods you'd have to include significant amounts of them in a diet to achieve that 200 micrograms a day that's recommended.

Julie Abayomi:

But if you think about, it's not just milk, it's yogurts, it's cheese, it's all the things that are made from milk that would add iodine to the diet. The only products that are fortified with iodine, the plant based alternatives are the milks. If you look at any of the other products, the yogurts, the cheeses those type of alternatives, none of them are fortified with iodine. So you're solely relying on one product to give you iodine and your diet. So if the levels are inadequate or you've got to drink one and a half liters to get your, your recommended intake, it's, it's not really practical.

Danny Lennon:

Thanks for outlining that. Julie, so with that, we've, we've touched on a number of these really important, crucial nutrients to include, but of course, on the other side, there are a number of either nutrients or compounds that people need to be wary of. And in addition to the usual suspects, when we talk about healthy eating making sure not to go overboard on salt or saturated fat; for pregnancy, there's some specific ones and probably most notably, I guess, is mercury. Can you maybe outline why mercury is something that is talked about, and then what that means for pragmatic dietary recommendations for the pregnancy period

Julie Abayomi:

Mercury is, is a heavy metal that can be found in seas and oceans. And there is re research to show that a high mercury intake can also affect fetal development. So there's certain types of fish that pregnant women are advised to avoid because they may be contaminated with mercury. This includes shark, swordfish, and Marlin, which we don't tend to eat an awful lot of in the UK. But there's also a recommendation of limiting tuna intake to, to reduce risk of mercury contamination as well. And really interesting going back to the iodine argument is again, another potential plant source of iodine would be seaweed, but seaweed is another food that is not recommended in pregnancy because it can also be contaminated with mercury and heavy metals. So seaweed wouldn't be a suitable alternative in pregnancy, either

Danny Lennon:

One of the other nutrients that I've seen some research about, but I suppose is very at front of mind for a lot of people giving how ubiquitous coffee consumption is within the population is consumption of caffeine. And at what point caffeine may or may not be an issue. What do we know about the effect of caffeine intakes during pregnancy? Do we see certain levels where that becomes problematic? If so, what way do we view that? And how should something like coffee consumption be viewed by someone throughout the pregnancy?

Julie Abayomi:

So high caffeine intake is associated with increased risk of miscarriage in pregnancy. So it would be a really good idea to limit caffeine intake. The recommendation is, I can't remember the actual figures, but I know it's the equivalent of two cups of instant coffee a day. Pregnant women shouldn't be consuming any more than that. Obviously filter coffee and things like that are going to be stronger. So

they're probably not a good idea to consume stronger coffees during pregnancy. So, I mean, decaf would be fine. There's, there's less caffeine in in tea or, you know, if you wanted to be super careful, you could use decaf tea as well. But I think one of the possibly the hidden sources of caffeine that people are not as aware of is things like Cola drinks are very high in caffeine and some of the energy drinks can be very high in caffeine. So things like that would be really dangerous for pregnant women to be consuming. They could get a really high dose of caffeine from those type of drinks.

Danny Lennon:

One thing I really did wanna ask about that, that you touched on earlier is in relation to potentially improving this situation in healthcare going forward. And so not only how to support pregnant women that are, are presenting at the hospital, but then also help practitioners, whether that's dietitians that may be consulting with them, or most notably midwives who are gonna have probably the highest degree of contact. And I know some of your work has really looked at this in addition to the work you've actually done, but actually your academic work as well of looking at the experiences of both patients and midwives. And you touched on this a bit earlier about this idea of midwives being hesitant to give advice in certain situations. And then in others, they might note that maybe they don't feel confident enough to give certain recommendations from an overview level. What is your current sense of how midwives are currently supported in being able to give nutrition advice and how much more work would I ideally need to be done? Let's say, in an ideal world for now, before we talk about logistically getting that done really

Julie Abayomi:

Interesting question. We do have a NICE guideline for antinatal care that says that all pregnant women should be advised about healthy diet by midwives during their antinatal appointment. This led me to, to another research project that I was in involved in, where we actually interviewed midwives. And we asked them, you know, how much training have you received about healthy diet and nutrition, and how confident do you feel having conversations with pregnant women about healthy diet for pregnancy? And none of the midwives that we interviewed had had any training at all about nutrition or healthy diet, and yet there's this expectation that they can deliver this information. So that's really started me on a bit of a mission really. And I've been doing lots of training with midwives to upscale their knowledge about pregnancy specific nutrition and giving them some of the skills and the confidence that they need to have these useful conversations about healthy diet and healthy weight gain in pregnancy.

Julie Abayomi:

So I'm my current job. I do have some teaching with the undergraduate midwives in a couple of universities in the Northwest now. So they're getting some, some input from me. I have done some post registration training as well with qualified midwives. So I was invited to a number of CPD workshops to deliver some nutrition training with qualified midwives previously. And I've just been asked to write the chapter "Nutrition for a Healthy Pregnancy" in the Mayes' Midwifery handbook, which is the "midwifery Bible", if you like, it's the textbook that they all use. So this is the first time that, that chapter's actually been written by a dietitian. It was written by a midwife previously. So hopefully that chapter now is much more evidence-based and pregnancy specific. So I'm hoping, you know, with some of these initiatives that, that will really improve the skills and the knowledge and the confidence of midwives to be able to have these useful conversations.

Danny Lennon:

Fantastic. That all sounds amazing. And certainly if that could be pushed out at a larger scope, I'm sure that degree of nutrition training alone would, would help many professionals. But beyond that, I think in terms of the support that could be given to midwives, even nurses or dietitians that are gonna be working with some of these women, I could ask about what ideally they need more of, but that could be a very long list given I think at least from my experience here in Ireland and in the UK as well, how maybe understaffed and underresourced, they are relative to what is needed or deserved in lieu of that, though. What do you think are maybe some of the most immediate concerns that beyond just getting more nutrition education, maybe throughout undergrad, or even as CPD, are there other areas that could really benefit both practitioners that would have a knock on effect of better quality care for pregnant women, do you think?

Julie Abayomi:

Better teamwork, really. So midwives and dietitians working as a team and part of the training that I've been doing with undergraduate midwives, and I've referred to this in the chapter as well, is that part of the midwives role is going to be deciding which of the women that they can offer the basic, healthy eating advice to, and which of the women that are more complex and need additional support and need referral elsewhere. Because I think that's part of the problem. You know, they're not going to become dietitians. They're not going to be able to advise women about much more complex needs. You know, if they there's, if they've got medical problems, if they're severely underweight, if you know, there are other things going on that needs a referral to a dietitian. And some of the conversations have been having with midwives with the training is part of the problem is they don't know if they've got access to a dietitian and they don't know how to make that referral. They don't know, they don't know if they've got access to weight management services or how to refer to weight management services. So there's a lot of unknowns and communication. And if we can improve that so that, you know, midwives can do the basics, but then they, they've got a clear care pathway of who they need to refer to and how they can refer women where the situation's more complex and they need additional support.

Danny Lennon:

Maybe I'll finish on this final question. And it, it came from off the basis of one of the qualitative studies that you published that I was reading. And within that, one of the aspects that you had uncovered was that this wish fr from pregnant women to want more of the dietary advice that they get to be based on what they should include, as opposed to just being, giving a list of things to limit or avoid. Can you maybe just speak a bit more to that of not only that, that finding, but how you've seen that play out, actually in practice.

Julie Abayomi:

I suppose the what to exclude is the easy bit, isn't it, there's, there's this list of foods that you, you shouldn't avoid that you shouldn't include and you should avoid. And, and that's quite easy. And from the conversations I've had with women, pregnant women, and with midwives, they all say, that's the bit that they're comfortable with. That's the bit that they're confident with. So they tend to focus on that, which as, as you suggested it, you know, in the paper, we've said that that that's overly negative if they're just giving them a list of things not to do. And I think probably the other side of it, the things that they should be including, that's where it starts getting a little bit more complicated because there's no one size fits all. There is no one list that these are the things you should be focusing on.

Julie Abayomi:

So what I've tried to do in the chapter in the handbook is to say, you know, looking at the individual woman that you are caring for and her individual circumstances that should help you to decide which of the things I need to focus on. So if, for example, your pregnant woman is vegan or vegetarian, then there are key things that would be really important, like talking about fortification of plant products. Are they getting a source of iodine in their diet, those things. So that's gonna be like the really key things to focus on for somebody on a vegetarian or a vegan diet. If that woman happens to be overweight, then possibly there's a different focus there you'd, you know, you you'd want to focus on all the things that are relevant to that woman who's overweight and may be concerned about weight gain in her diet. So I suppose it that's the difficult bit because it, you've got to tailor it to that individual woman's circumstances. And if you haven't got the in depth knowledge of nutrition, that's really difficult to do. So they're the things that I've been focusing on working with midwives and on the things that are focused on in the chapter as well, so that they can almost focus that, that advice into the things that are going to be really important and really relevant for those women, depending on their circumstances.

Danny Lennon:

Julie, before I get to the very final question just for people listening, who may want to get into contact with you, or to find more of your work or find any resources that you may recommend who are maybe working in this area, can you let people know where they might be able to find you either on social media or any resources you'd like to point their direction towards or anything else like that?

Julie Abayomi:

So I am quite active on Twitter. I do have a Twitter account and I do tweet quite a bit about maternal nutrition. I'm also part of the British Dietetic Association specialist maternal and fertility nutrition group. So we run training courses for health professionals and we have annual conferences and we have online meetings and things. So we're, we're a very active group as well in terms of maternal nutrition. So the BDA, British Dietetic Association website, there are a number of fact files available on the British Dietetic Association website, which are free to download and can be used with patients. Health professionals are more than welcome to download those resources and the pregnancy resource that's on there. I actually wrote that particular pregnancy resource with another member of the specialist group. So that was updated last year, so that that's another resource that people might find helpful.

Danny Lennon:

Excellent. Thank you so much. And for everyone listening, they will be linked up in the show notes. So go and click through to all of that, with that we get to the final question that I always end the podcast on, and this can be completely outside of anything we've discussed today. It's quite a broad question. So apologies for putting you on the spot with it. But nevertheless, it's, if you could advise people to do one thing each day, that would have a positive impact on any area of their life. What might that one thing be?

Julie Abayomi:

I would say get a good night's sleep. <Laugh> I think it's so important for me for mental and physical health

Danny Lennon:

That is speaking my language. I know I'm half the person I normally am if my sleep is terrible. So with that, I wanna say a massive thank you to Dr. Abayomi for coming on. And for this conversation, I I've

really enjoyed talking to you. And even more than that, I've really enjoyed reading your work up to this point and for all the work that you continue to do, I'm sure it's very much appreciated by a lot of people. So thank you for giving up your time to come and talk to me. Thank

Julie Abayomi:

You very much for having me.