



"I didn't think we'd be dealing with stuff like this": A qualitative study of volunteer support for very disadvantaged pregnant women and new mothers

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ABSTRACT

Objective: to identify the particular issues associated with volunteer support for very disadvantaged mothers (who were young, had insecure immigration status, were recent migrants whose English was poor, misused drugs or alcohol, or were involved in crime), from the perspective of the volunteers.

Design: a qualitative descriptive study, informed by phenomenological social psychology. Semi-structured qualitative interviews were carried out between July 2013 and March 2015. Interview transcripts were analysed using inductive thematic analysis.

Setting: nine volunteer support projects for pregnant women and new mothers, run by third sector organisations in England.

Participants: 38 volunteer supporters.

Measurements and findings: three key themes were identified: 'Meeting challenges', 'Needing support' and 'Identifying successes'. 'Meeting challenges' contained the subthemes 'making the relationship of trust', 'remaining non-judgemental', 'maintaining boundaries' and 'dealing with child protection'. 'Needing support' contained the subthemes 'feeling prepared', 'feeling supported' and 'staying safe'. 'Identifying successes' contained the subthemes 'celebrating the small wins', 'validation as a mother', and 'supporting access to services'.

Key conclusions: volunteers were able to build strong, empowering relationships with some very disadvantaged women during pregnancy and afterwards, including where the mothers did not readily engage with professionals. However, supporting women with complex needs is emotionally challenging and volunteers need to be carefully selected, realistically trained and robustly supervised and supported during their volunteering.

Implications for practice: third sector organisations offering volunteer support for pregnant women and new mothers can be valuable partners in reaching very disadvantaged women who may find it difficult to engage with services. Volunteers can build up a relationship of trust with vulnerable mothers over time, but need to be well supported to do this safely and effectively.

Background

Disadvantaged pregnant women and their children are affected by significant health inequalities in the United Kingdom: mothers and babies who are Black or Asian or live in poor areas are more likely to die (Knight et al., 2015; Manktelow et al., 2015). Babies are more likely to have a low birthweight and to be born prematurely if their mothers are under 20, from lower socio-economic groups, from some Black and minority ethnic groups or born in Africa or South Asia (Aveyard et al.,

2002; Office for National Statistics, 2016). Poor maternal mental health is associated with being poor, a single parent, socially isolated, or a young mother (Liao, 2003; Lancaster et al., 2010).

There are also inequalities in the use of maternity care: mothers are more likely to begin maternity care later than recommended, and to miss appointments, if they have a low socio-economic status, belong to a minority ethnic group, are poorly educated or are very young (Downe et al., 2009). Women who are seeking asylum, homeless, dependent on drugs or alcohol, or who are Gypsy Travellers, may be deterred from

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attending maternity care by fears of being judged or having their children taken into care, chaotic lives, unaffordable transport, or ignorance of an unfamiliar system (Parry et al., 2004; Dartnall et al., 2005; McLeish, 2005; Hall and van Teijlingen, 2006; Knight et al., 2015). The National Institute of Health and Care Excellence identifies pregnant women as having “complex social factors” if they misuse substances, are recent migrants, do not read or speak English, are under 20, or experience domestic abuse (National Institute for Health and Care Excellence, 2010). Their guidance recommends making maternity care and information more accessible and tailored to the needs of vulnerable women.

There is a long tradition in the UK of third sector organisations offering volunteer support to families with young children (McAuley et al., 2004; Suppiah, 2008), and more recently the third sector has begun providing one-to-one volunteer support during pregnancy (Bhavnani et al., 2015; Spiby et al., 2015). Rates of mothers engaging with volunteers or subsequently disengaging are often unreported, but where this has been reported, 47–80% of the mothers referred took up support (Lederer, 2009; Barlow and Coe, 2012; Cupples et al., 2011; Lederer, 2009). Disadvantaged parents are generally less likely to engage than more advantaged parents, and yet once engaged, disadvantaged parents less likely to drop out (Barnes et al., 2006; Suppiah, 2008). However, young mothers may be particularly likely to disengage (Spiby et al., 2015). Projects that specifically target very disadvantaged mothers report more success at engaging with them than projects where the support is less targeted (Lederer, 2009; Barlow and Coe, 2012; Cupples et al., 2011).

It is difficult to investigate why some mothers decline home visiting support, because those mothers are often reluctant to speak with researchers (Barlow et al., 2005). Where mothers' reasons for turning down volunteer support have been reported, these included not needing the service, not having time to take on an additional commitment, and unease about the motivation of volunteers and allowing a stranger into their home (Barnes et al., 2006; Spiby et al., 2015), mirroring reasons for turning down professional home visiting (Barlow et al., 2005). The morale of those offering support may be adversely affected where a high proportion of mothers do not want or value it (Murphy et al., 2008).

This study is part of a larger programme of work on peer support during pregnancy and early motherhood in England, for which a previous paper described the different models and perceptions of peer support for mothers from a range of backgrounds (McLeish and Redshaw, 2015). Three core elements were identified in the support: active listening; providing information about pregnancy, birth, parenting, and official systems; and signposting to local services. In many cases the volunteers also offered material and practical support.

This analysis focuses on the issues that arise when offering volunteer support to pregnant women and new mothers who are very disadvantaged, defined in this paper as mothers who are young, have insecure immigration status including seeking asylum, are recent migrants whose English is poor, misuse drugs or alcohol, or are involved in crime. It specifically aims to understand the volunteers' experiences of supporting these very disadvantaged mothers.

Methods

Setting

The research was carried out at nine sites in England (in Bristol, Bradford, Burnley, Halifax, Huddersfield, London and rural North Yorkshire). At each site a third sector organisation ran a project which offered support from unpaid volunteers during pregnancy and the postnatal period. The projects defined their service users in a variety of ways, as mothers who: were from Black and minority ethnic communities, were asylum seekers and refugees, were young, were in prison, had very complex needs, were living with HIV, had mental health

problems, or lived in a particular area. The volunteers were generally mothers from the local community, and in some projects were recruited because they had specific peer experiences in common with those they supported. The volunteer support began in pregnancy and continued until the baby was between six weeks and two years old. There was wide variation in the intensity of support, which could comprise weekly visits, rising to daily visits immediately after birth, or visits as little as once a month. One project also offered volunteer ‘doula’ support during birth.

In the eight projects with a formal training programme, volunteers received initial training of between 8 and 75 contact hours before working with mothers. In all the projects, volunteers received ongoing regular support and supervision from the project co-ordinator. When a mother was referred to the project she was matched to an individual volunteer (in one project, to a small group of volunteers). The volunteer's visits might take place in the mother's home or other settings.

Study design

This was an qualitative descriptive study (Sandelowski, 2000), based on semi-structured, in-depth interviews, theoretically informed by phenomenological social psychology (Landridge, 2008), and underpinned by contextualism (Madill et al., 2000) in which the social and cultural context is emphasised. This “low-inference” (Sandelowski, 2000) design was chosen because the purpose of the study was to explore participants' own perceptions and thus to stay close to their accounts (Landridge, 2008), while acknowledging the role of both participants' understandings and the researchers' interpretations in the production of knowledge (Pidgeon and Henwood, 1997).

The Oxford University Medical Sciences Research Ethics Committee (reference MSD-IDREC-C1-2013-111) approved the study.

The co-ordinator of each volunteer support project (chosen to reflect diversity of location and target population) was contacted to introduce the research. In an initial meeting with each co-ordinator, the researcher (JM) gained an understanding of the project and described the research. The co-ordinator then explained the research to the volunteers using the study information leaflets and invited them to participate. Where a volunteer agreed to participate, the co-ordinator asked her permission for the researcher to contact her, or arranged an interview. The sampling was thus purposive insofar as all participants had experience of giving volunteer support. The researcher did not have any prior contact with participants. One volunteer who had initially agreed to her contact details being passed on, chose not to participate due to childcare commitments.

Data collection

Semi-structured qualitative interviews, which ranged in duration from 20–96 minutes (median 49 minutes), were conducted between July 2013 and March 2015. Each interview took place at a time and place of the participant's choice, after explaining the reasons for the study and obtaining written informed consent (all chose their home, the project base or a café). The topics covered included training, support activities, support received from the project, and the impact on supported women and on the volunteer. After the first six interviews, the topic guide was modified to pursue an emerging theme on specific peer experiences. One participant was interviewed by telephone where it was not possible to arrange such a meeting (oral informed consent was given and recorded in writing), and on two occasions, two participants were interviewed together at their request. No one else was present during the interviews. Each participant was interviewed once, and all interviews were carried out in English, audio-recorded and fully professionally transcribed.

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