

**ARTICLE TITLE: Public Health and Wellbeing: A matter for the
Midwife?**

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Key Phrases

This paper will report a critical narrative review of research that focuses on public health interventions in pregnancy an attempt will be made to identify specific public health interventions used in pregnancy and how midwives perceive their role in implementing them. Barriers to providing public health interventions are explored and conclusions are drawn as to how Midwives can build upon their vital role as public health practitioners.

Public Health and Wellbeing: A matter for the Midwife?

Abstract

This paper will report a critical narrative review of research that focuses on public health interventions in pregnancy. The following databases were searched from the dates 2005 these were Medline, BNI and CINAHL.

To begin with, an examination of the historical and political context of public health and midwifery will be used to give background to the present midwifery public health agenda. Thereafter, an attempt will be made to identify specific public health interventions used in pregnancy and how midwives perceive their role in implementing them. As a result of this, the findings will conclude that midwives are important public health practitioners, who alongside other agencies can make a long-term, positive contribution to the life course of women and their families.

Public Health

By definition, public health is a multi-faceted structure, which is characterized by:

- A concern for the health of the whole population
- A concern for the prevention of illness
- A recognition of the many social factors which contribute to health

(Naidoo and Wills, 2000).

Wanless (2004) takes the traditional view of public health further and places responsibility on society, organisation's, communities and individuals to implement public health improvement through their organised efforts. It can indeed be argued that each and every one of us has some involvement in public health and can take responsibility for health promotion, disease prevention and prolonging life. Public health seeks to protect and improve the health of communities, identifying causes of poor health, disease and illness in a population and examining it from the wider social and economic standpoint. Public health makes links between factors such as employment and education to the level of health and well being in and across populations and uses it with the aim of positively impacting on the wider social determinants of health and wellbeing.

Pregnancy offers maternity care providers the opportunity to maximise the health and wellbeing of women and their families. Women may see many different providers during their pregnancy but it is the midwife's unique position to be able to build relationships through continuity of care that enables the possibility of impacting on public health outcomes – both short and long-term. Public health interventions are varied in pregnancy and range from smoking cessation support, identification of mental and emotional health problems to supporting families where domestic abuse

has been identified. Pertinent research will be critiqued which examines how midwives perceive their role in delivering these interventions.

The political and historical context of Midwifery and Public Health

Legal recognition of midwifery started in 1902 as part of the Midwives Act. This enabled regulation of a profession in which many practitioners were unqualified and uncertified. The act was amended and added to by later midwives acts and was retained with the formation of the National Health Service (NHS).

If a brief history of midwifery is examined in the United Kingdom, public health is central to its core themes of care, despite not always being recognised or acknowledged. In the late 1880's The Midwives Institute campaigned for the training and practice of midwives to be regulated, which resulted in the Maternal and Child Welfare Act of 1918. Prior to this there was very little in the way of preventative antenatal care. By the 1930's a national maternity service had been established co-ordinated by local public health authorities provided in the homes of women and families, however over the next few decades Midwifery gradually moved into a more institutionalised and medicalised model of care. The document Changing Childbirth (Department of Health, 1993) started the movement away from the model of medicalised care and changed the focus so that services became flexible and responsive to the families it cared for. As a result of this, once again public health started to become more of a recognised part of the midwives role, moving it away from the medicalised model of care and transitioning, arguably once again to the social model.

As an example of this, in the current climate there is an increasing emphasis on the psychological and social needs of pregnant women. For midwives, evidence such as the Confidential enquiry into maternal and child death (CEMACH) supports the fact that public health impacts on mortality and morbidity of women and babies and requires maternity services to act to reduce risk.

This demonstrates that politics and policy very much drive the public health agenda and is further backed up by the recent Compassion in Practice Guidance (Department of Health, 2013). This document serves as a key illustration of this point as it focuses upon meeting the challenges of reducing inequalities through improving maternal and population health. It confirms partnership working between agencies as opposed to midwives working in isolation is the best approach to ensure the best start in life and achieve a healthy life expectancy.

What does being healthy in pregnancy mean?

For all public health practitioners it is pertinent to have an understanding of the concept of health. Midwives particularly are aware of looking holistically at an individual to gauge the health of the woman and her unborn child.

There are many definitions of health, How Chow, (2011) describes health as the ability to adapt and self- manage in the face of social, physical, and emotional challenges. In comparison (Baggot 2011) divides the traditional biomedical concept of health to a positive perspective, which also considers the social, environmental and psychological aspects of health. Other definitions agree that health is holistic and includes different dimensions, each of which need to be considered, with dimensions (Naidoo and Wills, 2000). This thinking moves away from the World

Health Organisation (WHO) who first attempted to define health in its broader sense in 1946 as

"a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity'.

Although the WHO definition started a change in the traditional thinking that good health encompassed the absence of disease, the inclusion of the word 'complete' means that it would be unlikely an individual could be healthy for a reasonable length of time (Üstün and Jakob 2005).

On the understanding that health is more than the absence of disease, it's appropriate that effective approaches to public health are based upon participation, collaboration, co-operation and empowerment within the mechanism of partnership working (Davies and Foley 2007). Pregnancy is generally not considered a state of ill health but rather a natural process that precedes the birth of a child. Pregnancy is unique in giving a window of opportunity for making changes to lifestyle and habits and at no other time do individuals come into contact with health professionals on such a regular basis for an intense period of time. However, each pregnancy is different and each woman has different needs that may affect her pregnancy.

Pregnancy and Wellbeing

In considering the term 'health' as a construct, the midwife would come to the conclusion that there is no one commonly agreed definition and opinions vary widely. In contrast when reviewing the term 'wellbeing', this encompasses the multi-faceted elements of health. Although still subjective, the two main approaches to wellbeing measure the extent to which physical and psychological needs are met, as well as

the realization of potential or the ability of a person to evolve and flourish (Hemingway 2011). The World Health Organisation (WHO) (2008) identifies several areas, which impact upon health and wellbeing, pregnancy and early childhood experience. A child's experience in its early life sets a foundation for the entire life course. A child's early physical, social, emotional and language development, strongly influences outcomes through life. The social determinants of health are the distribution among the population of social and economic conditions which impact upon a population's health and wellbeing such as local economy, culture, community and lifestyle (Barton and Grant, 2006). Daily living conditions, such as healthy physical environments, fair employment, social protection and access to health care has also been identified as having an impact on population health with distribution of power, money and resources being important (WHO, 2008).

In relation to the role of public health and midwifery, stress in pregnancy, poverty and exclusion have a particular impact on pregnancy which links to preterm delivery, low birth weight and higher rates of maternal mental health problems (Al-Saleh and Renzo 2009) all of which impact upon a child's early life experience. Where a woman lives, her employment status, her networks within a community and lifestyle and the demographics of people living in her population will have an effect on her health and that of her unborn baby.

For example, McCulloch (2001), in his study of social gradients and teenage pregnancy, illustrated that teenage pregnancy and teenage mothering show social gradients in the expected direction with high rates of pregnancy associated with high levels of deprivation. In another study, Spencer (2006), noted that women who had been in a manual working class social group at birth were more likely to be affected by other negative social gradient factors throughout the life course.

From these examples, the conclusion is drawn that it is not always one determinant that affects health outcomes. It is therefore vital that midwives work in partnership with other agencies as this is key to empowering and supporting women to enable good health and wellbeing. This may be through helping women to widen their social networks, manage finances or health promotion. In addition, it is important to have an awareness of the context of that individual or population's lives for example where they live, the economic situation and social support.

It is therefore important that good maternity services place the mother and her baby at the centre of care, and plan and provide services to meet their needs.

(Department of Health, 2004). The focus for midwives needs to be on the individual woman, whilst taking into account the context within which she lives her life.

Therefore consideration needs to be given to her health, her wellbeing and the factors that might affect them.

Midwives and their public health role

Pregnancy is a particularly vulnerable time when many outside factors can affect health and wellbeing. Midwives are experts in taking a holistic view of the woman and her baby, identifying pregnancy related health needs and referring to medical colleagues when required. Midwives support 'populations' of women or client groups whom have differing expectations and needs, for example pregnant teenagers or travelling communities. Midwives also care for groups of women who have particular health needs, for example mental health problems, where specific tailored care is required for that specific group

Despite evidence which links the importance of midwives in having a public health role (ICM, 2012), midwifery's dominant influence is the medical model of care, without an acknowledgment of the social context in which childbirth occurs (Kitzinger, 2005). The acknowledgement of public health strategies should be central to midwifery practice if midwives are to positively influence long-term health outcomes. However, Carlson (2005) points out that there are barriers to midwives recognising their contribution to public health, these barriers are professional and structural. The Nursing and Midwifery Council (2008) is clear that midwives should be actively encouraging women to think about their own health and the health of their babies and families, and how this can be improved as well as providing the traditional biomedical care.

As an example, the identification of domestic abuse is a key public health issue in which midwives are central. More than 30% of domestic abuse begins in pregnancy (CEMACH, 2007), having a significant impact upon the woman and her unborn baby's physical and emotional health. Caution should be exercised in looking at statistical evidence surrounding domestic abuse as it is evidenced to be under reported (WHO, 2004). However, this further illustrates a potential for midwives to fulfil their role as being key to identifying and supporting women where domestic abuse is present. Domestic abuse in pregnancy is defined as any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality (Walby and Allen, 2004).

Lazenbatt, (2010) examined how midwives perceive their role in raising the issue of domestic abuse with women. In a study of 448 midwives from different areas of practice they found that only 28% of midwives directly raised the issue of abuse with

a client. The presence of a partner was identified as a main barrier to routine questioning and this is supported by the evidence (Salmon et al, 2006 and Stennesson et al, 2001) and is a challenging barrier to overcome. Price et al (2007) also identified Midwives concerns around personal risk in domestic abuse situation's specifically as many Midwives are lone worker's. When questioning midwives about their perceived role in identifying domestic abuse Lazenbatt (2005) noted that confidence was a major factor in dealing with issues around addressing domestic abuse. Buck and Collins (2007) completed a systematic review of 13 studies examining midwives identification of domestic abuse and agreed that confidence was an issue for practitioners but also identified time being a factor in midwives ability to address domestic abuse. Historically midwives have found it difficult to identify child abuse or domestic abuse. However in a five year follow up of the Bristol Domestic Abuse Enquiry Programme, researchers noticed that midwives had begun to feel more confident in their ability to ask about abuse in the home as well as a statistically significant increase in self-reported knowledge on how to deal with disclosure of violence (Baird et al, 2013). This illustrates that with the instigated mandatory training throughout the UK, midwives are becoming more proficient at carrying out this vital public health enquiry and providing interventions to deal with disclosure. A Swedish study by Finnbogadottir and Dykes, (2012) looked to explore midwives awareness of a clinical experience regarding domestic abuse and supports the view that continuous education and professional support is vital.

Smoking cessation is another important area, where midwives can promote positive change. Smoking remains one of the few modifiable risk factors in pregnancy, however just over 12.7% of women still smoke in pregnancy in the UK (HSCIS,

2013). Herbert and Sykes (2012) noted that the perceptions of midwives who provide smoking cessation advice, related to the outcome of that advice, personal experience, and the relationship with the client and perception of their role.

Interestingly midwives were not noted to perceive smoking cessation support as a negative part of their role but often prioritised other areas due to the extent of their responsibilities. This is a common theme in research on midwives and public health, with prioritisation going to the biomedical aspects of the midwives role. It has been evidenced that the majority of midwives feel a professional responsibility to intervene with smokers but felt that there are often personal and organisation barriers to providing an effective service (Bull, 2007).

In addition, the recognition of perinatal mental health as a public health concern has been highlighted through the confidential enquires into maternal deaths, with findings that point to suicide or psychiatric causes as the leading cause of maternal death in the United Kingdom (RCOG, 2004). In a study by Lavender (2001), which assessed midwives attitudes into taking a greater public health role by looking at specific areas including postnatal depression, the researchers found that midwives felt that they could make 'a lot' of difference. However midwives did highlight the need for adequate training resources and time to implement changes. Jones et al (2010) agree in their study of 815 Australian Midwives perceived lack of competence as the main barrier rather than lack of interest.

In a study that examined midwives attitudes to assessing mental health problems in pregnancy, Ross-Davie et al (2006) used a survey, which was sent to 187 midwives working in inner London. Researchers wanted to answer the question "Are midwives ready for the development of their public health role in mental health"? They found positive attitudes among midwives in wanting to take on a more developed role.

Midwives responded that they felt screening for mental health problems should be part of their core role. As with findings in previous studies, midwives highlighted the need for increased education and training around identification and increasing confidence to support women. Midwives need to have an understanding of mental health conditions to be able to screen effectively, identify symptoms and be able to refer appropriately. In a further study by Ross-Davie et al (2007) following a training session for midwives, an improvement was noted in recording of mental health problems in the notes. This however was a service innovation and not performed as a research study so it is difficult to ascertain the reliability of results. However, this provides some assistance in promoting the need for further research into training and the provision of resources to assist midwives to realise their full potential in perinatal mental health screening.

These findings are mirrored in a study by McNeill (2012) who completed a systematic review of public health interventions in midwifery. They identified thirty-six systematic reviews that examined a diverse range of public health interventions. Its overarching finding was the identified gaps in knowledge around the impact of midwifery practice on public health outcomes. The review identified limited systematic evidence to support the implementation of midwifery interventions and highlighted the difficulty in measuring impact due to some interventions not being well evaluated. Throughout the research, similar themes can be noted which include lack or perceived lack of knowledge, confidence in delivering public health strategies and the research focus on the biomedical element of midwifery practice, with limited research on midwives delivering public health strategies. Studies, which explore midwives preparation for their public health role, are relatively limited. Mcneill et al (2012b) using mixed methods examined the public health education in pre-

registration midwifery finding it generally was not taught as a separate subject but combined with other aspects of the course. This is an important point for if midwives are to address the public health agenda and improve outcomes; it is vital that they are equipped with the theoretical knowledge at the start of their career to proceed.

Conclusion

Both research and policy points to public health having a greater prominence in the midwifery agenda. Although historically midwives have always provided public health interventions, particularly health promotion, it has not always been recognised that they are pivotal public health practitioners. The evidence concludes that research is still scarce on midwives and public health, particularly around midwives and their perceptions of their public health role. However the available research shows that midwives are increasingly engaging with the public health agenda. Barriers have been identified and midwives themselves note that delivering public health strategies are difficult due to constraints on time and resources as well as training and education around public health agenda's.

To be effective, public health practitioners and midwives need to be able to work in collaboration with other agencies such as social care and voluntary services.

Commissioners and managers need to consider the evidence for specialist midwives who focus on the health of the local community and who would enable targeted action for vulnerable groups. Educational establishments need to ensure that public health is high on the agenda for midwifery student's education so that they have the tools and knowledge to see themselves as pivotal public health practitioners.

Midwives are in a unique position to support women to make healthy choices in order to prevent ill health and promote health in line with the increasing recognition of the importance of maximising health for infants and children at the start of their

lives. Midwives provide a range of public health interventions on a regular basis, but do not always place this intervention in the public health context, considering the long-term wellbeing of maternal and infant health. Midwives, managers and public health authorities all need to take responsibility for midwives to become a more pivotal part of the public health team.

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