

Do we acknowledge families' sexual and reproductive health needs within maternity services? A practising midwife's reflection

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The role of the midwife involves caring for a diverse population of women. Although we are experts in providing holistic care throughout the antenatal, intrapartum and postnatal periods, on some occasions we may need to make referrals to specialist practitioners. These referrals often occur when care falls outside of our scope of practice (Nursing and Midwifery Council (NMC) 2015). As a naturally curious and ambitious individual I keep a reflective journal of themes and issues where I have made referrals. It has become apparent that some of these issues are fundamental to midwifery and that as midwives we should acquire the skills needed to provide the appropriate care. Furthermore, these skills are not outside my scope of practice if I develop the relevant competencies and confidence. Sexual health was a starting point for continued professional development that would broaden my experience and most importantly benefit the families that I work with.

As a rotational midwife practising in a large centralised maternity unit, I have provided care for a diverse population of women and their families, varying in age, socioeconomic status, cultural and religious beliefs, race and sexuality. Despite ethnic and social differences, all of the women that come through the service have their own personal sexual and reproductive health needs (Imison *et al* 2014). Some will have issues that need addressing, others may not wish to discuss or address sexual and reproductive needs, whilst some women and families will need more specialist support (Sung *et al* 2010). Public health is an underpinning requirement of midwifery practice and avoiding discussion of sexual health and its care provision is detrimental to women's sexual health, general health, mental health, intimacy and relationships (Johnson 2011).

Upon reflection, I have recognised that within my area of practice, sexual and reproductive health needs are often assumed to be the responsibility of the GP, genitourinary medicine (GUM) and contraception and sexual health (CASH) services. Therefore, women's needs, issues and anxieties are often missed or neglected. This opinion is supported by literature that has concluded that gaps in knowledge surrounding the positive impact that public health promotion has in conjunction with maternity care, has resulted in midwives avoiding public health topics (McNeill *et al* 2012).

Following critical evaluation of the literature I maintain the belief that there is a link between optimal sexual and reproductive health and improved maternal and neonatal outcomes. This view is supported by population data which demonstrates a strong link between untreated sexually transmitted infections and preterm delivery, infection, low birth weight and abnormalities of the neonate (Moodley & Sturm 2000). However, there is limited empirical evidence that supports poor sexual health and poor maternal and neonatal outcomes. The ethical implications of research in pregnancy have resulted in gaps in the literature. Ledward (2011) argues that all practice should be based upon evidence and that clinical experience and tradition should not inform practice. However, it is questionable that there is a need for more focus upon what practitioners should do when the research to inform practice is non-existent — should clinical expertise prevail? Although evidence-based practice is arguably an underpinning factor in providing safe care, where there is limited empirical evidence to establish guidelines, practitioners may feel reluctant to use clinical expertise and autonomy for fear of working outside recommendations (Tyssen *et al* 2013).

Reflexive and reflective consideration of a clinical scenario I was involved in has highlighted an awareness that time constraints affect midwives' motivation to address issues appropriately. In my personal experience taking time to address sexual health issues is not without difficulty, as often I felt I was hindering colleagues' other tasks by taking time with them to discuss and action a plan — on an already busy shift. However, after broadening my practice with continuous professional development (CPD) sexual health advising skills, I now have the confidence to maintain the view that although at times I may have concerns surrounding other colleagues' opinions of my practice, it is in the best interest of clients to put these beliefs to one side and not feel guilty for time spent with these women. Saunamäki *et al* (2010) support the theory that one of the main reasons practitioners do not facilitate difficult discussions is due to time constraints and lack of confidence. Time constraint is a difficult issue to address; more research is needed to examine why practitioners do not feel confident prioritising and justifying time spent with complex cases (Hemsley *et al* 2012).

Closure is arguably a phenomenon within midwifery practice; a reluctance to reduce interprofessional boundaries or to expand and diversify the role of a midwife has been addressed by strategic recommendations on numerous occasions and although some advanced specialised roles have been developed, there is still strong protest to maintain a separate professional identity (Prowse & Prowse 2008). Research in Chile confirms that midwives' interactional barriers with other professionals may be a national problem and suggests that

boundary expansion could contribute to conflicts between groups — as professionals may view others as impeding upon their specialities (Ayala *et al* 2015). The research, however, further states that multidisciplinary working is more powerful with a view to political and strategic change — a concept we must consider in our everyday interactions within practice.

The joining of workforces could be powerful in ensuring sexual and reproductive health remains a public health priority on government agendas. In some areas of the UK, specialist link professionals for sexual and reproductive health meet and address issues using a multifaceted approach. However, it is argued that this is largely unfeasible to roll out nationally due to financial, time and attendance constraints (Gott *et al* 2004). Following reflection of clinical practice and critical evaluation of the literature, I conclude that the constraints proposed by research must be viewed with caution. I maintain a multifaceted approach benefits patient care and commissioning. Furthermore, I encourage midwives to speak to managers and primary care links to discuss the value of acknowledging families' sexual and reproductive health needs within local maternity service provision — with a sense of optimism that in future, maternity service providers and midwives will make sexual health a public health priority.

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References

- Ayala R, Binfa L, Vanderstraeten R *et al* (2015). Exploring historical conflicts between midwives and nurses: a perspective from Chile. *Journal of Interprofessional Care* 29(3):216-22.
- Gott M, Galena E, Hinchliff S *et al* (2004). 'Opening a can of worms': GP and practice nurse barriers to talking about sexual health in primary care. *Family Practice* 21(5):528-36.
- Hemsley B, Balandin S, Worrall L (2012). Nursing the patient with complex communication needs: time as a barrier and a facilitator to effective communication in hospital. *Journal of Advanced Nursing* 68(1):116-26.
- Imison C, Sonala L, Honeyman M *et al* (2014). *The reconfiguration of clinical services: what is the evidence?* London: The Kings Fund.
- Johnson CE (2011). Sexual health during pregnancy and the postpartum. *Journal of Sexual Medicine* 8(5):1267-84.
- Ledward A (2011). Informed consent: ethical issues for midwife research. *Evidenced Based Midwifery* 9(1):23-9.

- McNeill J, Lynn F, Alderdice F (2012). Public health interventions in midwifery: a systematic review of systematic reviews. *BMC Public Health* 8(12):955.
- Moodley P, Sturm AW (2000). Sexually transmitted infections, adverse pregnancy outcome and neonatal infection. *Seminars in Neonatology* 5(3):255-69.
- Nursing and Midwifery Council (2015). *The Code: professional standards of practice and behaviour for nurses and midwives*. London: NMC.
- Prowse J, Prowse P (2008). Role redesign in the National Health Service: the effects on midwives' work and professional boundaries. *Work, Employment and Society* 22(4):695-712.
- Tyssen R, Palmer K, Solberg IB *et al* (2013). Physicians' perceptions of quality of care, professional autonomy, and job satisfaction in Canada, Norway, and the United States. *BMC Health Services Research* 13(516).
- Saunamäki N, Andersson M, Engström M (2010). Discussing sexuality with patients: nurses' attitudes and beliefs. *Journal of Advanced Nursing* 66(6):1308-16.
- Sung SC, Yeh MY, Lin YC (2010). An exploration of the nurses' perspectives and their current practice on sex consultation. *Formosan Journal of Sexology* 16:1-15.
- Crisp E. MIDIRS Midwifery Digest, vol 28, no 2, June 2018, pp ??**
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