The Application of Salutogenesis in Birth, Neonatal, and Infant Care Settings

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Introduction

As noted elsewhere in this volume, salutogenic theory was first introduced by medical sociologist Aaron Antonovsky (1979). His unique contribution to theory, practice, and policy is the focus on the origins and experience of health, as well as the causes and manifestations of disease. Antonovsky believed that the health status of an individual shifts over their life along an ease/disease continuum. This approach is in direct contradiction to the currently hegemonic medical/technocratic downstream emphasis on identifying pathology and testing the efficacy and cost-effectiveness of consequent treatment. Given that the kind of research that is generally funded in health and social care is inevitably influenced by the medical–scientific norms that prevail, studies assessing actual or potential pathology, and subsequent interventions, are highly prevalent in early years of research. A turn to salutogenic theory has the potential to create a space for new research programmes, and new types of practical solutions, by advocating a balance between downstream pathogenic perspectives and upstream health promotion. Such studies and solutions focus on the creation, enhancement, and maintenance of well-being.

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The sense of coherence (SOC) is a key salutogenic concept. It is considered to be an adaptive life orientation that enables one to cope and manage adverse experiences (Antonovsky, 1979; Eriksson et al., 2007). The mechanism of effect is the capacity to integrate high levels of meaningfulness, comprehensibility, and manageability when faced with challenging situations or events. A person with strong SOC will be able to understand and integrate (comprehensibility), to make sense of (meaningfulness), and to handle (manageability) a disease, crisis, or challenging experience more successfully than someone with a weaker SOC. Therefore, a stronger SOC is often associated with, and predictive of, positive physical and psychological health outcomes (Lindström et al., 2010). The degree to which the SOC is present for an individual has been associated with four types of life experiences: consistency, load balance, participation in shaping outcomes (Antonovsky, 1991), and (identified more recently) emotional closeness (Sagy & Antonovsky, 2000) (Box 43.1).

Box 43.1: Types of Life Experience, Contributing to the Development of the Sense of Coherence

Type of life experience	Definition	Component of sense of coherence
Consistency	The extent which during the course of growing up, there is clear order and structure instead of a chaotic environment	Comprehensibility
Load balance	The extent to which one experiences overload or underload in the balance between the demands of others and one's resources	Manageability
Participation in shaping outcomes	The extent to which one is able to decide one's own fate, independent of the whim of others	Meaningfulness

Type of life experience	Definition	Component of sense of coherence
Emotional closeness	The extent to which one feels consistent emotional bonds and a sense of belonging in a social group which one is a member	Meaningfulness

SOC is a central concept in salutogenesis theory. Other theories and concepts have also been included under the general ‘salutogenic’ umbrella. These include Bowlby’s attachment theory, Bandura’s self-efficacy theory, learned resourcefulness, locus of control, and connectedness (Lindström et al., 2010). All these concepts share a similar view of health being a resource for life, and on the value of maximizing optimal health, even in the presence of illness.

Salutogenesis and Maternity Care

Pregnancy, birth, and the early postnatal period and infancy (the first 1000 days) are times when the physical, psychological, and emotional development of humans is highly plastic (Barker & Osmond, 1986; Georgieff et al., 2015; Schwarzenberg & Georgieff, 2018). Social and environmental influences during this period can strongly affect child development and the maternal/paternal/parental bond. There is a large amount of evidence on the potential for epigenetic and microbiotal damage during this period, secondary to environmental and social deprivation (the so-called Barker hypothesis) and the long-term impact on chronic adult diseases (Indrio et al., 2017). However, the salutogenic aspect of this critical period of development is a particularly under-researched area.

To date, most studies of salutogenesis in perinatal care have been focused on measuring and promoting parental SOC and well-being, as the basis for improving parental health outcomes that will indirectly affect infant birth and developmental outcomes (Browne et al., 2014; Escuriet et al., 2015; Ferguson et al., 2016; Shorey & Ng, 2020). Since infants and neonates are highly dependent on primary caregivers to address and manage their needs, strong parental SOC and well-being are vital in ensuring healthy infant developmental outcomes. SOC is not measurable in early infancy. Despite this, the development of SOC is believed to span across the entire lifecycle starting from infancy and the infant’s experience of its socio-cultural and historic context (Sullivan, 1993). Socialization from infancy to early adult-

hood provides the opportunity to develop a certain degree of SOC. The socialization process in infancy begins with exposure to a stimulus, in which the nature of the infant’s response (i.e. positive or negative) determines a set of experiences that leads to the development of meaningfulness. As children grow older, Antonovsky hypothesized that various socio-cultural factors and personality characteristics would continue to shape the development of their SOC (Antonovsky, 1998).

In recent years, the concept of salutogenesis has been gradually gaining traction among maternity and perinatal care researchers, promoting the transition of an almost exclusive pathogenic orientation towards one that also includes a more health-promoting salutogenic orientation (Perrez-Botella et al., 2015; Ferguson et al., 2016). The World Health Organization (WHO) has been stepping up efforts to improve maternal and newborn health, to improve parental care provided at home by women and families, to increase community support for mothers and infants, and to increase accessibility to and the use of skilled care (World Health Organization, 2015). The intention of the WHO to ensure that both pregnancy and childbirth are optimal for women and their newborns is captured in the inclusion of the term ‘positive experience’ in the titles of the most recent WHO antenatal and intrapartum guidelines (WHO, 2014, 2018a, b).

The turn towards a positive experience is driven by a new emphasis on finding out what matters to women, families, service providers, and policymakers, based on qualitative evidence of their views and experiences. This serves to balance the evidence from randomized trial evidence. Such trials have also usually included only or mainly pathogenic outcomes, such as death and severe morbidity. Given that, for the vast majority of women, babies, and families, the maternity episode is one of growth, joy, and fulfilment, such outcomes fail to measure the spectrum of what matters (Downe et al., 2018). Along with measures such as rates of breastfeeding, and parental sense of competence and confidence, this shift in emphasis is also beginning to introduce more positive, salutogenic outcomes into primary research studies in maternity care (Smith et al., 2014).

As evidence of this turn, maternal health-promoting interventions that have been strongly recommended by WHO in recent guidelines have involved birth preparedness and complication readiness, male partner involvement, partnership with traditional birth attendants, providing culturally appropriate skilled maternity care, continuity of midwifery care, respectful care, having a companion of choice at birth, and community group support (World Health Organization, 2015).

Salutogenic Approaches to Neonatal and Infant Service Provision

It is increasingly recognized that neonatal well-being is dependent on what has happened in utero, and during birth. Good maternal nutrition and social support during pregnancy have been associated with improved outcomes (Borge et al., 2017; Koletzko et al., 2019). The way a baby is born can affect its epigenome and microbiome in ways that are only recently becoming evident (Indrio et al., 2017). The consequences of these effects include impacts (for better or worse) on the immune system and the expression of health or disease in later life (Indrio et al., 2017; Schwarzenberg & Georgieff, 2018).

Historically, neonates who required special or intensive care were subjected to parental separation, sterile and non-therapeutic environments, and a range of noxious interventions. This was partly because the importance of closeness to a nurturing adult was not recognized, and because of a widespread belief that neonates (and especially premature neonates) could not feel pain. More recent moves towards family-centred neonatal care, recognition of the acute sensitivity of neonatal senses, and the potential for neonate and family-centred design for neonatal units have started to shift the balance for these very vulnerable babies. Neonatal staff are engaged in a range of innovations that are designed to move the focus from pathology and hospital-centric environments and treatments to more salutogenic configurations and regimes (Thomson et al., 2013).

Considering the importance of parent–child attachment in the first year of a child’s life and how nurturance and responsiveness are the primary determinants of attachment, we examine three widespread solutions with a salutogenic-like ethos. These are skin-to-skin contact (including kangaroo care for premature or sick neonates), breastfeeding, and family-centred care.

Sustained skin-to-skin contact between mother/parent and baby immediately after birth is one of the cardinal steps of the Baby Friendly Hospital Initiative (BFHI) launched by the WHO and UNICEF in 1991 (World Health Organization, 1991; UNICEF, 1991) and updated to be more mother-friendly in 2018 (World Health Organization, 2018b). The inclusion of cuddling the baby naked directly against the mother’s body is because it has been shown to increase the potential for successful breastfeeding, which, in itself, is linked with a range of positive outcomes throughout life (Dieterich et al., 2013; Horta et al., 2015; Sankar et al., 2015). However, skin-to-skin contact is also independently associated with other health and beneficial psychosocial effects for both mother and baby, in terms of bonding, stabi-

lizing breathing and temperature control, the adaptation of a range of neonatal organs and systems to healthy functioning in external life, oxytocin and endorphin production in both mother and baby (associated with feelings of happiness and joy), and increased cytokine and natural killer cell production, which is associated with more rapid recovery from the intense effort (and, in some cases, the physical damage and infection risk) of giving birth and being born (Crenshaw, 2014; Moore et al., 2012; Safari et al., 2018).

For premature or sick neonates, the extension of this practice into kangaroo care entails the baby being held skin to skin with the mother/parent or caregiver for long periods, where this is clinically possible. Indeed, the best neonatal units are designed around the facilitation of this approach (rather than trying to fit kangaroo care around clinical technologies and equipment). Where this is done, the unit itself becomes a catalyst for salutogenesis, not just in what is done, but in how expectations for parents and staff are constructed (Chan et al., 2017; Golembiewski, 2017). If a unit is designed to make it easy and normal to undertake skin-to-skin/kangaroo care, then this will be the norm (Chan et al., 2017; Golembiewski, 2017). This salutogenic-centric design has been adopted in a number of neonatal units in Sweden. Flacking et al. (2016) undertook a qualitative study of parents’ experiences in neonatal units in England, Sweden, and Finland, using what the authors described as a ‘salutogenic approach’. The analysis revealed several hypothesized pathways to the establishment of emotional closeness between parent and infant. These included the power of physical closeness, the reassurance of and contribution to infant wellness, having realistic expectations and knowing what to do, the joy of feeling engaged, and being able to spend time and bond as a family.

In terms of breastfeeding, the BFHI could be conceptualized as a worldwide salutogenic initiative to protect, promote, and support exclusive breastfeeding for the first 6 months. In 2009, the BFHI was revised and expanded to include integrated care for preterm or sick infants and their mothers (World Health Organization, 2009). A report by Nyqvist et al. (2013) expanded on the original ten steps guide for healthcare providers to facilitate successful breastfeeding for infants in the neonatal intensive care unit (NICU). This recommended a specific breastfeeding policy for NICU, which requires healthcare professionals to have knowledge and skills in lactation and breastfeeding support, including the provision of antenatal information pertaining to neonatal care. Emphasis was made on early initiation of breastfeeding, and the facilitation of early, continuous, and prolonged skin-to-skin contact between infant and mother, with minimal parent–infant separation. Upon discharge, the report rec-

ommended that parents should also be adequately informed about available support resources and that they should be provided with a follow-up plan.

In relation to feeding practices in general, a qualitative study by Holdren et al. (2019) revealed that pumping breast milk was more common in US mothers than in Finnish mothers, for whom breastfeeding was more prevalent. This seemed to be because Finnish parents saw breastfeeding as a social as well as a nutritional act. They believed that breastfeeding was an important component of closer parent–infant bonding. In contrast, American parents saw breastfeeding primarily as a means to promote infant nutritional health. This may be partly a result of different return-to-work policies and provisions for women in these two countries, since US mothers are under pressure to return to work very early, in contrast to Finnish mothers. The conceptualization of breastfeeding as social bonding and intimate relationship building has important implications for the development of the SOC concepts of comprehensibility, manageability, and meaningfulness for both mother and baby (Thomson & Dykes, 2011). In this study, comprehensibility was associated with the method and type of information provided to mothers from healthcare providers, and the need for consistency and choice. The manageability of breastfeeding was influenced by the women's birth experience, handling of their breasts by midwives, and the nature and extent of available support during feeding. Lastly, the meaningfulness of the experience was derived from public or media portrayal of infant feeding messages, perceptions of breastfeeding, their own emotionality, and difficulties associated with breastfeeding (Thomson & Dykes, 2011).

This might be an area where government policy could be changed to enhance the capacity of mothers and babies to experience feeding as more than just a transactional enterprise. If this could be done, it is possible that a consequence would be the development of strong SOC for both mother and baby into later life. In support of this hypothesis, Holdren et al. (2019) concluded that breastfeeding coupled with skin-to-skin contact was found to enhance a salutogenic care approach for the whole family, beyond the provision of a nutrition source for the baby.

Another hospital-based salutogenic intervention, Family-Centred Care (FCC), was proposed by Helen Harrison in 1993 (Harrison, 1993; Gooding et al., 2011). The core concepts of FCC include respect, diversity, recognizing and building on the strengths of each infant and family, choice, flexibility, information sharing, support, collaboration, and empowerment (Gooding et al., 2011). The FCC principles helped set the foundation for the recent family-integrated care model (Franck & O' Brien, 2019). FCC is built on the development of a healthy therapeutic alliance between family and healthcare provider through sharing of infant care

responsibilities to balance out the power and authority of the provider, build positive entrustment, and improve quality of care (Maria & Dasgupta, 2016). The hypothesis is that this approach could lay the foundation for the continuum of care for the baby at home, after being discharged from the neonatal unit. Despite limited research comparing the effectiveness of FCC models to current care models, the review by Gooding et al. (2011) reported that more robust programmes tend to include family-centred NICU design, policies, support services, and clinical team education and support. Such FCC models have also been found to lead to favourable outcomes for neonates in NICU, the family, and healthcare providers. Positive impacts on the neonate include greater weight gain, higher breastfeeding rates, fewer signs of stress, better performance on a neurobehavioral exam, shorter length of hospital stays, and fewer readmissions (Bastani et al., 2015; Byers et al., 2006; Lv et al., 2019; Yu et al., 2017). Parents are also more satisfied with FCC model that provide them with better information, and that helps them to cope better with stress, improve their psychological well-being, and be more confident in their parenting roles (Bastani et al., 2015; Maria & Dasgupta, 2016; Melnyk et al., 2006; Yu et al., 2017). However, due to poorly defined components of the FCC model, Franck and O' Brien (2019) cautioned against the interpretation of findings from studies to date in this area and called for improvements to be made to the model in future. One basis for this might be the conceptual discussion paper produced by Thomson and colleagues that examined the FCC principles in the context of the SOC and suggested that practices that optimize manageability, meaningfulness, and comprehensibility may be an appropriate conceptual basis for (re) designing FCC in future (Thomson et al., 2013).

Salutogenesis and Attachment in Infancy

Infancy and early childhood are critical developmental periods for language and communication skills, cognitive skills, socioemotional functioning, and self-regulation (Mowder et al., 2009). The foundations of a child's mental health are also established during this period as early experiences mould the development of the brain structure (Miller & Kinsbourne, 2012). These early emotional experiences of neonates and infants mostly occur through interaction with their caregivers. The association between positive emotions and the availability and responsiveness of the caregiver is strengthened during infancy, affecting behavioural and brain architecture development (Cassidy, 1994). Therefore, parents' and caregivers' relationship with their infants and newborns plays a critical role in shaping the emotional, cognitive, and social development of their child.

As mentioned previously, emotional closeness is one of the four types of life experiences that contribute to the development of SOC (Sagy & Antonovsky, 2000). The concept of establishing close emotional relationships with others is also dominant in Bowlby's attachment theory (Bowlby, 1980). Attachment theory emphasizes the development of a specific and enduring relationship between infants and their primary caregivers over the first year of life (Ainsworth & Wittig, 1969). According to Bowlby (1980), attachment is a lifelong connectedness between humans and also part of an innate behavioural process where children seek proximity from their caregivers to receive comfort and protection. The primary caregivers' availability and responsiveness to an infant's needs allow the child to develop a sense of security, knowing that the caregiver is dependable, which then creates a secure base for the child while they explore the world.

The development of attachment varies throughout the first year of life. Over this time, the availability of a caregiver, and the degree to which this caregiver provides consistency and responsiveness, influences the extent to which the infant can form secure attachments (Bowlby, 1980). Infants of responsive and available caregivers are more like to develop trusting and secure attachments. In contrast, infants of unavailable, unresponsive, or inconsistent caregivers are more likely to perceive the world as threatening, unpredictable, or rejecting (Ainsworth & Wittig, 1969). The ability to establish secure attachments in infancy may subsequently lead to stronger self-esteem, better self-reliance, successful social relations, better school performance, and decreased risk of psychological and behavioural disorders (e.g. depression, anxiety, oppositional defiant disorder and conduct disorder) as they grow older (Cassidy & Shaver, 1999; Malekpour, 2007). Such secure attachments have also been associated with strong SOC expression (Al-Yagon, 2003).

The Nature and Impact of Early Support

Early support to optimize parenting capacity, and short and longer term well-being for infants and parents, includes comprehensive, systematic and integrative social, health and educational policy development, the creation, coordination and networking of structures and organizations in the social, health and educational system, and an orientation towards equal opportunities. These could be conceptualized as resources that could maximize the meaningfulness, manageability, and comprehensiveness of parenting and (in the older child) of understanding and dealing with relationships and with the world. Given the evidence cited above on the dynamic nature of infant growth and development in the first

1000 days (up to the age of two) the availability of and access to such resources is particularly important for vulnerable and stressed families in these early years if the intention is for the achievement of the best possible life for all.

Early support includes services, offers, and structures that support social integration, as well as catalysing the healthy and holistic development of children in the period from the mother's pregnancy to the child's entry into kindergarten. When such support is accessible, acceptable, and effective, it can enhance the ability of the child to learn through experience. The primary social living space for children in the first years of life is the family. The primary caregivers are usually the parents but whoever is there consistently in the first few years of the child's life will have the greatest influence on their early development (Perry & Fantuzzo, 2010). The early childhood physical, psychological, and social environment also significantly shapes lifelong health and cognitive, emotional, and social development (Walker et al., 2011). For this reason, early support can be offered to parents to enable their children to enjoy good family conditions within which they can develop securely.

Early support is usually designed (explicitly or not) to strengthen the health-promoting resources of children and their families. Arguably, developing a strong positive sense of coherence (SOC) is central to this endeavour, whether programmes acknowledge this or not. Individuals with stronger levels of the SOC have a greater capacity to activate existing resources, to maintain their health and well-being, and to protect themselves against health stressors (Lindström & Eriksson, 2019).

As noted elsewhere in this chapter and this book, the sense of coherence has been defined as a persistent basic trust in life and one's abilities to cope with life (Antonovsky, 1987). In terms of parenting, this can be translated as (Meier & Walter-Laager, 2016):

1. Trust that events and tasks of life related to the upbringing of one's children are fundamentally understandable, that the tasks ahead are predictable to a certain degree and that events and challenges can be cognitively classified (comprehensibility)
2. The conviction that the tasks and challenges of raising children have to be mastered, that the required resources are available, and that help can be found in the outside world if there are insufficient resources within the family (manageability)
3. A belief that there is an intrinsic value or worth to raising children and that this makes it worthwhile and rewarding to engage with the complexities and difficulties of parenting (meaningfulness)

In the area of early childhood, both the SOC of mothers, and the sense of family coherence, have been widely examined (Al-Yagon, 2003, 2008; Ngai & Ngu, 2013, 2014; Idan et al., 2017). There is much less research on fathers SOC in this context. Mothers with a strong sense of coherence have better mental health and have a lower risk of depression, anxiety disorders, and other psychological problems as well as reductions in the prevalence of a range of physical illnesses (Lindström & Eriksson, 2019). Pregnant women with a strong sense of coherence experience fewer birth complications (Perrez-Botella et al., 2015). A positive experience of pregnancy and childbirth—regardless of the birth mode—is a function of a pre-existing strong positive sense of coherence (Ferguson et al., 2016).

Children whose mothers have a strong sense of coherence have fewer psychosomatic complaints as infants and toddlers (Olsson & Hwang, 2008), are less anxious, less depressed, and show less internalizing and externalizing problem behaviour (Books et al., 2010; Honkinen et al., 2009; Svavarsdottir et al., 2005). In addition, they generally have more stable social and emotional health in the first years of life (Al-Yagon, 2008). Previous research on the sense of coherence has also shown positive connections between the SOC of mothers and the lifelong mental and physical health of children and their health behaviour in adolescence (Honkinen et al., 2009).

Parents and children (including parents in formal early support schemes) who have a strong SOC are psychologically and physically healthier throughout their lives, are better able to cope with stress, and are more able to cope with chronic illnesses and disabilities (e.g. Lindström & Eriksson, 2019; Einav et al., 2012; Hedov et al., 2002; Pozo Cabanillas et al., 2006; Svavarsdottir et al., 2005; Schmitt et al., 2008). Parents with a strong sense of coherence have a better expectation of self-efficacy with regard to their parenting skills, and they build more secure bonds with their children (Perrez-Botella et al., 2015). Family cohesion is stronger when mothers or parents have a strong sense of coherence (Einav et al., 2012).

There are indications that families with a strong sense of coherence make more use of preventive services for their children (Silva-Sanigorski et al., 2013). Indeed, when controlled for other variables, it was evident that usage behaviour was determined more by the sense of coherence than by social class. However, other studies suggest that families with a low socio-economic status generally have a weaker sense of coherence than better-off families. They tend to have less confidence in understanding their skills, situations, and tasks, and they tend to be less likely to believe that it is worthwhile to commit to these tasks or that they can master events that arise (Ying, 1999; Lundberg, 1997). This suggests that, while families in low socio-economic groups with a strong SOC do well, families in these settings are

more likely than others to have a weaker SOC. This group, in particular, may benefit from formal support, if it can be shown to be effective in strengthening their sense of coherence.

Strengthening the SOC in Families

The sense of coherence can be influenced (Sagy & Antonovsky, 2000; Hakanen et al., 2007), especially around the time of childbirth (Röhl & Schücking, 2006) and in the early years of life (Habroe & Schmidt, 2007). For early support, this means that offers should enable parents to have experiences that strengthen their sense of coherence by helping them to experience challenges as comprehensible, manageable, and meaningful. Where structural and social inequalities are the root of these problems, strengthening the SOC of an individual may also help them to challenge such inequalities, and, by themselves or with others, to force those in power to enact positive change that reduces such inequities.

Access to Early Education Offers

As an example of how parents access pregnancy and postnatal/early childcare provision, we describe a large-scale evaluation undertaken in Switzerland with 489 respondents (the AFFIS study, Meier Magistretti et al., 2019). The evaluation included the views of parents on the offer of early support, the accessibility of the programme, the outcomes, and the effects on the families involved. The SOC-13 scale was included in the evaluation design. Parents were interviewed in two cohorts, each at two different time points: once, when their children were 0–2 (cohort 1) and 2–3 years of age (cohort 2) and a second time at the children ages of 3–4 years (cohort one) and the age of 5 at the beginning of kindergarten (cohort 2). All interviews were conducted face to face, if needed with the help of professional interpreters who were trained for these types of interviews, and who, between them, were fluent in 19 different languages. In most families, mothers were the only respondents. In less than 1% of cases, both parents, or fathers only, took part. The interviews lasted between 40 and 90 min each. The analysis divided participants into three sub-groups: those who represented the general local population (66% of the sample), those who were migrants living in disadvantaged conditions (22%), and those who were non-migrants in receipt of social welfare (11%).

The kinds of support on offer for pregnant mothers and parents with children up to the age of 5 in the local (German-speaking) area of Switzerland are set out in Box 43.2.

Box 43.2: The Kinds of Support on Offer. Main Services for Early Childhood Care and Education Provided in Switzerland

Type of service	Content	Availability ^a	Costs for parents	Remarks
Prenatal check-up	Seven medical or midwife appointments	(not specifically investigated as this is routinely provided to all)	Covered by the health insurance system all Swiss inhabitants are part of	All maternity care (prenatal, postnatal, and mother and child centres) are available for all Swiss habitants. Special free services are provided for women refugees and 'sans papiers' (migrants living illegally in Switzerland). Hospitals and midwives generally provide translations, but mother and child consultations do so only in cities with special EDC programmes
Midwifery postnatal home care	Ten visits at home after discharge from the place of birth	In 24% of Swiss communities	Covered by the health insurance system all Swiss inhabitants are part of	Mothers have to find a midwife and book the service, which isn't always done (or even known about by mothers)
Mother and child consultation centres	Help and advice relating to the health, development, management, and support of support of babies, toddlers, and preschool children	In 58% of Swiss communities	The service is for free and open to every family. Communities, regions cover the costs	
Daycare	Daycare from 7 am to 6 pm for preschool children from 3 months of age	In 44% of Swiss communities	Costs depend on parent's income	Daycare is expensive: a part-time middle-class mother can spend almost her whole salary on daycare. Many mothers stay at home or use informal services
Playgroups	Semi-professionally guided playgroups for children aged 2 to 5 years (generally once or twice a week for about 2 h)	In 61% of Swiss communities	Paid for by parents, but relatively affordable	
House visit programmes	Supportive house visits for vulnerable families, in some cases combined with parent's groups, parent's education, or access to family centres	In 10% of Swiss communities	Free of charge for parents, but costly for the cities and communities which offer the service	

^aAvailability refers to a study in 785 small and medium Swiss communities (Meier Magistretti & Schraner, 2018). They show the percentage of communities who offer specific services. Parents in communities that lack offers have to search for services in other communities than the one they live in

The full range of local population socio-demographics was represented across the respondents. The profile of the participants varied across the socio-economic groups. Broadly, parents from the general population were well educated, working in stable employment, with few financial problems. Subjectively, however, they tended to report a high burden of parenting, due to time pressure, fatigue, and exhaustion.

Figure 43.1 provides details of the access to and uptake of services by socio-demographic group.

Generally, respondents in all groups reported having similar access to clinical care in pregnancy. Most attended antenatal check-ups, and these were generally highly rated. The

parents emphasized the benefits of this offer, the information they received from doctors and midwives before the birth, the security they gained from antenatal and intrapartum care provision, and the relationships of trust with the specialists that arose, especially where continuous support with a known care provider was available.

However, access to postnatal home care from midwives was experienced differently between the groups. About 80% of parents from the general population and those with a migration background reported access to this service, as compared to less than two-thirds of those in receipt of social welfare. Some in this group reported that they did not know they could have access to such a service. Others stated that

Fig. 43.1 Use of services by different types of families in the Swiss-German AFFIS study. (Adapted with permission of interact Verlag. © Claudia Meier Magistretti et al., 2019)

they were unable to take advantage of this and other linked offers (e.g. mother and father counselling) after the birth of the child, due to their health problems or those of their baby.

After the early postnatal period, access to support dropped off sharply for all groups. Only a little over a quarter of parents who received social assistance had a playgroup place (22%) or a place in a daycare centre (28%) for their child. For parents with a migration background, the usage figures were about 28% for both types of provision. The somewhat higher proportion of children with a migration background in playgroups could be attributed to the high demand for playgroups with integrated language support. From the wider literature, stressed families benefit particularly strongly from home visit programmes, in which they can be supported by trained specialists in creating good development conditions for their child and in interacting adequately with them (Walter-Laager & Meier Magistretti, 2016). However, less than 10% of the disadvantaged groups in the AFFIS survey had access to or were able to use this offer.

Coherence and Early Support

Although families with and without a migrant background were not able to have equal access to all offers of early support, in the AFFIS study all parents had used at least one offer of early support, at least temporarily. Analysis of the change in SOC-13 values over 18 months for families of the general population with younger children (age 0–2) showed slightly weaker SOC values at the second measurement

point. In the preschool cohort, that is, for parents with children aged 2.5–4 years at the first measurement, and 4–6 years at the second measurement, SOC remains stable. This could be at least partly because the SOC value usually rises after birth and then returns to the prenatal level within 1 year after birth (Hildingsson, 2017). In contrast, the families receiving welfare benefits and those with a migrant background showed a significantly stronger average SOC value over time, as illustrated in Fig. 43.2.

This is counter-intuitive based on the literature that more marginalized families tend to have a weaker SOC. It could suggest that parenting and family life for more marginalized populations is more likely to be seen as comprehensible, manageable, and meaningful than for those whose identity is more bound up with validation external to the family, such as employment. It could also mean that families who are threatened by marginalization, such as poor and migrant families, gain an accepted societal role, when they become parents. Whatever the mechanism of effect, a finding of increased SOC in marginalized families during the early years of parenting could have important implications for later well-being for their children.

In addition, contrary to expectations, there were no correlations between the changes in SOC values and the use of individual offers, the available social support, the age of the child, and other parameters. On the one hand, this could be due to the sample size, which did not allow path analysis and other analytical statistical methods. On the other hand, the lack of clear correlations confirms recent findings from salutogenesis research. These are based on the realization that

Fig. 43.2 Changes in mothers' Sense of Coherence (SOC-13-Scale) between interview 1 and interview 2 (18 months after). (Adapted with permission of interact Verlag. © Claudia Meier Magistretti et al., 2019)

the subjectively experienced qualities of the experiences people have in everyday life are significant for any change in their sense of coherence (Maass, 2019). In particular, so-called transformative experiences, such as those that change attitudes towards the world, play an important role here. The birth of a child can be highly transformative in this respect, and, for some groups, where achievement in other spheres is less easy to reach, this experience can be one of the highlights of their lives. Such a positive experience might outweigh the benefits of social or other types of formal support.

However, it is catalysed, a stronger sense of coherence enables existing resources to be better perceived and used. In this way, the uptake of offers of early support after the birth of a child could trigger a 'positive spiral'. In support of this hypothesis, when asked why they did not continue to use services after an initial visit, almost all respondents stated that this was because they did not feel they needed any more support. On the other hand, while reduced uptake over time might indeed be evidence that an initial visit triggers capacity to parent effectively, and to feel confident and confident in doing so, lack of future uptake could also be because the design of the service is not aligned to the actual needs of the

intended recipients. This could be especially true for families that continue to have a weak sense of coherence in the post-natal and early childhood period. If specialists in early support want to consciously strengthen parenting capacity, particularly in those who are more socially isolated and with a weak SOC, the active participation of children and parents could contribute to the optimum design of future offers. In addition to this, alternative settings for service provision could enable longer term social integration of families into communities and peer support groups. These could include family and neighbourhood centres, shops, places of worship, or multi-generational houses.

Discussion

It is widely accepted that caregivers contribute to strengthening the sense of coherence in children if they practice a parenting style geared to the needs of the child (Feldt et al., 2005), if they engage with and play with the child and if they can develop an authentically loving relationship (Sagy & Antonovsky, 2000). Success in this endeavour can be particularly difficult where there are chronic stressors on the fam-

ily (Barroso et al., 2018). These stressors can be structural (poverty, homelessness, forced migration, for instance) or they could be caused or intensified by particular events, such as illness in pregnancy, or traumatic birth, or illness or disability in the child, or lack of available family support in the postnatal and early childhood period. There is a growing awareness of the value of salutogenic approaches to the provision of maternity care (Shorey & Ng, 2020), and to facilities and services to enhance parenting and well-being in infancy and early childhood. As we have shown, specific activities and services can enhance the capacity for parents to trigger an existing SOC, or, indeed, to strengthen it. This, in turn, can enable improved responses to stressors in the future, in a positive feedback loop that could be mirrored across generations. It is known that persistent adversity leaves an epigenetic imprint that can be expressed in chronic adverse mental and physical health across generations (Sokolowski & Boyce, 2017). It would be logical to assume that optimizing the capacity for the development of a strong SOC as a result of positive maternity and parenting experiences may be associated with a reversal in such a trend. However, this has, to date, not been subject to formal investigation.

The kinds of salutogenic approaches we have described are only examples. They have a reasonable evidence base behind them. They cover what can be done very easily by individual practitioners on a person-to-person basis (skin-to-skin/kangaroo care and breastfeeding support) or, with some adjustment, across whole service provision (family-centred neonatal care). We have also examined the impact of current standard family support (maternity care in general, and the range of childcare and development support) through the lens of one national social care ecology, the German-speaking area of Switzerland. The finding that families who are in employment and highly educated might find the adjustment to parenting more difficult than those who are migrants or in receipt of benefits is intriguing. The further evidence that those on welfare benefits may improve their SOC as they become families and parents, and that this improvement is independent of the experience of formal parenting support, raises a range of fascinating questions about the mechanism of the SOC in different socio-economic contexts. All of these data raise intriguing questions for future research.

Research Gaps and Future Direction

In addition to the limited available literature on salutogenesis in the infant care setting, the concepts of salutogenesis and sense of coherence are more prominent in studies examining neonatal intensive care units (NICU), parents of preterm infants or infants with developmental delays. Moreover, salutogenesis is increasingly invoked during the antenatal

and intrapartum period in relation to the birth of a healthy infant and positive maternal outcomes. However, there is still little application of the theory to service provision in the postpartum period and during infancy. This is an important research gap.

Research on salutogenic impacts in the first 1000 days could also benefit from the new developments in epigenetic research and from the growth in big data sets that have accompanying banked human tissue material. As the measurement of the SOC (and/or of parallel concepts) becomes more mainstream in longitudinal birth cohort studies, it will become increasingly possible to correlate SOC over time and across generations with epigenetic and data, to examine how far a sense of SOC becomes encoded in physiological and psychological responses in both children and parents.

More pragmatically, there is a need to examine which parents and families could benefit the most from the formal provision of health and social care designed to optimize family well-being and the thriving and flourishing of children in the short and longer terms. As the AFFIS study demonstrates, not all poor or migrant families have support deficits, and some families in advantaged socio-economic groups have very high needs for improved parenting skills and experiences. Using SOC as a measure of need and change is an important component of such research, independent of the usual measures of socio-demographic need. This would help with targeting of services more precisely, to enable the ideal goal of proportional universalism to ensure maximum benefit for parents, children, families, and societies, based on tailored inputs. Participatory action research to examine the impact of co-production of the design and delivery mechanisms for such tailored inputs with the families who need them most is also an important research direction for the future.

Conclusion

Salutogenic theory is as relevant for describing and catalysing maternity, parenting, and infant well-being as it is for other phases of human life. In this chapter, we have picked up on the growing interest in the potential of the first 1000 days of life. We have examined salutogenic impacts of experiences over this time, for parents and their children. We have also shown how salutogenic thinking has underpinned new developments, including the recognition of the importance of positive pregnancy and childbirth experiences, the institution of skin-to-skin and kangaroo care after birth, breastfeeding support, and for family-centred neonatal care. We have also shown that the standard provision of family and parenting support services in one country (Switzerland) does not always produce the expected effects and that relative weakness of SOC, and a reduced capacity for it to be

enhanced as a result of parenting, may be a better indicator of the need for parenting support than simple socio-demographics. The research gaps we have identified range from basic epigenetic science to organizational change and implementation science. From these analyses, it is clear that the first 1000 days of life are an important catalyst for salutogenic flourishing, in both the short and longer terms and, potentially, across generations.

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