Women and Birth 31 (2018) e341–e347

Contents lists available at ScienceDirect

Women and Birth

journal homepage: www.elsevier.com/locate/wombi

Original Research - Qualitative

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

Marie-Clare Balaam[a,*], Gill Thomson[b]

[a] Research in Childbirth and Health (ReaCH), School of Community Health and Midwifery University of Central Lancashire, Brook Building, Preston PR1 2HE, UK

[b] Maternal and Infant Nutrition and Nurture (MAINN), School of Community Health and Midwifery University of Central Lancashire, UK

ARTICLE INFO

Article history:
Received 25 May 2017
Received in revised form 27 November 2017
Accepted 22 December 2017

Keywords:
Midwifery
Vulnerable
Marginalised
Wellbeing
Health inequalities

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.

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.

* Corresponding author.
E-mail address: mbalaam@uclan.ac.uk (M.-C. Balaam).

https://doi.org/10.1016/j.wombi.2017.12.010
1871-5192/

1. Introduction

Health inequalities in the UK has been an area of political and academic concern since the publication of the Black report in 1980[1] 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 appointments[7] and have lower levels of health literacy.[8] They can experience low levels of social support[9] 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) babies[5] 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 care[13] 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 provision[16] 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 mortality[22] 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

interviews were securely transferred to the research team for transcription and analysis purposes. Socio-demographic, birth related/outcome data and reason for referral to the VABM service for all women interviewed were also recorded. The interviews took between 20 and 48 min to complete.

2.4. Ethics

Ethical/governance approval was gained from a National Research Ethics Service committee (14/NW/0353), the Research and Development unit at the participating hospital trust and from an ethics sub-committee (project no. 251) at the authors' institution. Ethical issues of informed consent, confidentiality, voluntary nature of participation and withdrawal were considered at all stages of the research project.

2.5. Analysis

Analysis of the interview data was undertaken by both authors using Braun and Clark's thematic framework[25] and supported by MAXQDA qualitative data analysis software. This framework involves familiarisation with the data through in-depth reading of the interview transcripts followed by organising and mapping of the data into meaningful groups or networks. Re-reading was undertaken to ensure accuracy and coherence with the material being re-organised as appropriate. Both authors analysed the interview transcripts independently and then discussed and refined the themes until agreement was reached.

3. Findings

Here we present insights from the interviews undertaken with 11 women who received additional targeted support from; Birth Companions (n = 5), Birth Companions and the VABM (n = 4) or VABM only (n = 2). The demographic details for these women are presented in Table 1. The women had been referred to the VABM service due to issues such as: poor mental health, homelessness, substance use, social isolation, domestic abuse, having children in care, or being asylum seekers or refugees.

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 and confidence'. Participant quotes have been used to contextualise the issues being raised. A pseudonym has been used to protect the women's identity and a code added to indicate the type of support they received (i.e. BC — Birth Companions, VABM — Vulnerable Adults and Babies Midwifery team).

3.1. Enabling needs-led care and support

Birth Companions and the VABM team provided physical and social opportunities for women to receive needs-led care throughout the perinatal period. Women frequently referred to how the VABM midwives would co-plan where and when antenatal contacts would take place to ensure that appropriate care was provided. This ensured that women had the best chance to access timely antenatal care:

> '*They know that I'm not very good at appointments. So they used to reschedule them for me . . . to make sure I never miss my antenatal.*' (Lynne_BC&VABM)

VABM antenatal support was designed to fit individual lifestyles and women valued the fact that they could contact someone '*24 hours*' rather than at specific times:

> '*She* [VABM midwife] *gave me her phone number, and said if you have an emergency, call, you've got my number. And if my phone is off, just leave a message and someone will phone.*' (Gina_BC&-VABM)

Birth Companions also provided accessible, available needs-led support via home visits, meetings in community locations, and support by telephone and text. These multiple support options provided flexibility in attempts to meet women's needs and their

Table 1
Demographics.

	Birth Companions (n = 5)	Birth Companions & VABM (n = 4)	VABM (n = 2)
Age (years)			
20–24		1 (25%)	1 (50%)
25–29	3 (60%)		1 (50%)
30–34		2 (50%)	
35–39	1 (20%)		
40+	1 (20%)	1 (25%)	
Ethnic group			
White	2 (40%)	4 (100%)	
Asian/Asian British			
Black/African/Caribbean/Black British	1 (20%)		1 (50%)
Mixed/multiple ethnic groups	1 (20%)		1 (50%)
Other ethnic group	1 (20%)		
Number of previous pregnancies			
0	4 (80%)		2 (100%)
1–2	1 (20%)	2 (50%)	
3–4		1 (25%)	
5+		1 (25%)	
Gestational age at booking (weeks)			
10 and under	2 (40%)		
11–15	1 (20%)	1 (25%)	
16–20		3 (75%)	1 (50%)
21–25			
26–29			
30–35	1 (20%)		
Not recorded	1 (20%)		1 (50%)

specific circumstances. Women often described a sense of empowerment in terms of how they could negotiate the support when they needed it, and on their terms:

'*They're always asking, do you know like if I need any advice about anything or if I need help with anything, or if I've got everything I need for the baby, because they can provide stuff. But I'm actually quite alright, it's just the company that I like, the fact that I can go out for coffee with them or something*' *(Louise_BC)*

The frequency of support offered by Birth Companions was repeatedly highlighted in the narratives. Women reported how the volunteers would visit '*couple of times a week*', '*everyday*', *'sometimes four times a week'* as well as stay with them for protracted periods of time, e.g. *'two, three hours'*. Some also referred to the way in which Birth Companions were on *'stand by'*, to come *'straight away'* when labour commenced as well as how they provided a continual presence during the labour and birth:

'*They stayed with me, the Birth Companions, and I stayed in hospital. Then one left and another one came, so I always had someone with me throughout the whole day and everything.*' (Louise_BC)

In some circumstances, advocacy and other forms of emotional support were offered to women during their interactions with social care and other professionals in what were often very challenging circumstances (i.e. a child being taken into care). Anna explained how:

'[They] *came to meetings when Social Services came to see us on the ward. They'd* [VABM team] *chat to us before and afterwards. They'd give us private rooms . . . to go and talk in if we needed to, away from the ward. They were fantastic emotionally, they were really supportive.*' (Anna_VABM)

For Sally, a member of the VABM team enabled her to stay on the postnatal ward so she was in closer proximity to her daughter:

'*she managed to make me stay another couple of nights, even though I wasn't clinically really in need of, it was just in order to stay closer to my daughter because I don't live near.*' (Sally_VABM)

The VABM and Birth Companions also coordinated and facilitated support to meet women's wider needs. This included providing information about statutory procedures, contacting social workers, writing letters on their behalf, as well as coordinating and facilitating meetings with other statutory agencies (e.g. Housing departments, Home Office).

3.2. Empowering through knowledge

Several participants discussed how members of the VABM and/or Birth Companions helped them prepare for childbirth through providing clear explanations and answering their questions. Sally described how:

'*I could ask a lot of questions, especially with end of pregnancy . . . and so they were really clear about explaining to me . . . so yes, I was really well informed before the birth how everything was going to be going, when the time had come.*' (Sally_VABM)

Leah explained how in her sessions with her Birth companion she was told;

'*a lot of information about how you do easy born baby*' (Leah_BC)

Women also referred to the ways in which support from both the VABM and Birth Companions enabled them to receive information relevant to their particular needs. This included support writing birth plans and providing health-related information such as *'eating healthy food'*. Information to help them prepare for clinical procedures during labour (i.e. a caesarean section) was also provided:

'*Everything was explained to me prior and right before, you know, what the procedure would be like and what I would have felt and everything. Many checks were being done of like my sensitivity, you know, to see that the anaesthetic was working. And so the support, fully satisfied I would say.*' (Mandy_VABM)

Women were also supported by the provision of specialist information, such as the care of their infant post birth. Sally explained:

'*I could ask a lot of questions, especially with end of pregnancy, they* [VABM midwives] *showed me where, because I knew that my baby would have had to stay in a special care unit because she would have probably, most likely showed withdrawal symptoms. And so they were really clear about explaining to me how this procedure would have happened, how long we will have to stay in the hospital, if we will have stayed together. I wanted to know if I was able to breastfeed and how the situation would be kept private. And they answered all the questions, they showed me the special care baby unit so yes, I was really well informed before the birth.*' (Sally_VABM)

Other women received what they referred to as *'good'* infant feeding support via instrumental assistance by a volunteer who was a '*breast feeding expert*' as well as other volunteers who provided information on issues such as '*paced feeding*', '*expressed feeding*' as well as the safe storage of breast milk:

'They're [Birth Companions] *supporting me around expressed feeding and expressing my milk to give to X* [son]. *It's better for him, yes. And they're going to look into supplying a breast pump for when I leave hospital and some like storing bottle things, some milk bags.*' (Kathy_BC&VABM)

3.3. The value of a supportive presence

A number of women described the positive emotional impact of being able to access and receive support throughout the perinatal period. This appeared to be particularly important for those who had limited social networks:

'[she was] *there when I needed her the most because I haven't got anyone, and she supported me throughout.*' (Lynne_BC&VABM)

The flexibility and availability of support, particularly from Birth Companions provided women with feelings of reassurance and enhanced wellbeing. Mandy explained how she could, '*just call them and they will come and see me, they will help me*', and the sense of comfort this provided '*so good* [. . .] *I've always got someone on the end of the phone that will come and see me.*' Those who received volunteer support during the intrapartum period also highlighted how the continued supportive presence reduced their feelings of anxiety, increased their sense of control, and enhanced their self-beliefs: '*She made it so easy and so calming and she made me believe that I could do it* [give birth].'

The key to being able to accept and benefit from the support offered was the creation of positive relationships with VABM staff and/or Birth Companions. A number of women highlighted the significance of their non-judgemental approach. One explained '*it felt like that she wasn't judging me and that she understood.*' Anna highlighted how such an accepting attitude was at odds with her expectations and how it had challenged her pre-existing beliefs:

'We thought that we'd be judged and . . . kind of be treated like we were nasty people and things like that. Whereas in . . . we were never judged on our circumstances, not once.' (Anna_VABM)

The manner in which the VABM and Birth Companions engaged with and interacted with women enabled a trust-based connection to develop. This in turn meant that women felt '*comfortable*', safe to '*open up*' and were able to disclose '*honest*' accounts of their

feelings, experiences or needs. It also allowed women to accept the care offered, which for some women like Lynne was a potentially challenging experience. Lynne referred to the '*bond*' she had with the volunteers and the VABM due to the care and support she was afforded, which in turn led her to feel; '*you could leave your life with them, in their hands really*'. The capacity to trust again was particularly significant for this mother due to her history of abuse; '*before I wouldn't trust anybody, being hurt and abused as a child*.'

The depth of connection and positive relationships with the VABM/Birth Companions volunteers led to some women describing the relationships using familial terms. One woman described how the support she received made her feel like '*your family is there*,' and that they '*were your mum or your parent for the day*'. Lynne described how the support she received was:

'*the best you can have when you give birth because they don't judge you. And if you've got nobody they're like your parents, they're there to help you.*' (Lynne_BC&VABM)

Regular social contacts (in hospital and home) with Birth Companions volunteers provided women with companionship and friendship, which in turn reduced their feelings of loneliness and isolation. Karla explained:

'*It was while I was actually in Whittington Hospital for those two weeks. I had, you know, sometimes I got a bit lonely being there. So I had some volunteers coming to visit me, which I really appreciated that, they were really lovely, all really lovely people. And just for companionship and just being very kind and supportive.*' (Karla_BC)

The valued support and social contact continued post discharge as the volunteers supporting women in their adjustment to new parenthood. Louise described:

'*She* [Birth Companion] *asks me what we want to do and we maybe, we went to the park last time, to the café in the park and we had a coffee, I had a hot chocolate. We just chat and she loves the baby.*' (Louise_BC)

Furthermore, at times it seemed that it was the continuity of support, rather than the care provided by a specific volunteer that was important:

'*I got introduced to a few different Birth Companions because you never know really which one's going to come' but found that every one of them that I met was so friendly. You felt like you'd known them for a long time, it's not like you'd just met them. They are just so all for you and made you feel happy.*' (Louise_BC)

3.4. Developing capabilities, motivation and confidence

Birth Companions provided direct and practical support for women as they began parenthood thereby enabling them to meet their and their babies' material needs. Mandy explained:

'*I didn't have pyjamas, you know, to stay in the hospital. I had but they were dirty, you know, from my blood, everything. And they bring me chocolates, they bring me card, they bring me new knickers, new pyjamas, yes. It was nice.*' (Mandy_BC)

Depending on the needs of the women/families, the volunteers were able to offer a range of items including; breast pumps and infant feeding supplies, phone 'top ups', clothes, baby equipment, nappies, money for travel as well as toys for older children. Women often internalised the receipt of these items as evidence of the care and concern that the volunteers felt towards them:

'*And Birth Companions were really lovely actually because they asked me if there's anything I needed. And I sort of mentioned, well I'm going to need to get a cot. And they, one of them organised, they came round, one of them brought the cot round. I mean its second hand but it's still really nice, and then they brought me a brand new mattress for the cot, which was really kind.*' (Karla_BC)

Women also identified how support, particularly from Birth Companions, helped them to address some of the practical challenges they faced by providing them with new skills and knowledge. For one woman this was '*holding baby for me and I have a shower*' — for others it was being shown '*how to use the baby carrier*' or help with getting out and about after birth. Mandy explained how a volunteer supported her to undertake a challenging journey with her new baby:

'*One time I had to go to the social workers, I didn't know, where was the place? And one from the Birth Companions she said, don't worry, I will take you to this place. She helped me with the pushchair, you know, she was holding the baby, we was going on the bus, you know.*' (Mandy_BC)

Others described how the support provided benefits such as through helping them to resolve their breastfeeding challenges and/or provide reassurance:

'*The breastfeeding expert* [Birth Companions volunteer] *she, like got in touch with me because at first I did have a bit of an issue with him because he liked one better than the other. So one was going and I didn't know how to get around it. She phoned me and she asked if, she wanted to come out and see me, but everything I told her I was doing, she said I was doing it perfect anyway and that's what I should have been doing*' (Louise_BC)

Or increasing their motivation and capabilities to abstain from illegal substances:

'*I'm now a previous drug user and they* [Birth Companions] *are supporting me around staying off of it, and just being there for me emotionally . . . they've come in every day to see me since I had X. And they've constantly just gave me compliments and how well I'm doing.*' (Kathy_BC&VABM)

The '*lifeline*' of contact with Birth Companions together with positive affirmations of their progress made some of women feel more confident both '*as a mother*' and '*as a family*'. One of the mothers referred to how the Birth Companions enabled her to have a '*happy*' pregnancy which in turn meant that she had a '*happy' baby.*' Gina also described how the VABM midwife went beyond normal care boundaries to empower her to have a new understanding of, and belief, in her abilities:

'*It's made me so, so confident to do what I'm doing. X* [VABM midwife] *said, yes, I'm going to help you, you're doing a good job, everything going to be OK. And I'm so proud for that woman, she make me so nice, she make me so, so confident.'* (Gina_BC&VABM)

4. Discussion

In this paper, we highlight how support provided by a specialist midwifery service and/or a 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. Extant literature on marginalised women is dominated by rehearsals of the negative implications of a lack of support.[5] In contrast, this paper offers a more salutogenic (i.e. focus on positive health and wellbeing) perspective. Recently, a more health orientated, wellbeing or salutogenic inspired approach towards maternity care has been advocated as a way of providing an alternative to a risk based/pathologic focus.[26]

Our study, congruent with the wider research, found that women who received targeted support were more likely to engage

in care provision, were more confident in undertaking maternal tasks and had improved emotional wellbeing.[9,16] The support was also identified to promote and increase health-promoting practices such as abstinence from harmful substances and improved infant feeding experiences. These insights are particularly promising as wider research highlights that vulnerable/marginalised tend to have lower levels of breastfeeding initiation and continuation.[27] The data we collected as part of the wider study also found that a higher percentage of women who had received targeted support had a vaginal presentation at birth and did not have a perineal tear when compared to unsupported vulnerable/marginalised women.[31] To date, there is little 'hard' evidence about the impact of targeted support on birth outcomes, and the samples in our study are too small for meaningful conclusions to be drawn. There is also a gap in the evidence-base in regards to the longer-term impact of targeted support on issues such as quality of life, mental health, attachment and familial relationships. These gaps call for prospective, long-term mixed-methods research designs to assess the impact of support for vulnerable/disadvantaged women, infants and families.

Our findings on the importance of the nature of relationship between vulnerable/marginalised woman and those who provide support are in line with other studies. Samele et al.[28] stress the importance of being listened to and treated with kindness.[28] McLeish and Redshaw's[9] recent study also illuminates how vulnerable women benefit from a sense of '*social connection*', and of '*being valued*'.[9] In our study, and as reflected in the wider literature, women appreciated continuity of care as it allowed them to build trusting relationships with those who cared for them.[14,28] These insights also support recent work on models of midwifery care which seek to maximise continuity of care/carer throughout the perinatal period.[15]

Other studies primarily focus on the role and impact of peer/volunteer support for socially marginalised women.[9,16,21,23] Whereas our study explores the support provided by both third-sector volunteers and maternity professionals working collaboratively within hospital and community settings. This partnership approach offers a holistic approach to care which seeks to promote women's wellbeing in the widest sense. The care acknowledged the significance of women's socioeconomic context and psychosocial needs as much as their clinical needs, and sought to address all aspects of women's lived realities in a non-judgemental way. While the sample size was too small to draw any meaningful differences between those who had received care from the specialist midwifery team and/or Birth Companions — the findings highlight that third-sector support offered an important extension, particularly with regard to the provision of practical items and frequency of support. This model of care provides an example of a partnership or multiagency approach currently being called for in key policy documents, thorough collaboration between women, clinical staff, the third-sector and wider governmental agencies.[15] Our study also resonates with other research suggesting that offering multi-agency person centred care, in the form of targeted rather than generalised care is key to enabling marginalised women to access and benefit from interventions.[23]

The need to identify the theoretical underpinnings of intervention designs is well highlighted in the literature.[29] A useful theoretical framework to consider here is the COM-B behaviour change framework.[29] This model highlights how behaviour change is based on a dynamic interaction between an individual's capability (C), motivation (M) and opportunities (O). This framework is generally used to evaluate change from an individual context-related perspective and has been identified as being of value to those working with pregnant and postpartum women.[30] In our study, women's capabilities were increased via needs led information and practical support. The trust-based woman–provider relationships and emotion-based affirmations enhanced women's motivation to express their needs and engage in care provision. Women's opportunities to receive care and support were also maximised by flexible and accessible care provision. All these components interacted and coalesced to promote positive health (e.g. sense of wellbeing, less stress, reduced social isolation) and parenting (e.g. breastfeeding, mothering capabilities) behaviours. Further consideration of how these components can be used and evaluated within intervention designs would prove beneficial.

A limitation of this study relates to the small sample size. However, it is important to reflect that research with vulnerable/marginalised women is often difficult due to their complicated lives, reticence to engage with formalised activities and the difficulties they face in accessing statutory provision. In this study the experiences of 11 women with complex needs were captured. While women who participated may represent those who were more positive about their care, they still offer important insights into the key mechanisms of effective support. A further limitation relates to combining the voices of women from different backgrounds, who face different life situations and who may have had specific needs. A more robust research design to elicit what, how and why certain features of support can create positive outcomes for different groups of women would be beneficial. This is particularly important when, for example, in the UK there are a wide and varying number of third-sector organisations and specialist maternity teams who provide support to disadvantaged families.

5. Conclusion

Mothers who are vulnerable/marginalised by virtue of complex life situations can face inequitable care provision and poorer health outcomes. This study highlights how a collaborative targeted intervention provided by a specialist midwifery team and volunteer provision via a charitable organisation facilitated opportunities for needs-led care, and developed women's capabilities and motivation to engage in positive health and parenting behaviours. While further research is needed to assess the impact of such support on maternal, infant and family outcomes, these findings endorse the move within policy for continuity-based care provision, and multiagency collaborations between statutory and third-sector services. The targeted intervention offers a useful model for further areas to adopt — a holistic, creative, salutogenic and health promoting approach to providing support for the most vulnerable/marginalised women as they make the journey into parenthood.

Ethical statement

Ethical/governance approval was gained from a National Research Ethics Service committee(14/NW/0353–17th June, 2014–minor amendment approved 26th June, 2014 and substantial amendment no. 1–17th November, 2014; substantial amendment no. 2–28th April, 2015), the Research and Development unit at the participating hospital trust and from an ethics sub-committee (project no. 251) at the University of Central Lancashire.

Conflict of interest

The authors have no conflicts of interest to declare.

Acknowledgements

We would like to thank all the women who took part in this study. Thanks are also extended to Logan Van Lessen, Jo Austin and Heather Jenkins from the Whittingham Health NHS Hospital for

their support and commitment to the project. Funding for the study was obtained via Birth Companions.

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