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Building capacity and wellbeing in vulnerable/marginalised mothers: A qualitative study

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ABSTRACT

Problem: The persistence of health inequalities in pregnancy and infancy amongst vulnerable/marginalised groups in the UK.

Background: During pregnancy and early motherhood some women experience severe and multiple psychosocial and economic disadvantages that negatively affect their wellbeing and make them at increased risk of poor maternal and infant health outcomes.

Aim: To explore vulnerable/marginalised women's views and experiences of receiving targeted support from a specialist midwifery service and/or a charity.

Methods: A mixed-methods study was undertaken that involved analysis of routinely collected birth-related/outcome data and interviews with a sample of vulnerable/marginalised women who had/had not received targeted support from a specialist midwifery service and/or a charity. In this paper we present in-depth insights from the 11 women who had received targeted support.

Findings: Four key themes were identified; 'enabling needs-led care and support', 'empowering through knowledge, trust and acceptance', 'the value of a supportive presence' and 'developing capabilities, motivation and confidence'.

Discussion: Support provided by a specialist midwifery service and/or charity improved the maternity and parenting experiences of vulnerable/marginalised women. This was primarily achieved by developing a provider–woman relationship built on mutual trust and understanding and through which needs-led care and support was provided – leading to improved confidence, skills and capacities for positive parenting and health.

Conclusion: The collaborative, multiagency, targeted intervention provides a useful model for further research and development. It offers a creative, salutogenic and health promoting approach to provide support for the most vulnerable/marginalised women as they make the journey into parenthood.

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Statement of significance

Problem or issue

There are persistent health inequalities in pregnancy and infancy amongst vulnerable/marginalised groups in the UK.

What is already known

Women who are vulnerable/marginalised face complex psychosocial and economic challenges that make them at increased risk of poor maternal and infant health outcomes and perpetuating health inequalities.

What this paper adds

Evidence on how multiagency collaborative support between statutory and third-sector services can have positive effects on experiences of birth and early parenthood for vulnerable/marginalised women.

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1. Introduction

Health inequalities in the UK has been an area of political and academic concern since the publication of the Black report in 1980¹ and more recent research has continued to demonstrate the significance of health inequalities on families' lives.^{2,3} An area of particular concern has been health inequalities in pregnancy and infancy amongst vulnerable/marginalised groups.² The term vulnerable/marginalised is used to depict those who, due to complex life circumstances, have less access to rights, resources and opportunities.⁴ Research has identified that women who experience severe and multiple disadvantage (e.g. living in areas of high deprivation, from Black and Minority Ethnic (BME) backgrounds, experience domestic violence, have a history of substance use, homeless, are younger), can face complex psychosocial and economic challenges that negatively affect their wellbeing and increase risks of poor maternal and infant health outcomes.^{5,6}

Vulnerable/disadvantaged women often receive less antenatal care due to accessing care later in their pregnancy, face difficulties in accessing statutory appointments⁷ and have lower levels of health literacy.⁸ They can experience low levels of social support⁹ and higher levels of perinatal mental ill-health such as depression, anxiety and stress.¹⁰ They also have an increased risk of maternal mortality,^{7,11} preterm and low birth weight (LBW) babies⁵ as well as perinatal death and infant mortality.¹² These women often feel they have less agency and choices when making decisions about their maternity care¹³ and may experience higher levels of obstetric intervention.¹⁴

In the UK, the issues faced by vulnerable/marginalised women are evident in health policies and in initiatives to improve outcomes.¹⁵ These initiatives have included national guidelines,⁵ targeted midwifery provision¹⁶ and public health interventions to support families and young children such as those linked to Children's Centres,¹⁷ and the Healthy Child Programme.¹⁸ Services in this area are, however, increasingly provided by non-statutory services and charities working at local levels. They offer a range of services to different client groups including peer support and voluntary doula schemes.^{19,20}

While, as reflected above, the majority of available evidence documents negative outcomes faced by vulnerable/marginalised women, there are some reports that highlight how targeted support can: increase uptake of services,^{9,16,21} reduce pre-term delivery, low birth weight and infant mortality²² and facilitate a reduction in depressive symptoms.²³ Issues such as social vulnerability, literacy, language fluency and complicated, often transient, lifestyles often provide challenges to researchers seeking to work with these women.²⁴ However, the need for in-depth insights into the mechanisms of targeted support, and how it can intersect to improve outcomes for marginalised perinatal women is reported.²¹

In this paper, we focus on the qualitative data from a mixed method study that explored the experiences and outcomes of vulnerable/marginalised women who had or had not received targeted perinatal support (from a specialist midwifery service and/or a charity). The qualitative data presents insights from women who had received targeted support to highlight how this support facilitated opportunities for needs-led care, and developed women's capabilities and motivation to engage in positive parenting behaviours.

2. Methods

2.1. Study context

The study site was a maternity hospital in North London, UK. The hospital has a specialist midwifery service – the Vulnerable

Adults and Babies Midwives (VABM) team (comprising a service lead and two midwives who work on a job-share basis). All women who have safeguarding/child protection concerns are referred into the VABM team. The VABM provides a range of services such as directing women to sources of appropriate support, and providing information and advice to maternity colleagues and wider statutory services. The VABM midwives also case-load a small number of women (i.e. 14 women were case-loaded by VABM during the study period, 1st July 2014–30th June 2015); these are women who are considered to be the most vulnerable/marginalised and are unlikely to engage with traditional midwifery services. Women who have limited social networks or are reported to be socially isolated are referred to a local charity – Birth Companions. Birth Companions is a registered charity that provides non-judgemental, woman-centred volunteer support to pregnant women/new mothers who face severe disadvantage and who have complex psychosocial needs. All volunteers undergo a year of in-house training and have opportunities to shadow more experienced volunteers on visits to women and to undertake observation of the labour ward prior to providing direct support to women.

The VABM and Birth Companions services operate in a complementary way. The VABM team is an extension of the maternity care offered at the hospital Trust whereas Birth Companions provide support that is more aligned with a friend/family approach. The VABM primarily provide antenatal care, whereas Birth Companions offer evidence-based information, practical, emotional and social support throughout the perinatal period (antenatal, intrapartum (through doula services) and postnatal) at home, hospital and community locations. While there are no formal guidelines in place, the two services have established effective ways of partnership working. A Birth Companions community co-ordinator liaises with staff around referrals, coordination of care, information transfer and other complex issues (i.e. immigration status and interaction with multiple statutory agencies).

2.2. Design

A mixed-methods study was undertaken. Routinely collected birth-related/outcome data from a 12-month birth cohort (1st July, 2014–30th June, 2015) was obtained to compare differences between vulnerable and non-vulnerable women, and between vulnerable women who did/did not receive additional support (from VABM and/or Birth Companions). Interviews with a sample of vulnerable women who had/had not received targeted support were also undertaken. An overview of key findings from this study are reported elsewhere.³¹ In this paper, we offer focused and unreported in-depth interpretations of the qualitative interview data from women who had received additional support from the VABM team and/or Birth Companions.

2.3. Recruitment and data collection

Women who had been referred into the VABM service, had sufficient English to participate in an interview and had no complications post-birth were eligible to participate. Women were approached by midwifery staff either during the third trimester of pregnancy, or early postnatal period (i.e. on the postnatal ward) to participate; all interviews were undertaken within the first postnatal week either in the hospital or at the woman's home. Semi-structured interviews explored the availability, experiences and perceived utility of the support received across the perinatal period. Interviews were undertaken by two midwives and a supervisor of midwives at the Trust, all of whom had been trained and supported by the researchers throughout the study. All

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