Discover Public Health

PERSPECTIVE Open Access

The evolving relationship between public health and midwifery in the United Kingdom

Bethany Fletcher[1], Jillian C. M. Ireland[1,2] and Edwin van Teijlingen[2*]

*Correspondence:
Edwin van Teijlingen
evteijlingen@bournemouth.ac.uk
[1]University Hospitals Dorset NHS Foundation Trust, Bournemouth, UK
[2]Centre for Midwifery & Women's Health, Bournemouth University, Bournemouth BH8 8GP, UK

Abstract
Readers will agree that public health and health promotion are the responsibility of everybody, not just those working in the field of public health. For this reason, health promotion and disease prevention have long been part of the midwife's role. However, in several countries, such as the United Kingdom, the role and responsibilities of the midwife have expanded over the decades to incorporate additional public health issues. Many of these new public health tasks may require a lot of training and education of, and adaptation by, midwives. Given, the worldwide shortage of midwives, this increase in responsibilities may challenge midwives' fulfilling their more traditional task of providing midwifery and maternity care. This raises the question whether midwifery and public health can find the balance between being perfect partners and unhappy bedfellows. There has been an increase in specialised midwifery posts related to public health topics. This commentary article highlighted problems and concerns that have arisen, including alternatives and related opportunities. Midwifery is a unique profession; we should be careful not to add too many roles and tasks which potentially detract from core midwifery practices, without considering the implications of this on staff's workload, and consequently on maternity service users.

Keywords Specialist midwives, Public health, Health promotion, Workload, Health promotion

1 Background

Public Health, 'the art and science of preventing disease, prolonging life and promoting health through the organised efforts of society' [1] has long been part of the role of the midwife or nurse/midwife. Examples of public health promoted by midwives recently published in *Discover Public Health* range from breastfeeding in Ghana [2], to reducing maternal mortality in India [3] and to relaxing the one-child policy in China [4]. Public health is central to working as a midwife, since midwives generally work with healthy people and babies [5]. However, in the United Kingdom (UK) many specific aspects of public health have been added to the role of the midwife over the past decades. Public health was originally: (a) secondary to 'hands on' midwifery care; and (b) focusing on individual pregnant people, not the wider population. For example, six decades ago the

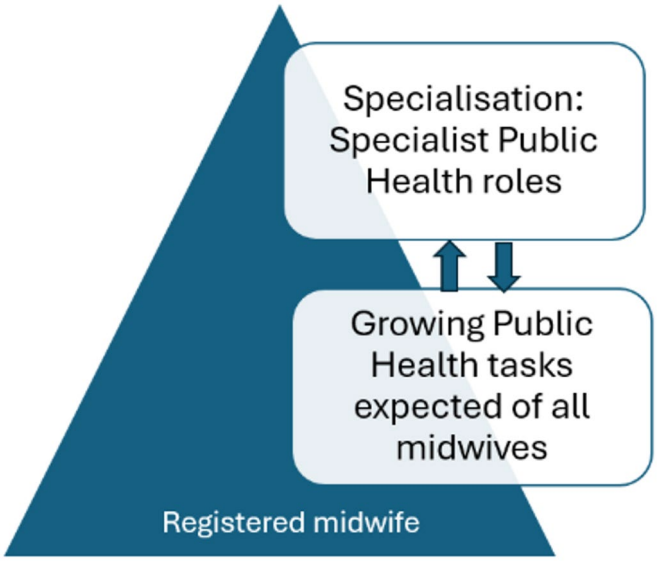

Fig. 1 Public health in midwifery: generic versus specialised

UK's key textbook *A Textbook for Midwives* had just one public health chapter (out of 41 chapters) 'Advice to the Pregnant Woman', which included that they should be advised to spend two hours a day in the fresh air; wear sensible shoes and alcohol should be strictly limited [6].

Since the late 1990 s, the public health focus of midwifery has become a central part of UK government policy (see Fig. 1). The public health role of the midwife was mentioned in several key government documents at the time, and it was clearly seen as core to the work that midwives do. However, a 2017 report produced by the Royal College of Midwives (RCM) [7], and funded by the government, found that midwives did not have sufficient time, confidence and training to discuss public health with maternity-service users, to ensure consistency of information and follow up support with consistency of care in conjunction with the multidisciplinary team. Since then, midwifery's extended public health and advocacy roles have been highlighted in key policy documents [8], whilst a 2024 regional UK study evaluating Public Health Prevention in Maternity noted similar problems, including workforce capacity e.g., staffing pressures, staff engagement with training, and time constraints within appointments [9].

2 Public health in midwifery

Addressing health inequalities means that provision of public health does not 'merely' mean giving advice on lifestyle and enrolling participants in various individual public health interventions. Since government policy aims to reduce health inequalities that underlie the disadvantaged lives and lifestyles of some people, the health promoting advice model advocated by Myles [6], in her day, is no longer sufficient for the needs of the childbearing population in the 21 st century.

The rapidly growing public health role of the UK midwife means that midwives now have surveillance and assessment tasks in the care they offer throughout the childbirth continuum. These include 'safeguarding'; 'domestic abuse'; 'alcohol use'; 'tobacco use'; 'drug misuse'; 'physical activity'; 'mental health', and 'obesity'. A straw poll conducted by the first two authors (both registered UK midwives) of six midwifery colleagues based in

Scotland and England combined with an analysis of the public health content of the risk assessment questions used for booking in a pregnant person suggests that public health makes up between 16% to over half of all questions. In our opinion, the proportion recognised as public health depends on: (a) the training and experience of the midwife; (b) what one includes in the definition of public health; and (c) the answers given to the questions. For example, if someone reports consuming alcohol in pregnancy, several follow-up questions automatically appear on the electronic booking form. Moreover, if any of these lifestyle factors are found to be below what is recommended (e.g. exercise) or above (e.g. smoking), the midwife is encouraged to introduce an appropriate short-term intervention or refer the pregnant person to an appropriate specialist.

New specialist midwifery roles (see Fig. 1) have been developed over the past two decades creating new jobs including: teenage pregnancy midwife, safeguarding midwife, breastfeeding-support midwife, asthma midwife, scanning midwife, digital midwife, mental health midwife, 'Sure Start' midwife, screening midwife, diet and exercise midwife, and smoking cessation midwife. Such specialist midwife roles are included in the RCM's 2017 document, *Stepping up to Public Health* [7].

The increase in public health responsibilities can have unintended consequences: (a) midwives have less capacity to provide clinical care to pregnant people; (b) they introduce an extra element of surveillance on lifestyle factors which might harm the trust and relationship between the client/service user and her midwife; (c) midwives might lack the confidence and/or communication skills to deal with the more difficult ethical and cultural issues around, for example, antenatal screening, drug misuse, smoking cessation; (d) midwives might also be keen to sign up for the specialist roles as a solution to frustration with the generic role, rather than from a particular interest in public health issues. A change of role might of course stop midwives from leaving the profession of midwifery and/or experiencing burn-out and stress, but (e) midwives may leave their clinical job as they do not see public health as central an element to their post as policy-makers do; and (f) clinical midwives perception of specialist midwives as not 'pulling their weight' as they are not visible in clinical area. It could be argued that midwives should not be burdened with too many additional roles, since extra public health tasks may devalue midwifery clinical practice and reduce the focus on the core elements of what a midwife does in terms of perinatal care and support for the wider family. Instead, some would argue that midwives focus more on supporting women through pregnancy, labour and in the postpartum period,

3 Midwifery versus public health perspective?

Many midwives work on the principle of 'taking people as they are' without making 'moral' judgements about them, their lives or their families. Some regard this non-judgemental approach as an essential element in midwifery [10, 11]. This non-judgemental and accepting approach which includes the midwife's respect for a woman's autonomy, culture, personal safety, etc., may make it more difficult to discuss sensitive issues such as obesity, smoking and alcohol use. Conflict arising from a potential dissonance in philosophy and expanding the role of the midwife at a time of a serious shortage of midwives, with its associated workload pressures and time constraints is a threat to retention.

There is evidence from other health professionals whose job contains a substantial public health element, for example health visitors, practice nurses, pharmacists and

family doctors, that giving health promotion advice and/or interventions to patients who come to them with a self-identified problem or symptom—usually medical in nature, is challenging [12]. Introducing non-clinical issues in a consultation can perhaps also work against the approach of partnership—working with the pregnant person—especially when maternity service users do not consider anything wrong in their lifestyle or wishes to keep it private. An example of the latter was found in a study of low-income Californians using alcohol and drugs [13]. Most study participants did not mind alcohol screening, but many were averse to drug screening. They reported that they were worried that identification of drug usage may have psychological, social, and legal consequences as well as feeling that their care providers would be judgmental and be required to report them to Child Protective Services [13]. The risk is that people who do not want to be identified avoid the kind of care where they will be subjected to mandatory testing [13, 14] and/or do not tell the truth if screening is based on verbal disclosure [15].

4 The specialist public health midwife

Creating the post of a specialist midwife has the potential to increase the amount of time available to other midwives and maternity support workers to give more public health messages during routine appointments. Employing specialists means that the people most in need and/or most likely to benefit from tailored behavioural support can be given the input that would be impossible to offer in routine appointments. Specialist midwives bring both expertise and coordination to a range of public health issues from the use of alcohol or tobacco to domestic abuse and poverty.

Take for example, quitting smoking; for over two decades there has been pressure on both pregnant people and midwives to reduce smoking prevalence [16]. However, many maternity-service users are left feeling unable to meet the standards set and experience a high degree of guilt, which again can act as a barrier to speaking to their midwife [17]. Whilst Condliffe and colleagues (2005) noted that although midwives considered themselves to have role in smoking cessation, this did not translate into practice [18]. We know from tobacco research that in anti-smoking environments people are more likely to underreport their smoking [17, 19]. Also, the way in which the smoking question is posed may affect the relationship between a pregnant person and her midwife [20], as poorly asked questions can become a barrier to good partnerships. The UK recommends in-house smoking cessation support with a combination of Nicotine Replacement Therapy (NRT) and behavioural support over a 12-week programme, with a minimum of weekly appointments for the first four weeks. Targeted motivational interviewing and behavioural change from a skilled practitioner increases quit rate success by up to three times, in comparison to trying to quit alone [21]. However, tobacco advisor training is costly and training all midwives is often not feasible, with the further repercussion of reduced time to spend on antenatal care of the individual.

One of the problems is that policymakers, researchers, the media, and single-issue campaigners often call for their topic to be a priority in midwifery care, be it alcohol, obesity, tobacco, or stress. Thus, we regularly see conclusions in the literature with suggestions that midwives need to prioritise screening for condition A, or start advising people on public health problem B. It is often forgotten that there will be costs in midwives advocating for lifestyle changes (e.g. diet and exercise) in pregnancy and their wider families. In other words, if midwives have to spend more time providing health

promotion advice on risk factor 'A' which may prevent them from fulfilling their clinical midwifery role, or from spending enough time on improving lifestyle factor 'B'. As Buck and Collins concluded, "having to screen for domestic violence in a clinical appointment that is already full is often considered onerous" [22], and may not always be effective [23].

There is also an assumption that pregnancy is a time when people are very likely to 'make a fresh start' in terms of their own and their family's health. It is unclear how accurate this perception is, or whether changes made in pregnancy are sustained. Behavioural scientists are convinced that people (here 'midwives') are more likely to do things or do them 'well' if they believe their action is going to be effective and worthwhile [24], the equivalent of the placebo effect in clinical care. We know that it is unlikely that midwives (or other health staff) are able to make much difference in people's lifestyles, and as found in Lavender and colleagues' study, the majority of midwives did not believe their interventions made a significant difference, with the exception of advice on postnatal depression, diet and contraception [25].

5 Final thoughts

Both midwifery and public health are wide-ranging disciplines. Midwives are generalists, expert in normal birth, whilst public health is in its nature truly interdisciplinary [26] hence the two disciplines seem to be well matched. In the UK the typical approach is for the generalist midwife to cover generic public health issues, with specialist midwives to address specific or more serious public health and/or social problems. On the one hand, delivering public health is a key task for all midwives as part of the 'day job' of providing maternity care, and yet, many maternity services have appointed dedicated specialised public health midwives. The latter brings professional development and new career opportunities for individual midwives. However, the mixed message of (a) 'public health is every midwife's business' whilst at the same time promoting (b) 'specialist public health midwives' may affect midwives' professional identity [27]. Perhaps more importantly, it can also lead to confusion, not just for the general public, but also for midwives.

We warn against the continual adding of tasks to the midwife's role. There are costs, in terms of individual public health topics competing with each other as well as in terms of workload of a profession already suffering from staff shortages in the UK and internationally. Equally, if maternity services allocate specific tasks to specialist midwives, non-specialist midwives are far more likely refer maternity-service users with public health issues to the specialist public health midwives becoming less skilled in the process.

Acknowledgements
Thank you to Professor Emerita Kath Ryan (New Zealand) for comments on an earlier draft.

Author contributions
BF, JI and EvT wrote the main manuscript and all authors reviewed the final resubmitted version.

Funding
This project received no funding.

Data availability
No datasets were generated or analysed during the current study.

Declarations

Ethics approval and consent to participate
No individuals participated in this commentary and discussion other than the authors.

Consent for publication
All three authors consent to publication.

Competing interests
The authors declare no competing interests.

Received: 6 February 2026 / Accepted: 4 August 2026
Published online: 19 August 2026

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