Are we getting the message across? Women's perceptions of public health messages in pregnancy

Abstract

As the primary health professionals involved with families from their very beginnings, midwives have an ideal opportunity to promote health and wellbeing through family-centred conversations around key public health issues. To explore and articulate this aspect of the role of midwives and maternity support workers, the Royal College of Midwives has developed a new model for public health within midwifery services. As part of this project, a focus group was conducted using a closed Facebook group to investigate how women using the service perceive the delivery of public health messages. Three major themes emerged: pressures on the midwife–woman relationship; different media for health messages; and midwives' and maternity support workers' communication skills.

Keywords: Antenatal care, Pregnancy, Midwives, Public health, Health promotion

The potential for midwives to have a long-term impact on families by engaging purposefully in their public health role has been more clearly recognised in recent years, with publications such as *Midwifery 2020* (Chief Nursing Officers of England, Northern Ireland, Scotland and Wales, 2010) highlighting this unique contribution. Aiming to further articulate this vital aspect of the role of midwives, and to explore how maternity support workers (MSWs) can also engage in the public health remit, the Royal College of Midwives (RCM) received funding from the Department of Health to develop a new model for the public health role of the midwifery team.

As part of the RCM's project, Dr Sanders and colleagues from Cardiff University used closed groups on Facebook to conduct focus groups for various professionals within the maternity setting, raising a wide range of key themes and recommendations (Sanders et al, 2016). However, a limitation of their study was that it exclusively examined professionals' views, without giving a voice to those using the service; recognising this, the authors recommended further study (Sanders et al, 2016: 8):

> ***'It is also important to gain insights into the experiences of families receiving midwifery public health activities, thus it is recommended that the service user perspective is included in any future research.'***

This article reports on a focus group of women's views, which was undertaken to fill that gap and supplement the findings of the work of Sanders et al (2016).

Methods

Recruitment

Service users were recruited via a group for new mothers run by the author in the London Borough of Barking and Dagenham. After an initial face-to-face discussion, the 12 women in the group were sent an invitation to a closed Facebook group set up for the purpose of the focus group, and were asked to invite friends from other geographical areas. The criterion for involvement was that the participant should be the parent of a child under 2 years old, born in the UK. The term 'parent' was used in order to include fathers, if they wished to be involved.

Participation and ethical considerations

Of all those invited—including the original group members and those they invited themselves—24 women accepted an invitation to the focus group and, of these, 14 took part in the discussion. No men participated. These women had been cared for by 14 different NHS Trusts across England; some had given birth in different areas of the country with different pregnancies. Ethical approval was not sought, as participants were informed that no identifying comments would be used without their express permission. All participants were informed about the purpose

Lucy November, public health advisor, Royal College of Midwives
lucy.november@rcm.org.uk

of the study, what participation would entail, and measures taken to protect their identity. As this was a closed Facebook group and included women who had received care in many different places, the project steering group believed that the risk of any responses being recognised as relating to any specific maternity service was minimal.

Process

The focus group was set up on 22 March 2015 and was active for 4 weeks, with the last contribution being made on 19 April 2015. The initial starting question was as follows:

> ***'To kick off our discussion, below is a list of issues that midwives may have discussed with you before, during or after your pregnancy:***
>
> - ***Smoking***
> - ***Drinking alcohol***
> - ***Drugs and medicines in pregnancy***
> - ***Diet in pregnancy***
> - ***Supplements***
> - ***Managing your weight***
> - ***Exercise***
> - ***Your feelings/mental health***
> - ***Immunisations***
> - ***Infections in pregnancy***
> - ***Screening tests***
> - ***Preparation for birth and parenting***
> - ***Breastfeeding and bottle feeding***
> - ***Bonding and skin-to-skin contact***
> - ***Care of pelvic floor/postnatal exercise***
> - ***Female genital mutilation***
> - ***Contraception***
> - ***Domestic violence***
> - ***Keeping your baby safe***
> - ***Safe sleeping practices***
> - ***Support services in your area.***
>
> ***Do you remember your midwife discussing these with you? How did it go? Were there any which you wanted her to discuss but she didn't? Were there any which she discussed which you felt were irrelevant and the time could have been better spent? Are there any other issues which you think midwives should be discussing with women and their partners? The floor is yours.'***

The scope was deliberately broad initially, to allow topics to be picked up according to the interest and experience of the participants. After this, prompts were used to pick up on particular topics that were of interest for the project. Discussion flowed well, with the majority of comments being made within the first 10 days. Prompts at this stage provoked some fresh discussion. Regular new prompts and questions produced dwindling responses until the final day of the focus group when a 'thank you and any last comments' entry produced one final contribution.

Analysis

The data were transferred to a Word document, and names removed from the text. Contributions were identified by the code SU1 to SU14 (service user 1 to 14). City names and areas were left in as they gave a sense of geographical spread without risking identifying a participant. All names of individuals in the text were removed. Three major themes emerged from the data:

- Pressures on the midwife–woman relationship
- Different media for health messages
- Midwives' and MSWs' communication skills.

Limitations

It is acknowledged that there was some selection bias at work in the recruitment of women for this study. Although the group of women in the source group was ethnically diverse, with an age range of 15–41 years, the four women from the source group who chose to participate were all white British within an age range of 25–38 years. These four women invited the other participants from across England, who tended to be of a similar demographic, resulting in a fairly homogenous group. This clearly limits how representative the group's views are of the population as a whole, especially of much younger women and women with little or no English or literacy. However, a strength of this study is that the women represent 14 NHS Trusts across England, so their experiences are not just from one or two settings. Despite specific encouragement for participants to ask their partners to join the discussion, no contributions from fathers were made.

Some important topics were not raised at all: smoking cessation, obesity, alcohol in pregnancy, and screening. It is not clear whether participants simply had no interest in discussing these topics, or whether they saw them as relevant but did not want to discuss them in a large group.

Findings

Pressures on the midwife–woman relationship

Time pressures

The frustration regarding time constraints expressed by midwives in the Cardiff study

(Sanders et al, 2016) was strongly echoed by service users as they described their experiences of care. Comments showed recognition of the time pressures that midwives are under, and some participants made the point that where a midwife is a skilled communicator, this can mitigate against the time pressure felt by the woman.

One result of perceived time pressure for women was that there was not enough time to discuss issues they were concerned about:

> ***'The community midwives were always running late in appointments and then in such a rush to get you out and the next person in, so I had to get my info from other sources.' (SU11)***

> ***'In general, the community midwife I saw for my check-ups was pretty "to the point" and I felt I could only really squeeze one question into each appointment, so I always asked the most urgent one and hoped I was doing OK with the rest.' (SU2)***

> ***'I know the NHS has a very tight budget but being given time and one-to-one care was better than any leaflet or series of tick boxes.' (SU6)***

Care as a tick-list

Within the theme of time pressures was the feeling that some midwives saw giving information simply as a tick-list. This was viewed as an impersonal, or even dishonest, approach to care:

> ***'One of the community midwives after birth was lovely, but the one who discharged me barely spoke to me. I watched her tick boxes that said "mental health discussed". Looking back, I should have said something.' (SU4)***

One woman said she was frustrated by the use of tick boxes as a way of midwives 'covering their backs', and made an interesting suggestion to address this:

> ***'I was really surprised after I was discharged home from hospital after giving birth to find a checklist of topics discussed in my notes... all ticked and signed by the midwife, many of which hadn't even been mentioned let alone discussed. They included things like checking good latching onto breast and how to express, and safe sleeping, but no one came to watch me feed or even asked how it was going. At best, it would seem that the midwife had seen it was my fourth child and presumed I would have previously been given advice; at worst it is a complete falsification of records... and certainly not good care or practice. My notes weren't about the care I had been given but a tick list to show the midwife had (supposedly) done her job. I think it should be the woman who signs to say what has been discussed—it would also ensure there was opportunity to ask any questions she may have rather than presuming that advice has been given, therefore adequate care given.' (SU6)***

Continuity of care

Again, the frustration of the midwives regarding the lack of opportunity for continuity of care resounds within the service user group:

> ***'There were supposedly two midwives based at my GP surgery but it was never that straightforward. I think consistency is so important for building relationship and trust so that they know you and your "story". I had an emergency caesarean section and then had complications with feeding my daughter. I was really disappointed that I saw completely different midwives for the couple of weeks once I was back home. I had someone visiting regularly yet it was almost a different midwife every time so I'd have to explain the same thing time and time again and they always had different opinions and advice (which were sometimes conflicting) and it was really hard to deal with, particularly during baby blues!!' (SU11)***

Another participant made a clear case for continuity of care in terms of how it facilitates better communication, which can then lessen the negative impact of time constraints:

> ***'For my first two pregnancies in Southampton I saw the same midwife for all my antenatal appointments and really valued that. She managed to build a good positive relationship even in the short appointment times we had. She both listened and answered questions and [I] felt like she really prepared me for my labour and early days and gave***

good health promotion advice. I really missed that in my third and fourth pregnancies.' (SU6)

All of the women who commented about continuity of carer viewed it positively; for one woman, with mental health concerns, the lack of continuity she experienced highlights the crucial role that building a relationship with one or two midwives can have for some women:

'I found that I wasn't given enough support when it came to my mental health. Having suffered from mental health problems for 10 years and having taken anti-depressants for 7 years prior to becoming pregnant, I was told at my first midwife appointment that I would be referred to a special mental health team within the hospital. This never happened, even after me asking many of the different midwives that I saw... I think that it was just a lack of communication and also the fact that I never saw one midwife more than once so never was able to build a relationship or personal bond between myself and them.' (SU12)

Different media for health messages

The internet as a source of information

Referring to the limited opportunities to discuss issues with their midwives, the women talked about their experiences of using the internet as a source of information. The internet was identified as a common way of finding out information, but its unregulated nature was a source of stress.

'I had a tendency to just Google issues which would leave me convinced both the baby and I were going to die very soon! Had to decide to stop Googling as a lot of the forums are just people who had the worst things happen sharing their stories and a lot of people freely sharing advice and opinion without much input themselves beyond personal experience! Would be great to have forums monitored by midwives.' (SU1)

'Never had a website suggested. I also had to ban late-night Googling.' (SU5)

Within this theme there was a lot of discussion about the use of leaflets as a substitute or reinforcement for a public health message. The response about the use of leaflets was unanimously negative, with women feeling bombarded with information. This is an interesting finding considering the higher-than-average level of literacy of the group, which may be considered an indication that written materials may have been desirable. This was not the case:

'Not sure I read any of my leaflet mountain—just sifted through for the freebies!!' (SU1)

'So many leaflets!!!!!! When exactly do they expect you to read them?' (SU5)

'Keeping baby safe and pelvic floor exercises were not discussed, just leaflets given and the last thing I wanted to do when I got home was read through leaflets! I also felt unsure about best practice for looking after myself to avoid infection.' (SU9)

Antenatal classes

It is notable that, having said that they valued the time and opportunity for one-to-one interactions, several participants also commented on the usefulness of antenatal classes to have discussions in a group setting:

'First time round, most of the things you have listed were covered in the free antenatal classes I went to at the hospital, although it was mostly focused on what to expect in labour and breastfeeding. I felt prepared for labour and felt certain I wanted to breastfeed, but not really prepared for what to expect afterwards.' (SU3)

'I think the classes at the hospital were best for asking questions and getting information as there was much more time for discussion.' (SU7)

'I went to two antenatal classes at the hospital about a month before my due date. One was on breastfeeding and the other was on labour. Both were really helpful and I was told about skin-to-skin for the first time.' (SU11)

Midwives' and maternity support workers' communication skills

The 'how' of communication

The importance of active listening and empathy were specifically mentioned by some participants:

'Forgot to mention my best midwife! She was ace because she was a great listener.

Sometimes you just need to hear, "I know it's tough."' (SU5)

'I felt that my community midwife didn't really listen when I asked her about my level of exercise. I danced a lot, including lifting people, and did a show at 19 weeks pregnant. My back and hips really suffered later on and I had to be referred to physio.' (SU13)

'Think it varied very much from midwife to midwife; the worst never even looked at me when filling in the booking forms, the best really seemed to understand where I was at and very reassuring. After having C, we had to stay under the community midwives for the full month for prolonged jaundice and they either visited or called every other day for what felt like ages! They were generally really warm and reassuring about it all and very encouraging. However, during my first pregnancy, the community midwife rarely talked to me and didn't really seem to care at all.' (SU1)

This finding reinforces the need for midwives to be trained in the 'how' of communication, rather than simply the 'what' of the message. This training gap is picked up in the main report (Sanders et al, 2016: 5):

'...training focused on the content of public health messages rather than how best to engage with women.'

Women's experiences were that the quality of the interaction, and therefore the message conveyed, was strongly dependent on the ability of the midwife to put the woman at ease, and to be non-judgemental in her approach.

'I was quite shocked when I had a different midwife one week and she suddenly said "does your partner hit you?" I had to ask her to repeat it as it came so out of the blue, very bizarre. I laughed as I was so taken aback! For the record he doesn't and it goes without saying there may be better ways of broaching the subject!' (SU7)

The content of the message

Having said that midwives perceive their training needs to be around having difficult conversations rather than the content of the public health message, there was clearly a range of experiences around the quality of the content of the message.

'...info on preventing infection—I had so much conflicting advice from different midwives and doctors which was quite scary at the time as it felt like I might be increasing my chances of infection whatever I did!' (SU4)

Regarding breastfeeding, whereas midwives and MSWs believed that breastfeeding was broadly covered, the women in this study presented a more mixed experience. This seemed to highlight differences in midwives' attitudes and knowledge within the same maternity setting, and differences between settings, which possibly reflects Baby Friendly status.

'...my community midwife never talked to me about feeding. Just after labour however, the midwife who delivered the baby helped me to latch him on and gave me advice so it really does differ between midwives.' (SU2)

'This time round the only discussion about feeding was a midwife standing at the door of our four-bedded ward and calling to me, "breast or bottle mum?" I replied "breast" and she wrote on the notes in her hand and left... that was the full extent of discussion and support I received.' (SU6)

Regarding formula feeding, findings are congruent with the Cardiff study in that it is rarely mentioned, and women felt unsupported when choosing to formula feed.

'In my antenatal class one woman expecting twins asked about mixed feeding and the midwife said she'd speak to her privately afterwards as she didn't want to talk about bottle-feeding in the group. We felt like we could have done with info on how to bottle-feed safely when we had to give formula.' (SU4)

In terms of how often particular topics were raised throughout pregnancy, two topics were highlighted. Women felt that they were asked about contraception too frequently and that it 'seemed like an obsession', but that pelvic floor exercises and care were not addressed sufficiently.

One woman with persistent pelvic floor problems felt that the timing of pelvic dysfunction, typically in later life, meant that midwives bothered less with these conversations as they did not occur on the midwife's 'watch' during the woman's life.

The need for unbiased, evidence-based information

There was a perception among the women that some information-sharing was biased, either by the midwife's own opinion or by a feeling they had to 'toe the party line'; a strong driver seeming to be avoiding blame or litigation. Regarding safe sleeping—particularly co-sleeping associated with breastfeeding—there was a feeling that midwives were reluctant to discuss how to co-sleep safely, despite this being a fairly common practice for breastfeeding women. Some comments suggest coercion rather than a sharing of information to allow an informed choice, and that midwives may be reluctant to advise women on how to make co-sleeping safer:

> ***'I do feel that in both cases soon after my babies were born, midwives who I was looking to for reassurance and sensible, balanced advice applied undue amounts of pressure on me to do what they wanted me to do, based on one set of values/information. With my second child I had a midwife make me promise that I would never bed-share with my baby or I "would smother her". I felt pushed into promising not to do it, and only did so as disagreeing with a midwife after the birth of my first child had backed me into a corner in such a negative way that I would do anything just to get her to move on.' (SU14)***

> ***'I felt with both breastfeeding and safe sleeping the midwives were nervous to advise me to exclusively breastfeed in case he lost weight and terrified of me co-sleeping in case I smothered him! It felt like they didn't want anything they said to come back and bite them!' (SU1)***

> ***'I agree with H about toeing the party line. Sometimes I felt like asking, "But what do you really think?" However, I can see why the messages do need to be reasonably consistent.' (SU3)***

> ***'When my first lost a lot of weight and struggled to put it back on, the midwife said I needed to give formula top-ups. I was happy to follow her advice and just wanted my baby to thrive. She then said, "You will feel guilty but I think it's what we need to do." I felt like she was putting that guilt on me, which was a bit unfair.' (SU4)***

Presuming lack of need

As discussed, the group of women in this focus group was fairly homogenous in not falling into some of the well-known categories of vulnerability (although one participant spoke frankly about her mental health). In addition, most of the participants had more than one child. A number of women felt that they were seen as fitting the midwives' stereotype of not needing advice or support due to a perception of higher social class, normality or experience, which led to assumptions and closed questions:

> ***'I did get told by one midwife that I must be fine as I spoke English, had a job, was married and had a house... I think round here that may be not the norm.' (SU1)***

> ***'At booking in I did get asked, "You aren't suffering from domestic abuse, are you?" Found that a bit shocking!' (SU4)***

> ***'Similar to L, I got a lot of questions where they assumed everything was OK, but had to ask: "You don't smoke, do you?... You're not scared at home, are you?"' (SU3)***

> ***'I think everything was very different with [my] second child. I don't think my midwife gave me much information at all, probably assuming that I knew from first time round.' (SU3)***

The role of specialist referral services

Two of the participants were cared for outside of midwifery-led care, with their experiences of specialist care being very different in terms of the public health advice and support they were given. For one of these women (SU13), that she was cared for by a hospital consultant (for Crohn's disease) left her with the sense that she had missed out on the conversations she would normally have had with a midwife. For the other (SU4), who was cared for by a public health midwife specialising in diabetes, her experience of genuine continuity of care was seen to add real value to her care.

> ***'It would have made a huge difference to my care to have had named midwives.***

Key points

- Midwives have an optimum opportunity to promote health and wellbeing through family-centred conversations around key public health issues
- A focus group was conducted using a closed Facebook group to investigate how women using the midwifery service perceive the delivery of public health messages
- Qualitative data were collected from 14 women who had received midwifery care in different NHS Trusts across England
- The women revealed that they wanted consistent, unbiased information, delivered without coercion in a clear and sensitive way
- Time constraints and lack of continuity of care were seen as the two major barriers to midwives effectively fulfilling their public health role
- The issues raised by this focus group are part of the data currently being used to inform a new model for public health in midwifery services in England

I felt very unsupported throughout pregnancy and didn't feel I had a good patient/professional rapport with anyone. Because I was scheduled for a caesarean section (which actually didn't happen in the end as he arrived too quickly!) I felt I missed out on talking about other things like breastfeeding, which may have been covered in more depth under midwife care.' (SU13)

'I was lucky to be under an amazing midwife as I have type 1 diabetes. She was very helpful, not patronising and always available on the phone. One of few perks to being diabetic. The consultant was also brilliant and they seemed to communicate between each other and me really well.' (SU4)

Conclusion

This focus group has sought to add insight into the public health role of the midwifery team by asking service users how they perceive the way various issues are discussed or information shared. Fourteen women representing 14 NHS Trusts took part, with contributions expressed on a wide variety of topics. Many of these concur with the views expressed in a similar study by Sanders et al (2016) of professionals' views; others present a novel perspective. Both professionals and service users experience frustration with issues of time constraints and lack of continuity of care; the women in this focus group saw these issues as the two major barriers to midwives effectively fulfilling their public health role. However, throughout the discussions, service users stressed the importance to them of warm, empathetic care and good communication skills, which were seen to some degree to lessen the negative effects of lack of time and continuity.

> Women want consistent, unbiased information, delivered without coercion in a clear and sensitive way

When broken down into the 'what' and the 'how' of public health messages, the women expressed that they want consistent, unbiased information, delivered without coercion in a clear and sensitive way. Face-to-face conversations as part of midwifery care or antenatal classes were favoured, whereas the use of leaflets was not seen as helpful, especially when used as a substitute for a real conversation. It was felt that some midwives use tick boxes inappropriately, as a way of 'covering their backs'; some women expressed that midwives had ticked boxes for advice and support which they had not given, rather than as a simple way of recording the care they had provided. As was acknowledged by many of the midwives in the Cardiff study, the broad scope of the public health role requires sensitivity to the needs of individuals to tailor advice appropriately, while recognising that there are some messages that are universally relevant.

A limitation of this study is the homogeneity of the group, with no representation of teenagers or, by nature of the online medium, women with limited literacy or language skills. It would be beneficial in any future research to specifically target such groups, using traditional focus groups where appropriate.

The issues raised by this study and others are currently being used to inform a new model for public health within midwifery services in England (Gomez, 2016). **BJM**

Chief Nursing Officers of England, Northern Ireland, Scotland and Wales (2010) *Midwifery 2020: Delivering Expectations*. http://tinyurl.com/kdp3emn (accessed 4 May 2016)

Gomez EA (2016) Stepping up to Public Health. *Midwives* **19**: 68–9

Sanders J, Hunter B, Warren L (2016) A wall of information? Exploring the public health component of maternity care in England. *Midwifery* **34**: 253–60. doi: 10.1016/j.midw.2015.10.013