Public Health and Midwifery Education – Scoping Project

Final Report

May 2011

School of Nursing & Midwifery
Queen’s University Belfast
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Section 1

Executive Summary

Introduction
This scoping exercise was undertaken following previous work around public health and midwifery for Midwifery 2020. The project was commissioned by NHS Education for Scotland and Queen’s University of Belfast were successful in the acquisition of the tender. The focus of the scoping exercise was to review the current provision of midwifery education (pre and post registration) in relation to public health and inequalities.

Background
Current national and international maternity care policy has very clear health promotion and public health principles. Wider policy on health inequalities throughout the life course also support the importance of investing in early years (WHO 2008; Marmot Review 2010). The overarching aim of these policies and programme is to maximise the health of infants and children at the start of life and to identify how midwives can potentially contribute thus placing midwives at the centre of public health policy. Evidence based pre and postnatal interventions that reduce adverse outcomes and promote well-being in pregnancy and infancy are needed to achieve these policy objectives. In order to achieve policy objectives it is essential to ascertain where midwives can effectively make a difference based on existing evidence and secondly evaluate current provision of midwifery education in this area. A systematic review was undertaken to consider evidence to support interventions with a public health outcome that were within a midwifery role (McNeill et al. 2010) which indicated that while there was evidence to support some interventions, the public health role of the midwife was not well articulated. Key aspects of the public health role of the midwife have not been examined extensively in the literature and it has been suggested that as midwifery is
dominated by a medical model of care, the social context of reproduction has received less focus (McKay 2008; Kitzinger 2005; Downe 2004). The medicalised model of health promotion may be easy to lift into midwifery education however the consequence of this introducing this model unadapted is that midwives may be delivering health education or health promotion messages without due consideration how it fits with the overarching concept of public health as an integral part of the core role of midwifery. In order to maximise the role of the midwife in relation to public health and inequalities it is necessary to consider the preparatory educational process to identify strengths and any potential limitations. As this information was not currently available within published literature, a review of current midwifery education (pre and post registration) on public health and inequalities, taking into account the perspective of midwives and midwifery students was commissioned. The project was led by NHS Education however encompassed a UK four country approach.

**Objectives**

1. To provide baseline data regarding current educational provision for midwives on public health and inequalities and
2. To identify gaps in educational provision that could be addressed through the development and co-ordination of educational solutions.

**Methodology**

The project comprised of two separate phases: an initial survey of all Higher Education Institutions (HEI’s) providing either pre or post registration midwifery education in the UK and a second phase which involved conducting focus groups with midwifery students and midwives across the UK. Phase 1 included the construction of two separate surveys; one for pre registration education and the second for post registration education which could be completed online, manually or over the telephone with a researcher. A pilot of both surveys was conducted prior to commencing. The surveys were distributed to 58 HEI’s across the UK of whom 31 responded (53%). Phase 2 involved conducting a series
of 9 focus groups across the UK with 59 midwives and midwifery students to facilitate discussion around midwifery education on public health and inequalities and subsequent translation into practice.

**Summary of Key Findings**

Survey findings from Phase 1 indicated the majority of recognised public health topics were included in pre registration education and public health was generally embedded rather than explicit in curricula. There was some diversity evident in relation to region or local need and the actual proportion of time allocated to teaching specific subjects. Current public health topics such as obesity were not well covered. Post registration was difficult to capture comprehensively however it was evident that a large proportion of education related to public health and midwifery, which although accessible to midwives, was often external to schools of nursing and midwifery. The range of subject areas and modules were diverse although very few explicitly referred to public health or inequalities in the title.

Three main categories were evident from the focus groups conducted with midwifery students across the UK. These included the role of public health within midwifery; discussing public health issues in practice; understanding public health and education. Findings from the focus groups with registered midwives yielded three key categories including the public health role of the midwife, clinical practice, and education.

**Conclusions**

Synthesis of the findings from Phase 1 and Phase 2 resulted in three key areas which should be considered carefully prior to the development of any future work around midwifery, public health and inequalities. They included promotion of a better understanding the role of public health and inequalities in midwifery; increasing the visibility of public health and inequalities in midwifery and the direction of public health education in midwifery.
Section 2

Project Team
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This report was commissioned by NHS Education for Scotland
Section 3

Background

The Marmot review (2010), a strategic review of health inequalities in England post 2010, highlighted as its primary objective that every child should have the best start to life. This has been echoed in recent policy from Scotland (Improving Maternal and Infant Nutrition 2011; Refreshed Framework for Maternity Services 2011; Vulnerable Families Pathway Project 2010, Getting It Right for Every Child Programme http://www.scotland.gov.uk/Topics/People/YoungPeople/childrensservices/girfec/progr amme-overview). The overarching aim of these policies and programmes recognises the importance of maximising health for infants and children at the start of life and how midwives can potentially contribute, therefore placing midwifery at the centre of public health policy. Current national and international maternity care policy has very clear health promotion and public health principles. The World Health Organisation (WHO) Making Pregnancy Safer initiative aims to enable women, their families and communities to increase control over, and to improve, their health and quality of life (WHO, 2010) and wider policy on health inequalities throughout the life course also supports the importance of investing in early years (WHO, 2008). Evidence based pre and postnatal interventions that reduce adverse outcomes and promote well-being in pregnancy and infancy are needed to achieve these policy objectives with consideration given to the everyday role of the midwife that will effectively impact on public health. Key aspects of the public health role of the midwife have not been examined extensively in the literature and it has been suggested that as midwifery is dominated by medical model of care the social context of reproduction has received less focus (McKay 2008; Kitzinger 2005; Downe 2004) and therefore follows a medicalised model of health promotion. The consequence of this introducing this model unadapted is that midwives may be delivering health education or health promotion messages without due consideration of how it fits with the overarching concept of public health as an integral
part of the core role of midwifery. An important aspect of improving evidence based public health led midwifery practice relates to the provision of education on public health and inequalities for midwives and midwifery students. In order to maximise the role of the midwife in relation to public health and inequalities it is necessary to consider the preparatory educational process to identify strengths and any potential limitations.

The provision of midwifery education in the UK is diverse ranging from Higher Education Institutions (HEI’s) to Provider Support Units which are linked to specific NHS Trusts or Authorities and may also include education study days or courses arranged by professional organisations such as the Royal College of Midwives (RCM). Pre registration education is regulated by the Nursing & Midwifery Council (NMC) and all HEI’s must have a designated Lead Midwife for Education (LME). A publically available database of all providing institutions and LME’s is available on their website (http://www.nmc-uk.org). Post registration education is not regulated in the same manner and therefore is more difficult to capture in its totality. Often Schools of Nursing and Midwifery are located within a Faculty or department housing many disciplines which may share modules on post registration or post graduate pathways. In addition, not all post registration or post graduate is linked to midwifery in name for e.g. Master’s level study in advanced or professional practice is common. The education provided by NHS linked training units is often specific to local need which varies significantly across the UK. The diverse sources and nature of education related to public health and inequalities means that the content and level of education available to midwives in this field has been largely unexplored in a systematic way.

This project evolved from the recent review of midwifery practice across the UK referred to as Midwifery 2020. Midwifery 2020 (www.midwifery2020.org) was a collaborative programme initiated by the Department of Health with representatives from each of the
four countries across the UK and input from the Royal Colleges and NMC. The aim was to review all aspects of midwifery practice including education, provision of services, career pathways and developing capacity and capability with regard to research based practice. Within the review there were 5 main work streams: Public Health; Measuring Quality; Education and career progression; Workforce and workload; Core role of the midwife. The current project team worked directly with the Public Health work stream previously and conducted a systematic review of systematic reviews in relation to the public health role of the midwife (McNeill et al. 2010). This systematic review of reviews identified many opportunities for midwives to impact on public health outcomes as they care for women and their families throughout pregnancy and the postnatal period. Midwives are the primary health professionals who can initiate and drive forward parenting education and effective antenatal and postnatal care into the next decade. However the impact of everyday midwifery practice on longer term, holistic maternal and family well-being outcomes is poorly articulated in review literature. From systematic review evidence it was clear that although there was some evidence to support midwifery interventions with a potential public health impact there were many areas which could be further developed. The discussion of findings concluded that a possible contributing factor was the perspective of midwives in relation to public health; ie much of what midwives do is not often labelled as such and yet the concept is intrinsic to midwifery practice. This served as a stimulus for further work and an invitation to tender was issued by NES Education for Scotland to undertake a scoping project in relation to public health education and inequalities provision and midwifery perspectives around this subject area. Queen’s University Belfast successfully secured the tender.
Section 4

Methodology

Project aim: to provide baseline data regarding current educational provision on public health and inequalities for midwives and identify gaps in provision which may ultimately be addressed through the development and co-ordination of educational solutions.

Objectives:
1. To outline the current provision of public health and inequalities education available for pre registration/post registration midwives
2. To identify gaps in the current provision of public health and inequalities education available for pre registration/post registration midwives
3. To outline the perspective of midwives and midwifery students on the current public health educational needs for midwives to support the core public health roles as outlined by Midwifery 2020
4. To outline the perspective of midwives and midwifery students in relation to the role of the midwifery workforce with respect to public health and inequalities

Ethical Approval

Prior to commencing data collection ethical approval was sought from the School of Nursing & Midwifery, Queen’s University Belfast Ethics Committee (SREC) and approval was issued January 13th 2011 (Application number 0712010).

Advisory Group

A UK wide Advisory Group was established from the outset of the project and served to provide expert guidance and advice on all aspects of the project, particularly the development of the data collection tools. The project team communicated with the
Advisory Group via email, conference call and two face to face meetings. The meetings were held in Belfast at developmental and conclusive stages of the project.

Methodology

The project comprised of two separate phases: an initial survey of all Higher Education Institutions (HEI’s) providing either pre or post registration midwifery education in the UK and the second phase involved conducting focus groups with midwifery students and midwives across the UK. Phase 1 included the construction of two separate surveys; one for pre registration education and the second for post registration. A pilot of both survey was conducted which has generated helpful feedback and necessitated some revisions.

Phase 1: Survey of UK HEI’s

The aim of Phase 1 was to survey all HEI’s to ascertain the current provision of education for midwives in relation to public health and inequalities on pre registration and post registration programmes. The Higher Education Statistics Office was contacted to identify all institutions offering midwifery programmes in the UK and the web pages of all HEI’S in the UK were searched to identify programmes offered, in order to secure a potential sample list. In addition this was cross checked with the NMC Register of ‘Lead Midwife for Education’ database which is available on the NMC website to ensure there were no omissions. The final list available from HESA totalled 59. One additional institution was identified through searching of HEI web pages. Of the 60 institutions the majority offered both pre and post registration education for midwives.

An invitation pack including a letter of invitation, an information leaflet, a consent form and a copy of both surveys was posted to all identified institutions (n=60). The participants had the option of completing the survey manually and returning in a pre paid envelope, completing it over the telephone with a member of the research team or completing it online via survey monkey. Approximately one-two weeks after institutions
had received the invitation pack, a follow up telephone call or email was conducted to ensure all had received the correct information and to answer any questions. Further email and telephone follow up occurred where necessary in order to maximise the response. To further enhance the response rate, the team offered to complete the survey on the LME’s behalf by accessing the institutions’ curriculum documents. Some institutions preferred this option and once the team member completed the survey it was sent to the relevant person for approval in the institution before submitting the data for analysis. All data were entered into MS Excel for analysis.

**Phase 2: Focus Groups**

The aim of Phase 2 was to conduct eight focus groups across England, Scotland, NI and Wales with midwives (n=4) and midwifery students (n=4) to ascertain their perspective on how education around public health and inequalities relates to practice and service delivery. The samples for the focus groups were recruited from the Royal College of Midwives and the related institutions of Advisory Group members. The RCM facilitate regular meetings within each Board (England, NI, Scotland and Wales) including for example Clinical Leads, Heads of Midwifery (academic and clinical), Consultant Midwives, and Supervisors of Midwives). The membership of each group varies slightly depending on local positions however generally there is representation from all aspects of midwifery. The RCM offices in London, Scotland, Wales and NI were contacted to arrange the focus groups and distributed the email invitation. Those interested in participating were asked to respond to the project team directly. The Lead Midwife for Education in each of the associated institutions was contacted to introduce the study and invite midwifery students to participate. The necessary ethical approval requirements in each participating institution were met. Consent forms were completed by all participants and a copies retained by the project team and individuals for their own records. All focus groups were recorded and transcribed into MS Word to facilitate analysis.
Section 5

Results

Phase 1

The letters of invitation were distributed in January 2011 and the final response to the survey received in April 2011. Sixty institutions were identified which offered pre or post registration midwifery education (or both) and invitation packs were distributed across the UK as follows: England 46, NI 2, Scotland 8 and Wales 4. Of the sixty institutions identified two replied to indicate they no longer offered midwifery education leaving the total number of eligible institutions as fifty eight. A total of 31 (both pre registration and post registration) institutions responded overall (53%) to the study, of whom 25 were in England, 4 in Scotland, 1 in Wales and 2 in NI and all were included in the study.

Respondents were given one month to complete the survey however responses were slow and several email and/or telephone reminders were required. Participants responded in a variety of methods; using the online survey, completing over the telephone or on a hard copy and returning via post. The majority of respondents replied via post. Some institutions (n=5) indicated they were unable to complete the survey due to time commitments and returned their curriculum document(s) which enabled a member of the project team to retrieve the required data for the survey. In such cases the completed survey was returned to the institution for verification that the information was correct.

Pre Registration

Fifty five institutions offered pre registration midwifery education; of these 29 institutions responded (53%) in relation to pre registration midwifery education regarding one or both of 3 year pre registration midwifery or 18mth shortened pre registration midwifery education (37 programmes in total). Figure 1 illustrates the programmes offered by duration. Of the 29 institutions that responded: 23 were in
England, 1 in NI, 3 in Scotland and 2 in Wales. Institutions reported that public health (PH) and inequalities (I) were offered as either as integrated into the programme (PH=14, I=20), as specific modules (PH= 2, I=2) or both (PH=21, I=15).

**Figure 1: Duration of Pre Registration Programmes Offered by Institutions**

![Bar chart showing the number of institutions offering different durations of pre-registration programmes.](chart.png)

The survey asked respondents to state how explicit (direct reference) the inclusion of public health and inequalities was in their curriculum philosophy or programme and module aims/objectives. The results are presented below in Figure 2. Examples of where public health was referred to explicitly in the curriculum philosophy included ‘the role of the midwife in the promotion of public health and normality in childbirth will be key to the curriculum’ and ‘throughout each unit of study, the three major themes, public health, professional practice and research methodology are interwoven’. Examples of where inequalities were referred to explicitly in the curriculum philosophy included ‘to demonstrate clinical effectiveness by making a difference to reduce health inequalities’. 
Specific Public Health and Inequalities Teaching

Respondents were invited to select from a list of pre defined topics on public health and inequalities and indicate whether they were included in their provision of pre registration education for and if so; some further details regarding modules and allocated time, the results of which are included in Table 1. It is interesting to note that there were only 2 topic areas which were included in all responses; health education and breast feeding/infant nutrition. Subject areas which were not included by at least 20% of respondents are illustrated in Figure 3. Some of these are surprising given the current level of interest in these areas, for example obesity.
### Table 1: Pre Registration Public Health and Inequalities Subject Areas

Key: I=integrated, SP=Specific module, NI=not included, *paper responses only, **range excludes 1 institution which offered 140 hours

<table>
<thead>
<tr>
<th>Subject Area</th>
<th>Method of inclusion</th>
<th>Length of time of session(s) (range in hours)</th>
<th>Example(s) of module title where included (eg of integrated module title followed by eg of specific module title)</th>
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<tr>
<td>Principles of PH</td>
<td>I 24 SP 11 NI 3</td>
<td>2-10</td>
<td>Foundations of Midwifery Practice/Public Health and the Challenges for Midwives</td>
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<td>Health &amp; Social Care Policy</td>
<td>31 5 2</td>
<td>2-6</td>
<td>Foundations of Midwifery Practice/Health promotion &amp; the midwife</td>
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<td>Epidemiology</td>
<td>26 3 5</td>
<td>1.5-6</td>
<td>Psychological &amp; sociological perspectives of professional midwifery practice/public health aspects of midwifery practice</td>
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<tr>
<td>Subst Misuse</td>
<td>30 4 1</td>
<td>1.5-11</td>
<td>Developing Midwifery Practice/Diversities and inequalities in health</td>
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<tr>
<td>Smoking</td>
<td>30 3 3</td>
<td>1-6</td>
<td>Health and psychosocial aspects of maternity care/Diversities and inequalities in health</td>
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<tr>
<td>Obesity/Wgt Management</td>
<td>25 2 8</td>
<td>1-6</td>
<td>Promoting normality for women with complex needs/Challenges of midwifery practice</td>
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<td>Maternal Nutrition</td>
<td>31 0 4</td>
<td>1.5-3</td>
<td>Foundations in Midwifery Practice</td>
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<tr>
<td>Health Promotion</td>
<td>29 8 1</td>
<td>1.5-4</td>
<td>Introduction to the Delivery of Professional Midwifery Practice/Public Health and the Challenges for Midwives</td>
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<td>1.5-4</td>
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<td>Blood Borne Viruses</td>
<td>31 2 3</td>
<td>1-4</td>
<td>Antenatal challenges/public health aspects of midwifery practice</td>
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<td>Domestic Viol</td>
<td>33 2 1</td>
<td>2-6</td>
<td>Diversity in lifestyles and inequalities in health/public health aspects of midwifery practice</td>
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<td>Homelessness</td>
<td>19 0 15</td>
<td>1.5-3</td>
<td>Skills for case load working</td>
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<tr>
<td>Ethnic Minority etc</td>
<td>25 3 8</td>
<td>1.5-4</td>
<td>Skills for case load working/Diversities in lifestyles and inequalities in health</td>
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<td>1-6</td>
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<td>Travellers</td>
<td>21 0 13</td>
<td>1.5-3</td>
<td>Art &amp; science of AN and IN Care; Art &amp; science of PN and NN care</td>
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<td>Parent support initiatives</td>
<td>29 3 4</td>
<td>1-6</td>
<td>Adaptation and Care in Childbirth/Transition to parenthood</td>
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<td>BF/Infant nutrition</td>
<td>32 5 0</td>
<td>3-16.5**</td>
<td>An Introduction to Practice Knowledge and Skills in Midwifery/Infant feeding</td>
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<td>Teenage Pregnancy</td>
<td>28 4 3</td>
<td>1-6</td>
<td>Health and society/public health aspects of midwifery practice</td>
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<td>Sexual health</td>
<td>28 4 3</td>
<td>2-10</td>
<td>Developing Midwifery Practice/Reproductive and Sexual Health</td>
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<td>1-6</td>
<td>Society and health/midwifery &amp; sexual health</td>
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<td>Antenatal neonatal and reproductive health/complicated childbirth</td>
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<td>Perinatal mental health</td>
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<td>1.5-14</td>
<td>The context of contemporary MW practice/Promoting maternal mental health</td>
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<td>Child protection</td>
<td>34 2 0</td>
<td>1-6</td>
<td>Skills for Case Load working/PH &amp; Midwifery</td>
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<td>Optimising Birth*</td>
<td>18 3 0</td>
<td>2.5-7</td>
<td>Keeping Childbirth Normal &amp; Dynamic/Childbirth &amp; Health/Principles of MW Care/Needs Assessment &amp; Care Planning</td>
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**Figure 3:** Specific Public Health and Inequality Subject Areas *not offered* by Pre Registration Programmes
Pre Registration Curriculum Gap and Limitations

Public Health
Respondents were asked to identify any gaps or limitations in the current pre registration provision of public health education for midwives; 25 respondents reported there were no gaps, 6 respondents reported they felt there were gaps; and 6 did not respond (including responses completed by a project team member form curriculum documents). Gaps and limitations identified included recognition that, although public health was explicit in institutional programmes, explicit consideration of inequalities was not. It was also reported that more time was needed to explore theoretical models in order to support application to practice. Respondents who reported that gaps existed were asked to comment. Some of the comments are included below.

“Although obesity is covered throughout the programme/integrated in different modules, this topic could be afforded dedicated time”

“The issue of obesity needs a clearer focus in our curriculum”

“In this curriculum the needs of women with mental health issues has been merged with childbirth and medical issues. More input regarding the needs to travellers, trafficked women”

Some respondents who reported that they felt there were no gaps in the curriculum also commented that the public health elements of their undergraduate curricula depended on good links with practice. They also noted the need for the curriculum to be regularly revisited in order to ensure relevance:

“In addition to the above explicit content from the curriculum, students are exposed to greater learning in the area of public health within practice
based modules. That said this curriculum if now 5 years old and although we have ensured it remains current there is a need to further develop its content to ensure some of the current needs are more explicit”

“I believe that we have addressed these in the new curriculum and the arrangements for placements, however I hope that the links that we have developed in relation to the placements with other professionals outside of the NHS will not be affected by changes in staff leading to breaking the communication links and the excellent joined up working that can be achieved”

Inequalities
Respondents were asked to identify any gaps or limitations in the current pre registration provision of inequalities education for midwives; 28 reported none, 5 respondents reported they felt there were gaps; and 4 did not respond. Comments from those who said yes to gaps or limitations included:

“Public health is explicit, but inequalities are not, this exercise has helped me to see that and we need to review how we approach inequalities”

“Travellers not included currently”

“We need more time to cover theory on the models to back up the application to practice”

Respondents were asked how they thought the current provision of education on public health and inequalities could be improved and a significant proportion of answers referred to the need for theory to be consolidated with practice:
“A dedicated module with key topics could raise the profile of public health in midwifery practice”

“I believe that what we have planned is going a long way towards getting it right – but much will depend on other professions being open to (midwifery) students’ observational placements. If the course was longer the students could undertake a period of voluntary work (e.g. assisting in a smoking cessation project) to develop this area of their knowledge & practice........or assisting in a mother and baby group and undertaking antenatal education in a deprived area”

“Closer links with public health specialists and more input from midwives who are taking initiative forward”

“Public health and inequalities should both be given a higher profile within theory and practice. The possible inclusion of specific placements, greater emphasis on inter-professional learning and explicit learning outcomes for each area (would help)”

Clinical Placements
Respondents were asked about the nature of clinical placements and whether these had a specific focus on public health and or inequalities. The results are presented in Figure 4. Respondents were also asked to provide further detail on the nature and assessment of clinical placements as presented in Table 2.
Figure 4: Clinical Placements with a Specific Focus on Public Health or Inequalities

Table 2: Details of Clinical Placements on Public Health/Inequalities

<table>
<thead>
<tr>
<th></th>
<th>Public Health</th>
<th>Inequalities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Type of placement (if included)</td>
<td>Community midwifery</td>
<td>Visits to voluntary organisations</td>
</tr>
<tr>
<td></td>
<td>SureStart</td>
<td>Inner city community placements</td>
</tr>
<tr>
<td></td>
<td>Family Nurse Placement</td>
<td>Care of vulnerable groups</td>
</tr>
<tr>
<td>Length of placement (range)</td>
<td>1-12 wks</td>
<td>1-12wks</td>
</tr>
<tr>
<td>Assessment type</td>
<td>Poster, practice assessments, assignments, viva voce, OSCE</td>
<td></td>
</tr>
</tbody>
</table>

*3 institutions did not respond to this question for both public health and inequalities
One university provided an example where students were facilitated to undertake public health focused placements within generic clinical placements:

“all students have the opportunity.....to spend one week....... observing the work of.....health visitors; incontinence advisors; smoking cessation advisors; physiotherapist; bereavement counsellors; community mental health nurses; drug & alcohol misuse advisors; women’s aid; flying start; teenage pregnancy midwives; contraception & sexual health clinics; Infertility/assisted conception labs; mother & baby groups; pathology labs; school nurses; diabetic nurse specialists; National Childbirth Trust teachers; social services; midwives working with vulnerable adults & in child protection”

Examples of reported methods of assessment ranged from completion of workbook to detailed application of theory to practice in relation to public health and included:

“Poster presentation; community focused profile which encompasses inequality in a targeted group of women”

“Verbal exam & coursework - 2000 words reflection on practice of public health”

"Prepare & deliver a teaching package on an aspect of public health or health promotion to a client or peer group; 50% clinical assessment

Public Health Role of Midwives

Respondents were asked to rate on a scale of 1-5 (5=essential) how much they thought public health was part of the core role of the midwife as presented in Table 4. Two responses (one institution, 2 programmes) commented that in the widest sense of
midwives role it was 4 or 5 but in relation to addressing inequalities it would be 3 (scored as 4). Some additional free text comments in relation to pre registration midwifery education provision are included after the table.

Table 3: Responses to Perception of Public Health Role of the Midwife (pre registration)

<table>
<thead>
<tr>
<th>How much do you think PUBLIC HEALTH is part of the CORE ROLE of the midwife?</th>
<th>1 (0)</th>
<th>2 (0)</th>
<th>3 (0)</th>
<th>4 (16)</th>
<th>5 (23)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not essential</td>
<td>Essential</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*a Responses given as frequency (%); b Missing (n=8, 22%)

“The students that are at (name of university) work with an inner city population of London and they experience inequalities in health. They work with women with varying needs. They undertake an assignment that helps address the issues of public health and the role of the midwife”

“We have a particular focus in our curriculum to meet the needs of vulnerable groups. Our University is placed in a large multicultural city in the Midlands in which social deprivation is a key factor. In addition minority groups dominate in the community in the city centre.”

“...It is an essential part, but addressed in small "bits" due to lack of time and specialist input. Midwifery mentors need to be encouraged to show how they address these issues, but I feel they are not aware enough of these things”

“Students will learn better if they see midwives practising and promoting these aspects. We need to focus on post registration (education) to make these aspects central to the midwives role”
Post Registration

Fifty six institutions were identified as providing pre registration midwifery education: 43 in England, 2 in NI, 7 in Scotland and 4 in Wales. The response to the post registration survey was slow and an email asking for specific information was distributed to non-responders at an advanced stage of data collection to try to improve the response. This resulted in a total of 16 (29%) responders; 12 in England, 2 in Scotland and 2 in NI. Varying levels of post registration education were offered by the responding institutions from diploma level through to Master’s and doctoral.

Inclusion of public health/inequalities

Of those who responded (n=12), 4 reported that post registration programmes available to midwives which offered a specific public health/inequalities module or a module which incorporated public health or inequalities in the title. The examples provided included: ‘Applied Public Health’ (not midwifery specific), ‘Public Health’, ‘Analysing Public Health’ and ‘Diversity and Inequalities’. These modules were offered at BSc/MSc level or as part of Continuing Professional development. Examples of module titles where the content related to public health and/or inequalities included: Cultural, Political Issues Influencing Maternal and Infant Wellbeing; Current issues in HIV/AIDs; Contraception and sexual health; Antenatal and Neonatal Screening; Preconception to childbirth: challenging the boundaries of health promotion. The majority of respondents indicated that public health and inequalities were both integrated into all programmes or specifically addressed in some programmes. One institution reported that inequalities were not included in any of their programmes. One of the questions in the survey was designed to ascertain the driver(s) for including education around public health and inequalities on the programmes offered. The results are shown in Table 4.
Table 4: *Programme Drivers for Including Public Health and Inequalities (n=9)*

<table>
<thead>
<tr>
<th>Driver for Inclusion in Programme</th>
<th>Public Health (Yes)</th>
<th>Inequalities (Yes)</th>
</tr>
</thead>
<tbody>
<tr>
<td>University Led</td>
<td>5</td>
<td>4</td>
</tr>
<tr>
<td>Commissioned</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>NMC</td>
<td>5</td>
<td>4</td>
</tr>
<tr>
<td>Current Policy/Guidelines</td>
<td>6</td>
<td>5</td>
</tr>
<tr>
<td>Student Led</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>

The survey asked respondents to state how explicit (direct reference) the inclusion of public health and inequalities were in their curriculum philosophy or programme and module aims/objectives. The results are presented in Table 6.

Table 5: *Inclusion of Public Health/Inequalities in Post Registration Programme Documentation (n=9)*

<table>
<thead>
<tr>
<th></th>
<th>Public health (Yes)</th>
<th>Inequalities (Yes)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Curriculum philosophy</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Curriculum aims</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Curriculum objectives</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Module aims</td>
<td>7</td>
<td>4</td>
</tr>
<tr>
<td>Module objectives</td>
<td>5</td>
<td>3</td>
</tr>
<tr>
<td>Module learning outcomes</td>
<td>4*</td>
<td>4</td>
</tr>
</tbody>
</table>

*1 respondent reported they did not have learning outcomes for modules
Specific Public Health and Inequalities Teaching

A significant section of the survey asked respondents to select from a list of pre defined topics on public health and inequalities as detailed in Table 6 and indicate whether they were included in their provision of post registration education for midwives.
**Table 6: Post Registration Public Health and Inequalities Subject Areas**

Key: I=integrated, SA=Standalone module, SP=Specific module, NI=not included, NR=no response, NA= not applicable, *Level 6, **Level 7***, paper responses only

<table>
<thead>
<tr>
<th>Method of Inclusion</th>
<th>Level of Study</th>
<th>Example(s) of Module Title where Included</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>I</td>
<td>SA</td>
</tr>
<tr>
<td>Principles of PH</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Health &amp; Social Care Policy</td>
<td>5</td>
<td>4</td>
</tr>
<tr>
<td>Epidemiology</td>
<td>5</td>
<td>4</td>
</tr>
<tr>
<td>Substance Misuse</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>Smoking</td>
<td>4</td>
<td>0</td>
</tr>
<tr>
<td>Obesity/Wgt Management</td>
<td>5</td>
<td>0</td>
</tr>
<tr>
<td>Maternal Nutrition</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>Health Promotion</td>
<td>7</td>
<td>4</td>
</tr>
<tr>
<td>Health Education</td>
<td>5</td>
<td>2</td>
</tr>
<tr>
<td>Blood Borne Viruses</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>Domestic Viol</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>Homelessness</td>
<td>4</td>
<td>0</td>
</tr>
<tr>
<td>Ethnic Minority etc</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>Asylum/Refugee</td>
<td>5</td>
<td>1</td>
</tr>
<tr>
<td>Travellers</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Parent support initiatives</td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td>BF/Infant nutrition</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Teenage Pregnancy</td>
<td>6</td>
<td>2</td>
</tr>
<tr>
<td>Sexual health</td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td>Sexual orientation</td>
<td>6</td>
<td>1</td>
</tr>
<tr>
<td>Perinatal morbidity</td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td>Perinatal mental health</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Child protection</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Optimising Birth***</td>
<td>3</td>
<td>3</td>
</tr>
</tbody>
</table>
Post Registration Curriculum Gaps and Limitations

Public Health
Respondents were asked to identify any gaps or limitations in the current post registration provision of public health education for midwives; 4 respondents reported they felt there were gaps, 2 reported none and 3 did not answer. Of the respondents who said ‘yes’, gaps and limitations identified included the impact of commissioning, size of the HEI, numbers of midwives accessing CPD courses and the need for post graduate specific public health education to be developed. Specific topic areas where gaps were identified included perinatal mental health, asylum seekers and homelessness, obesity, nutrition, alcohol. Of the respondents who did not answer 2 provided comments which were similar to those who said ‘yes’ relating to small numbers studying post graduate midwifery and the influence of trust manager preferences.

“Smoking/alcohol/obesity/nutrition/refuges, asylum seekers & homelessness - however numbers of midwives able to access continuing professional development courses is small so we focus on issues that are shared with other professionals to provide a viable number to run modules”

“Commissioning is the biggest problem with course development - the curriculum is needs drive and if Trusts do not want modules they will not be developed or if on offer not available without 6-10 students”

Inequalities
Respondents were asked to identify any gaps or limitations in the current post registration provision of education related to inequalities for midwives; 3 answered yes to indicate there are gaps or limitations, 3 answered no and 3 did not respond (2 of whom provided comments). Similar responses were reported as to the public health
question above with regard to limitations or gaps with one institution reporting they do not offer any post registration education on inequalities. One institution (who did not answer) commented:

“This probably needs to be more embedded in pre registration midwifery curriculum and possibly developed post grad especially in relation to specialist roles/service development”

Public Health Role of Midwives

Respondents were asked to rate on a scale of 1-5 how much they thought public health was part of the core role of the midwife which is presented in Table 7. One did not give a singular numerical answer: in the widest sense of midwives role it was 4 or 5 but in relation to addressing inequalities it would be 3 (scored as 4).

Table 7: Responses to Perception of Public Health Role of the Midwife (post registration)

<table>
<thead>
<tr>
<th>How much do you think PUBLIC HEALTH is part of the CORE ROLE of the midwife?</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not essential</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Essential</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>4</td>
<td>4</td>
</tr>
</tbody>
</table>

An example comment from one institution stated:

“I think we offer excellent opportunities for midwives to develop skills/practice post registration, but employers seem only willing to support midwives to undertake “skills” courses/modules such as the newborn exam modules. ‘Strategies for working in community midwifery practice’ was developed with input from local midwifery managers - but only 2 local midwives enrolled on the module”
Phase 2

Focus Groups

Phase 2 of the project involved arranging focus groups with two distinct groups; midwifery students and registered midwives. In total 9 focus groups including over 59 (34 midwifery students and 25 registered midwives) participants have been conducted with both midwifery students and midwives (facilitated by the RCM including midwives, managers, public health specialists and educationalists) in England, Scotland, Wales and Northern Ireland. Midwifery students were identified from the selected institutions via contact with the Lead Midwife for Education or Head of Department. One institution (Welsh) declined to participate citing the midwifery students had been recruited recently into a research project and it therefore was not appropriate to approach again. Four focus groups were conducted in the three participating institutions; two groups were held in one university as the initial group comprised of third year students who had recently completed a specific module on public health and therefore it was felt their perspective may not have been reflective of students at other stages in their course and also to provide comparative data (from second year students) within the institution.

The focus groups with registered midwives were arranged via the RCM offices in each country. Five focus groups have been conducted in England, NI, Scotland and Wales. The focus groups were conducted by JM, FL, JD and GA, recorded and transcribed independently. The transcripts were analysed by content primarily by JM with input from all members of the project team regarding emerging categories. Content analysis involves the identification of key topics or categories within the transcripts and then looking for relationships within the categories (Morse & Field 1996).
Focus Groups with Midwifery Students

Five main categories were evident from the focus groups conducted across the UK. These included the role of public health within midwifery; discussing public health issues in practice; understanding public health and education. In some cases underlying concepts overlapped within the categories.

The role of public health within midwifery

Throughout the group discussions it was evident in all groups that midwifery students did not have clear understanding of the public health role of midwives. In some groups initially it was seen as a specialist area and not as core given that midwives cannot be ‘experts’ in all areas however as the discussions continued within groups there eventually was consensus that public health was integral to midwifery practice and input from multidisciplinary teams or specialists could be utilised for additional support.

“I think the role of the midwife is really important but when I was doing my bit of research for my assignment one of the key things that was out there, a lot of midwives don’t accept that they have a role in public health” (Scotland)

“(It) springs back to sort of like how much of the public health role, you know, is that part of your job as a midwife. Because you can’t be all singing all dancing, you can’t do everything” (England)

Discussing Public Health Issues in Practice

A general lack of lack of confidence and some anxiety around discussing specific public health related topics with women was reported e.g. smoking cessation.
“I’ve completely avoided that huge area of public health and midwifery and I feel terrified of it now, you know, if I were to get a woman who was saying, ‘I’m smoking, what can I do about it’..... I wouldn’t know”. (England)

“....and it’s like they’re (pregnant women) scared you’re going to judge them and its hard then to broach those subjects“ (NI)

In one focus group there was recognition that the training had been helpful:

“....... Domestic violence is a good example, that’s almost half of the course for us, for discussing that and watching for it and screening for it. It’s one of those small things that has a massive impact and for most Trusts we would know where to refer on to in that area for women” (England)

Students were also aware of the impact of busy clinical environments and how that it limited the ability of midwives to address or discuss public health issues.

“I think time’s a big issue with all public health. I think midwives don’t have enough time to deal with all the public health issues that they need to deal with” (NI)

In some cases midwifery students were able to highlight good practice by midwives however some reported that not all midwives had a good understanding of public health which may link with the previous category regarding student midwives understanding of public health.

“ Maybe public health has been something different but, you know, not all midwives are actively promoting good health, or realising the public health aspect” (NI)”
Understanding Public Health

It was evident that students sometimes were unable to recognise aspects of public health as ‘public health’ which is demonstrated in the following excerpt after some prompting from the moderator.

“Moderator: Do you think about anything around like normal birth or reduction in caesarean sections, any of those types of things, would you see those as being come under health promotion and public health?

Participant: (maybe) for a normal birth and reducing these (caesarean section) rates and looking into why these rates are sort of rising....but again I don’t suppose any of us look at that, well I certainly don’t look at that as being within public health” (Scotland)

Education

The majority of students were able to recognise and name key public health topics relevant to midwifery practice however reported that although they perceived their level of theoretical knowledge was good, practical delivery was difficult. Several groups suggested some additional solutions such as motivational interviewing or training in communication skills through role play might help.

“Respondent 1: But it’s hard, I think, for us I think to go out and start telling people this. I think you need more than a, confidence lessons or something.....

Respondent 2: Or, just different approaches to how you go about health promotion. You know, do you ask how, what the woman knows about it first and getting into like dialogue and conversation as opposed to telling the woman what to do.
Respondent 1: Yeah.

Respondent 3: We had (a session) on motivational interviewing techniques....it was a very quick session, but I was really intrigued by that because that could help get communication with women.

Respondent 1: Yeah, so like more of the ‘how to’.

Respondent 2: Yeah, definitely. Role play.......I think that would be really good” (NI)
Focus Groups with Registered Midwives

Each transcript was read independently and then cross referenced with the others to analyse for differences and similarities across countries. Three main categories emerged from the focus groups with registered midwives which are outlined below.

Public Health Role of the Midwife

One of the questions in the focus group schedule was to ask firstly about a definition of public health and a follow on question about the extent of public health in midwifery practice. In all 5 groups the definition of public health was difficult to pinpoint precisely and generally the question was met by silence. One group identified that it was important for midwives to have ‘their’ definition of public health and what it means in midwifery practice as other disciplines have clearer understanding of what public health is.

“R: ...so I think what midwives need to do is (consider) what is our meaning, our understanding, our domain, what is our package of public health? What do we mean by it? What would be our targets? What would we want to see as perhaps, we can’t control the whole population but we can look at the whole of childbirth, say from maybe a little bit of preconcepton right up to is it midwives’ role up to 28 days after birth? What kind of targets, goals, public health things would fit in?” (England)

Although the groups were generally consensual about public health as an aspect of midwifery practice there was often debate as to the extent of this role and boundaries regarding core or specialist practice. Terminology such as ‘crucial’, ‘pivotal’, ‘the foundation of it’, ‘significant role’ was used to describe the public health role of the midwife in relation to the core aspect, although within groups there was confusion relating to if and how midwives viewed themselves as public health practitioners.
'It’s got to be the core function and then we build on top of that’ (Wales)

“I think that’s, that’s part of the point though in discussion like, you know, if you asked to midwives or do you think midwives see themselves as public health practitioners and I think you and I would express that I would not consider myself as a midwife as a public health practitioner” (Scotland)

“I personally think that it’s more about all the midwives having the overview and knowing how to signpost and I’m not sure that it always has to be a specialist midwife that does the aspects of it, because we have our own midwifery role to carry out which is around the, you know, the pregnancy and the birth” (NI)

One group discussed how difficult it was to marry the goals of public health and the aim of holistic midwifery care. It was felt that the goals of public health are overarching and at population level where in midwifery care the aim is more towards an individualised approach tailored to the specific needs of women and their families and therefore this may result in conflict (see quote below). This was not raised in subsequent groups however the moderator of the final focus group proposed the idea and it was supported.

“.......public health tends to take a very global approach and they want everybody vaccinated and everybody to give up smoking and everybody to breast feed. And the reality is that midwives, we’re actually dealing with individuals who are giving us very good reason for why they’re going to continue smoking and why they’re not breastfeeding which may not fit with the public health agenda. I think that there’s a fundamental problem between imposing that perhaps, on a midwife who is actually working with an individual and understands that woman’s context. Yes, she knows it’s
not good for her to smoke. Yes, she knows it’s going to give her cancer or whatever in the long term but right now she’s just trying to survive. And I think trying to superimpose this public health practitioner role on a midwife could actually lead to role confusion or completely role rejection”. (Scotland)

Clinical Practice
Although it was generally recognised that public health and inequalities are part of the midwives’ role, barriers in clinical practice were identified as influential on the effectiveness of that role. Barriers discussed included the shortage of time available clinically to care for women, the difficulty of providing a lot of health promotion information at the booking interview, the ‘tick box’ approach to care, midwives reluctance to develop conversations with women due to a lack of time, continual ‘adding onto’ the midwives’ role, models of care and the lack of vision regarding long term outcomes of care. Additional barriers were identified which focused more generally around professional issues such as heavy administration and bureaucracy, work load volume and leadership. However despite the recognised barriers the groups were unanimous that pregnancy was a time of opportunity for midwives to promote the overarching goals of public health.

“If you have midwifery models of care it’s much easier to see the public health role, but when you’ve got midwives working in a very, very pressurised, acute setting where it’s process driven, it’s a more difficult job to get them to see their part they can play in public health” (NI)

“....and they (midwives) are subsumed into our culture of defensive practice. You talk to midwives up and down the country; they’re just simply surviving, staying out of trouble. Maybe my picture is myopic or skewed but I meet midwives in every kind of unit and they are just basically
surviving, day to day on the job. They’ve got bureaucracy, they’ve got leadership problems, and they’ve got oppression. They’ve got isolation, (increasing) demands and volume of work” (London)

The recognition of a time of ‘opportunity’ was resonant through all the focus groups and there was a unanimous agreement both within and between groups that pregnancy is a time in women’s lives which could be influenced with regard to a public health message.

“You know, I think what we do have as midwives is a captive audience. We have an opportunity. We engage with women, somewhere in and around six to twelve weeks in their pregnancy depending on how early they do their pregnancy test and who they contact first. And we have access to those women who are like sponges for information for at least six months and it is an opportunity” (NI)

Education

Emerging sub themes within education centred on the availability of training, difficulty releasing staff for training and the type of training that is needed. It was acknowledged within the majority of groups that training currently exists however nature or topic is often politically motivated or a current hot topic for example the current focus on obesity, weight gain and pregnancy. Another issue raised regarding training available was that funding was usually available to ‘upskill’ midwives i.e. with medical prescribing or examination of the newborn rather than training or education in more generic roles as illustrated by a quote from a NHS midwifery manager as below:

“If a midwife came to me and said I want to go and do a module at (a HEI) or wherever on public health, unless she was doing it as part of a degree I can’t see her coming forward to do it, and I couldn’t support her unless I had a particularly, a particular role for her” (NI)
There was a recognition that public health was more prominent on pre registration education curriculum and that newly qualified midwives entering the service were perceived to be ‘steeped in public health” (Scotland) and ‘more conscious of public health than midwives trained a few years back’ (Wales). However other groups felt that while this may be true, there were concerns around the general lack of midwives’ confidence to discuss many public health issues with women, for example obesity, weight management, and routine enquiry about domestic abuse. An explanation offered by one focus group suggested that unlike some ‘technical’ aspects midwifery such as breech delivery or CTG training, it was something midwives could identify with on a personal level:

“….. (Public health).... is stuff that affects midwives personally”  (Wales)

Some of the discussion in the focus groups centered on how to address the barriers in order to maximise the public health role of the midwife. Recognition of the need for more training was identified and several examples of innovative practice were provided. For example a service manager in NI gave an example of how funding had been obtained through the British Heart Foundation for a midwife to link into a community based obesity networking and motivating programme.

Several methods of training to address gaps in the effectiveness of a midwifery public health role were suggested. Online training in the form of a toolkit was suggested in one group. This would have the advantage that midwives could access it in their own time; however another group felt that online learning was problematic in the area of public health as there was a need for an interactive element and also monitoring compliance with online learning could be difficult if the training was not mandatory. Increased knowledge of interventions which midwives could conduct was discussed as something that would be helpful. Brief intervention training which has been used effectively in
other areas of practice was also raised as a potential for midwives in the area of public health:

“......brief intervention training and I think that is key to everything” (Wales)

Underlying the recognition of training however was also the need for more emphasis on the application of public health to midwifery and for all midwives to understand better the relationship between public health and midwifery.

“........so I think the longer term thing would be to change the culture of how midwives see their role in public health and accept that and maybe see that it's not an add-on to our role” (NI)

“ I think a lot of it too is, is, you do have to get underneath the midwife’s thoughts processes as well, in it all....if they’re going to deliver the positive message you’ve got to understand them, haven’t you, as a person and build their confidence” (Wales)

The importance of utilising specialist expertise in education was identified in addition to the role of the midwife within the multidisciplinary team in relation to public health.

“........because you’ve got specialists around who have got lots of knowledge about stuff ....... and I think we do need to be more multidisciplinary when it comes to public health” (Wales2)

“Whatever you do, get, have, in midwifery programmes there have to be specialists involved” (Scotland)
Case Study

A consultant midwife in public health from England described the approach she had taken to address inequalities in her particular locality which had demonstrated measurable outcomes in relation to infant morbidity and mortality:

“For example, in our area they’ve began to know those issues (morbidity and mortality) now from that we have a map up on the wall, the local boundaries where services are provided, which is traditionally what’s in the community, or in hospital, because infant mortality is an issue in our local populations. Infant mortality is now has mapped on the geographical map so midwives can see just visually where they occurred. It’s like measles and it has also got mapped which services are provided in that area including where the services provided and are appropriately resourced. What that did was to raise a real awareness of the context in which a midwife student, a newly registered midwife or a midwife who had been there for years was working.

So if they were working in a certain practice where there should be six midwives and there’s only four, you can have discussions that will impact on your ability to cover labour care or impact on your ability to follow up somebody who doesn’t turn up for an appointment or to be able deliver that care differently. But the core, you know, we call it the social and, and that might be useful to identify but from a woman’s viewpoint if you’re mother planning you want to know, I mean, even to, what you’re using language and one of the things that changed in our area was I started saying if a woman comes, comes through this community practice as opposed to going another practice for her maternity care, does she know what her chances are for support to have a normal birth, and being able to
prevent a premature birth, being able to support her to breast feed. So it makes public health a really important aspect of care”

The consultant midwife also felt that a key aspect of the midwifery contribution to public health was through needs assessment and population profiles:

“So I’d like to see it shift, go back to first basics, what do midwives, can midwives do directly themselves or through signposting or if they’re the named midwife, checking that it’s happening in terms of co-ordination role, in their everyday practice, towards the health and well-being of the mother, that baby, that family, including parenting. At that level you need to know something about your local population demographics, your maternity population demographics, and how that impacts on how services are commissioned, provided. So that makes a difference on what midwives do on an everyday business. Where is the evidence? So, for example...what do we mean by prematurity? Do midwives know that they’re contributing then towards reducing mortality, perinatal mortality and infant mortality? Do they know that in their area where does that rank in mortality data for that population? In our area it’s number four and it’s above cancer and smoking as diseases. No I happen to know that because of the role I’m doing but I’m actually beginning to teach it. It’s again to put the context of, a midwife whether she’s newly registered, been in it for 30 years, it’s about saying that there are skills and a job to do that can contribute to reducing prematurity”

Limitations

Refining the questionnaire was challenging as the aim was to collect the most relevant data and maximise the return rate; however this had to balance with the time required
to complete the questionnaire. The nature of the questionnaire required respondents to refer to curriculum document(s) and therefore was time consuming to complete. Several respondents commented that the survey required detailed answers and the time spent completing it was significant. As a project team we were aware of this and tried to ensure respondents received maximum support throughout the process by close email and telephone contact to minimise the impact. In addition postal surveys often have low response rates. As a project team we attempted to maximise the return rate through providing various options i.e., online, sending the curriculum documents and via telephone and using reminders via telephone or email. The response rate from the post registration survey was much lower and we are not clear why exactly this was. Two contributing factors may have been that firstly, it was much easier to identify the lead individual for pre registration programmes as this is public information available from the NMC for all pre registration programmes and therefore it was likely the case that the pre registration survey reached the appropriate individuals. Identifying the lead individual for post registration education was more difficult and despite searching every single HEI website this information was not always available. The second possible factor is that often specific modules on public health and or inequalities are available to midwives but not be necessarily offered within the School of Nursing and Midwifery so the individual receiving the questionnaire may not have been aware of modules outside their own School and perceived it as irrelevant. In addition it must be recognised that the survey was limited to HEI’s and therefore may have excluded providers of education that are linked to health care trusts. The focus groups were generally representative of both students and practitioners as we had a variety of years of experience/education, gender as appropriate to a midwifery profile and current employment although in some cases had small numbers. In addition, the midwifery student focus groups were conducted in three of four potential locations and therefore the findings may not be representative of all midwifery students across the UK.
Section 6

Discussion

From synthesis of data from both phases of this project three clear areas were identified which will require significant consideration in order to maximise the public health role of the midwife. These are outlined below and represent broad themes discussed within the findings from Phase 1 and Phase 2.

Understanding the Role of Public Health and Inequalities in Midwifery

It was consistently difficult for individuals to articulate clearly their understanding and definition of public health in relation to midwifery. This lack of clarity created confusion around terminology in relation to public health and the subsequent application of the concept of public health everyday midwifery practice. This was a similar finding to research by McKay (2005) who explored perceptions of health promotion with midwifery students. McKay reported a limited understanding of health promotion in the context of public health and lack of clarity around the health promotion in midwifery practice although the sample size was small (n=8). In order to promote the public health role of midwives as outlined in the Midwifery 2020 Public Health Stream Report, barriers to introducing change need to be identified and further training in relation to public health awareness and how it relates to core midwifery practice will need to occur before any real progress can be made.

In 2004 an initiative focused on public health and midwifery in Glasgow was launched which resulted the development of a public health assessment tool which has since been incorporated into the hand held maternity notes in Scotland. Some of the early work on this initiative included discussions around public health and the definition of it in relation to midwifery practice with the conclusion that public health in midwifery was
not a new concept but one that was intrinsic to midwifery care (Holmes et al. 2004). This project has highlighted that midwives need to have a clear understanding of public health and how the principles are related to their everyday practice. It is essential this occurs in order to facilitate the achievement of population level public health goals. As demonstrated in the case study example provided that really progress can start with having an understanding of morbidity and mortality statistics in their area of practice and conducting comparisons with other local areas, national and international statistics. Midwifery care can then build on the needs of the community and tailored interventions can be introduced which are specific to the public health needs of local populations and are therefore more likely to impact on medium and long term health outcomes.

**Visibility of Public Health and Inequalities in Midwifery**

Within the focus groups it was clear that some midwives did not view themselves as public health practitioners or would not have described much of core midwifery practice as public health. This will require a culture shift and change in perspective from the majority of the profession to ensure the public health contribution from midwives is valued. Bick (2006 p288) comments on the ‘historical importance of effective public health’ and urges midwives maintain public health as the core of their practice. The current pre registration curriculum refers to essential competencies which must be achieved in order to register which are divided into four domains. Although the concept of public health is evident and underpins many of the requirements, for example under the domain of effective midwifery practice students are required to ‘actively encouraging women to think about their own health and the health of their babies and families, and how this can be improved’ the term public health is only used once: ‘planning and offering midwifery care within the context of public health policies’ (NMC 2009 p26).
Pre registration education in relation to public health and inequalities is for the most part integrated into the curriculum with very few universities offering specific modules. Whilst this was acknowledged in the focus groups as parallel to how midwifery and public health are related ie it underpins all of what midwives do an integrate approach does pose some concerns when it is linked to the lack of value placed on the public health role of midwives within the current midwifery culture. With this in mind the intrinsic embedded nature may contribute to the lack of recognition or awareness about public health and what exactly public health is as was apparent from the focus group discussions with midwifery students. In one particular focus group of second year students, they were asked about public health only to respond that they hadn’t covered it yet and on further exploration of the concept they then realised that in fact it was there from the commencement of their course. McKay (2005) reflected following her study that the educational approaches to teaching health promotion needed reviewed. This highlights a major challenge in relation to public health and midwifery and indicates that future work in this area must focus on promoting public health as core to midwifery role as supported by ‘Delivering Expectations’, the final programme report of Midwifery 2020.

Education appeared particularly limited in relation to specific public health/inequalities education in the responses received in relation to post registration midwifery. Although the response rate was low and data may not be representative of all midwifery schools across the UK, there may be some plausible explanations. A proportion of post registration education is commissioned from health and social care trusts and therefore providers of education are limited in their provision as it may be dictated to an extent by NHS Trusts. It was also clear that, whilst searching the websites of HEI’s included in the study, public health or inequalities specific modules are available to midwives but not situated within the discipline. In addition some midwives (specifically reported from senior midwives in clinical practice) do not see public health as a midwifery role and therefore do not value the importance of education in this area for midwives. This was
reported in several focus groups from across the UK and while the numbers were small it is a perspective to be considered.

**Direction of Public Health Education in Midwifery**

From the data collected in this study there was reasonable consistency across the UK in terms of the provision of pre registration education which is to be expected given the NMC requirements. Although the major topics are covered by the majority of HEI’s there was some variation in the provision of education for current hot topics e.g. obesity and weight management or maternal nutrition. This may reflect the time lag between what is current and the administration around changing curriculum to meet NMC requirements and that pre registration curriculum are generally only renewed every 3-5 years. The role of specialist practitioners was referred to in the focus groups and this may the mechanism to address the delay in translating current topics of interest in educational curricula. For example specialist practitioners could be invited to present a guest lecture for midwifery students thereby increasing exposure to current work and relevant good practice. There were some suggestions from respondents as to how education and training for midwives could be improved around public health, inequalities and midwifery, for example, Brief Intervention Training. Brief Intervention Training is based on delivering information on a chosen subject for a brief period of time (2-5 minutes) using the principles of motivational interviewing to improve communication around delivery of information about the intervention. Motivational interviewing is based on a client centred approach with emphasis on collaboration (Miller 1983). It has been used effectively in a range of areas for example to reduce excessive alcohol intake (Kaner et al. 2001) however evidence from systematic reviews is inconclusive (Stade et al. 2009; Lai et al. 2010) although the quality of included studies was poor and several had small numbers of participants. Everett-Murphy et al. (2010) observed midwives’ communication techniques in relation to counselling pregnant women about smoking cessation and recommended that brief motivational interviewing
had potential to improve counselling as the observed communication styles (traditional, authoritarian and paternalistic) were not effective.

Additional training around communication skills was discussed in both the focus groups with registered midwives and midwifery students. The discussion regarding the specific type of training focused on how to raise public health issues with women for registered midwives and more emphasis on communication skill development through role play in pre registration programmes. Communication skill training could be developed to address this gap through the development of an online toolkit with an interactive component that midwives work through and access at various times to complete and possibly receive accreditation towards continuing professional development. The interactive component is essential to facilitate the application of theory to practice in this area as identified by midwifery students in the results section. Training around communication could also potentially incorporate an element of reflection and self awareness around personal health and lifestyle which may be of value for midwives who find it difficult to discuss these issues with women due to their own health behaviours and choices. It may contribute to an increased understanding of the difficulty of behaviour change.

This project has also identified the need to work with local NHS trusts to develop training for midwives with the aim of raising the profile and changing the perspective of midwives about their public health role. As previously noted public health education in midwifery is generally provided using an integrated format which is consistent with public health being core to midwifery. While this approach is easily justified evidence from this project demonstrated that, firstly not all midwives view public health as core to their role and secondly midwifery activities that would potentially contribute to improving public health were not labelled as a public health role. It may be that the education currently available to midwives needs to focus more specifically on the public health role of the midwife rather than the midwife as an agent delivering health
education or promotion messages. This would fit more easily with the provision of midwifery care within a social model taking into account the context in which health promotion or health education is delivered. Such training would enable midwives to visualise and apply the concept of public health to midwifery practice and improve their overall understanding of public health. Subsequent provision of care would then be framed in the context of impacting on long term health outcomes of the broader population (Biro 2011). Training around interventions which have been effective in other areas such as the case study from England provided earlier would improve knowledge translation and address long term public health outcomes at population level. One of the key recommendations of the Public Health Midwifery 2020 Work Stream Report indicated that midwives need to capitalise on the opportunity to deliver evidence based public health interventions. The systematic review (McNeill et al. 2010) which reviewed public health interventions that could be conducted by midwives highlighted that while there was some evidence to support interventions evidence in this area. The report also included public health competencies for midwives in a range of roles including both those with routine and also those in with added responsibility in relation to public health therefore providing a framework to model practice and appropriate acquisition of skills in this area.
Section 7

Conclusion

In summary this scoping exercise has highlighted that the current level of understanding around midwifery and public health could be strengthened and will need further develop to maximise the public health impact of midwives. The survey data regarding educational programmes suggests that the key public health issues were included, however the focus group analysis suggests that theory was not translated well into practice. A gap was evident around perceptions relating to the confidence and ability of midwives to discuss public health issues with women effectively indicating the need for further training in this area. However the key issue emerging from the project was the lack of clarity and understanding about the meaning of public health and the recommended priority for any future work would be to develop a training tool with the aim of improving the visibility and ethos of public health amongst midwives.
Section 8

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