



A Constructivist Grounded Theory examining how trauma and the social determinants of health impacted perinatal women during the COVID-19 pandemic, and the role of caseloading midwives in tackling widening health inequalities in England

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Abstract

A Constructivist Grounded Theory examining how trauma and the social determinants of health impacted perinatal women during the COVID-19 pandemic, and the role of caseloading midwives in tackling widening health inequalities in England.

- by Charlotte Emily Roche

Background

England is an unfair nation, with deep-rooted inequalities that have shown no signs of improvement since the COVID-19 pandemic. Research indicates that the Social Determinants of Health (SDoH) - the root causes of health and wellbeing - negatively impact perinatal health inequalities. The evidence on the SDoH is poorly implemented in maternity care policy and interventions designed to address inequalities. Midwifery Continuity of Care (MCoC) models targeted at improving perinatal mortality and morbidity for women and babies facing multiple disadvantage, including socioeconomic inequalities, have a significant role to play in improving birth outcomes, experiences, and equity within the wider public health agenda.

This doctoral study explored the social complexities women faced and their experiences of these during the COVID-19 pandemic. In addition, the research explored the experiences of NHS midwives working in a MCoC model in a city in the south of England, to better understand how midwives tackled widening inequalities within the context of the COVID-19 pandemic. Examining these domains provided evidence on the social complexities women experienced during this global health crisis, mechanisms that underpin the known benefits of MCoC, and the evolving public health role of MCoC midwives in England.

Methods

A qualitative, Constructivist Grounded Theory (ConGT) was conducted during the COVID-19 pandemic. Semi-structured interviews with twenty-three perinatal women and thirteen MCoC midwives were conducted remotely, either by telephone or via Microsoft™ Teams or Zoom™. Data were analysed using ConGT techniques of initial, focused, and advanced coding, along with constant comparison and theoretical sampling.

Findings

This research identified two core categories. The first - *'sucking it up and getting on with it'* revealed the pervasiveness of trauma and the survival-based behaviours women had developed in response to their previous experiences. Most perinatal women were survivors of

Adverse Childhood Experiences and/or traumatic experiences in later life. These experiences were cumulative and were compounded by intersectional, structural inequalities, including the SDoH. This first category, supported by multiple subcategories, highlighted the pervasiveness of trauma on women's health and well-being during the perinatal period. These experiences significantly influenced women's survival strategies and maternity care journeys.

The second core category - ***'we're only really scratching the surface of the complexities women face'***, explained the challenges MCoC midwives faced when tackling widening inequalities. With a lack of prioritisation and investment in their professional development, plus limited community resources, MCoC midwives frequently *'stepped up'* in place of other organisations and professionals in order to meet women's needs. Midwives demonstrated remarkable resilience and agility, fostering strong, relationally attuned, and empathic relationships with women. Working in the MCoC model promoted the chance of midwives to establish a relationally attuned relationship with women, which enhanced midwives' professional curiosity and the quality-of-care women received - allowing for better identification of the psychosocial issues women faced.

To maintain integrity in the healthcare system, midwives attempted to influence the SDoH impacting women's lives such as housing and income inequalities, contraception, and perinatal mental health. Targeted efforts to address perinatal inequalities in the research setting were threatened by factors including inadequate data collection, and a lack of midwifery presence at strategic levels to influence local public health interventions.

Conclusion

This study highlights a critical gap in trauma-informed care within NHS maternity services. Moreover, despite compelling evidence on the impact of the SDoH on population health, these factors remain insufficiently addressed in maternity policy, education, and practice. This study offers several recommendations to improve maternity care and inform policy reform. Crucially, in order for maternity services to effectively support women with complex social factors and to keep pace with the changing needs and demands of society, the professional development of midwives must be prioritised. Training about the impact of trauma and the SDoH on the life chances of women and their babies must be prioritised. In parallel, policymakers must foster stronger collaboration between midwifery, integrated care systems, Local Authorities and wider partners to enhance service delivery and drive meaningful improvements in population health.

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Definitions and abbreviations

Adverse Childhood Experiences (ACEs)	ACEs are potentially traumatic events or circumstances occurring before the age of 18 that have been shown to increase the risk of adult mental health problems and disease. Such traumatic events may include - psychological, emotional, physical, or sexual abuse; violence against mother; or living with household members who were substance abusers, mentally ill, suicidal, criminal or imprisoned. Maltreatment (child abuse, sexual abuse, neglect, bullying, etc.) causes chronic stress that can disrupt early brain development, and the development of the nervous and immune systems.
Allostatic load	Allostatic load refers to the cumulative effects that chronic stress has on mental and physical health. More simply, it refers to the 'wear and tear' on the body that life events and environmental stressors create. When events occur that exceed an individual's capacity to cope, allostatic overload may occur.
Birth-related trauma	Birth-related trauma refers to the distress experienced during or after childbirth, which can sometimes lead to Post-Traumatic Stress Disorder. This can occur due to various complications and traumatic situations, such as emergency deliveries, prolonged or painful labour, inadequate pain relief, or feeling a lack of control during the birth process.
Global Ethnic Majority	In the United Kingdom (UK), the term Global Ethnic Majority refers to people from non-White ethnic backgrounds, including Black, Asian, Indigenous, mixed heritage, and other racially marked groups. This term is used to highlight that these groups collectively form the majority of the global population, challenging the notion of people being from 'minority' ethnic communities in the UK.
Health and wellbeing	From a lifecourse perspective in the UK, health and wellbeing are dynamic and interconnected across life stages. This approach considers how social, economic, and environmental factors influence health from preconception to old age. Key aspects

	include prenatal care, childhood development, adolescent support, healthy adult lifestyles, and maintaining quality of life in older age. Addressing health determinants at each stage improves overall wellbeing and reduces health inequalities.
Health equity	Health equity means ensuring that everyone has a fair and just opportunity to be as healthy as possible. This involves removing obstacles to health such as poverty, discrimination, and their consequences, including lack of access to good jobs, quality education, housing, safe environments, and healthcare. Health equity aims to eliminate unfair and avoidable differences in health among different population groups defined by social, economic, demographic, or geography.
Index of Multiple Deprivation	The Index of Multiple Deprivation (IMD) measures relative deprivation in UK areas using seven domains: income, employment, health, education, crime, housing, and living environment. It ranks areas to identify inequalities and guides resource allocation to improve conditions in the most deprived regions.
Midwifery-led continuity of care (MCoC) model (in the context of this research)	A team of 6-8 midwives provide continuity of care to a caseload of women facing social complexities. Each woman is assigned a named midwife who coordinates all care, multi-disciplinary communication, and referrals. The named midwife aims to provide the vast majority of clinical care, with other team members providing care when they are not on duty. Midwives are based in local community health centres and offered antenatal, intrapartum, and postnatal care in the home, community, or hospital setting.
Perinatal period	In the UK, the perinatal period is defined as the time from the start of pregnancy up to one year after childbirth involving the antenatal, intrapartum, and postnatal periods. This period is crucial for both the mother and the baby, encompassing significant physical and emotional changes. It is also a critical time for monitoring and supporting maternal mental health, as issues can arise during pregnancy and in the first year postpartum.

Perinatal woman/women	A perinatal woman is someone who is in the perinatal period, which spans from the onset of pregnancy up to one year after giving birth. This term encompasses both the antenatal and postnatal phases, highlighting the importance of monitoring and supporting the health and well-being of the mother during this critical time.
Psychosocial stressors	Psychosocial stressors are life events or situations that cause significant stress, impacting an individual's mental and social wellbeing. These can include daily stressors or major life challenges such as violence or job loss, chronic issues like poverty or discrimination, and catastrophic events like natural disasters. They affect how people interact with others and perceive their place in society, often leading to both psychological and physical health challenges.
Public health	Public health is the art and science of preventing disease, prolonging life, and promoting health through organised efforts and informed choices of society, organisations, communities, and individuals. It focuses on improving health outcomes by addressing the social determinants of health, promoting health equity, and reducing health disparities. Public health initiatives include vaccination programmes, health education, disease prevention, and policymaking to create healthier environments and communities.
Population health	Population health is an approach aimed at improving the health outcomes and wellbeing of an entire population. It focuses on reducing health inequalities by addressing a wide range of factors that influence health, such as social, economic, and environmental determinants. This approach involves coordinated efforts across healthcare, public health, and community services to provide proactive, preventative, and personalised care.
Routine clinical midwifery care	In the UK, routine clinical midwifery care includes comprehensive support during pregnancy, childbirth, and the postnatal period. This involves regular antenatal appointments, health education, and screenings, intrapartum care during labour and birth, and

	postnatal care. Midwives provide personalised care, addressing physical, emotional, and social needs throughout the maternity journey.
Social Determinants of Health	The social determinants of health are the conditions in which people are born, grow, live, work, and age. These include factors like socioeconomic status, education, neighbourhood and physical environment, employment, social support networks, and access to healthcare. They significantly influence health outcomes and contribute to health inequalities.
Standard or universal maternity care	Depending on medical risk factors women receive antenatal and postnatal care in either a community or hospital setting. For low-risk women care is usually provided by a community midwife in a GP surgery, Family Hub, or local health centre. For women at high-medical-risk care is provided at a hospital and shared between midwives, obstetricians, and the wider multidisciplinary team. Although women may be assigned a 'named' healthcare professional, there is less emphasis on the provision of continuity of care.
Trauma	Trauma refers to experiences perceived as physically or emotionally harmful or life-threatening, which produce lasting adverse effects on an individual's functioning and overall wellbeing. While early interpretations focused on extreme events such as war or violence, decades of interdisciplinary research have shown that trauma can arise from a wide range of circumstances, with similar physical and psychological impacts across both private and public forms of suffering.
Trauma-informed practice	Trauma-informed practice acknowledges that trauma can affect neurological, biological, psychological, and social development, shaping worldviews and relationships. It assumes many people will have trauma histories, impacting their ability to feel safe or trust services. This approach addresses barriers to care using six principles: safety, trust, choice, collaboration, empowerment, and cultural considerations.

Woman/women	The terms “woman” and “women” are used throughout this document to reflect the majority of individuals who are pregnant and giving birth. This includes girls, as well as people whose gender identity does not align with their sex or who identify as non-binary.

Author's declaration

This doctoral study is presented as an integrated thesis, incorporating two papers that were published in peer-reviewed journals (Clayton et al. 2022; Clayton 2021), and a systematic scoping review prepared for submission but unfortunately remains unpublished (Clayton et al. 2019). As a result of this, there might be areas of repetition in the thesis.

Table 1 displays the authors' declaration for each publication and the location of papers in the thesis.

Table 1. Table of integrated papers

Number	Reference and declaration	Location in thesis
1	Clayton, C., Hemingway, A., Hughes, M., Rawnsdon, S. (2019) <i>A scoping review exploring the daily lives of women from low-income backgrounds, living in high-income countries, during the perinatal period and their maternity care experiences</i>, (unpublished manuscript). My contribution to this unpublished manuscript: First and corresponding author, developed literature search strategy, conducted literature search, critically appraised selected studies, theme identification and synthesis, drafted and compiled the manuscript, and revised the manuscript based on comments by co-authors'.	Chapter 3
2	Clayton, C., Hemingway, A., Hughes, M., Rawnsdon, S. (2022). <i>The public health role of caseloading midwives in advancing health equity in perinatal women and babies living in socially deprived areas in England</i>. The Mi-CARE Study protocol. The European Journal of Midwifery. Vol 6, p.1-10. CC BY 4.0 My contribution to this published paper: First and corresponding author. I co-developed the study design with members of the public and in collaboration with my supervisory team. I developed the methodology and methods, data collection, and analysis for the study, drafted and revised the manuscript based on co-authors' comments, led the submission process, and revised the manuscript based on comments by peer-reviewers.	Chapter 5 - Section 5.4
3	Clayton, C. (2022) <i>Embracing the rapid acceleration of digital transformation in research during the COVID-19 pandemic</i>. The Practising Midwife Journal. Vol 24(8), p.8-9. My contribution to this published paper: Sole author, drafted the article, led the submission process, and revised the manuscript based on comments by peer-reviewers.	Chapter 5 - Section 5.5.4

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I did not imagine in a million years that I would be reflecting on my journey, a few months after the unexpected death of one my dearest friends, Glen. Glen and his wife, Anna, are two of the most important people in my life. I lived with them at the beginning of my doctoral journey when I relocated to start my PhD. Without their kindness, support, and friendship, many incredibly meaningful events would not have happened in my life. Welcoming me with open arms into their home, they were my family. I will always remember how supported and loved I felt.

Being gifted the opportunity to pause to consider where to live at the start of my PhD, I finally decided to move to Bournemouth and Anna and Glen helped me move into a shared apartment with another PhD student at the time and friend, Raysa El-Zein. On the very same day, we all met my future-husband-to-be Steve, and a wonderful friendship blossomed between us all. Six months later Steve and I were in a relationship – in the kind of secure relationship I had always hope for. He was kind, considerate, funny, handsome, and my biggest cheerleader – we both work in the NHS, so would often share stories about our experiences. He just ‘got’ me and accepted me unconditionally.

Five years later Steve and I married in the summer of 2023. Anna and Glen were an integral part our bridal party. Glen was one of Steve’s ushers and Anna was one of my bridesmaids. They both gave readings during our ceremony and Glen was a fabulous master of ceremonies – introducing us to all our guests as Mr and Mrs Roche. I will cherish the memories we made together and how supportive they both were in the week leading up to our wedding. They will always be our family.

Losing Glen unexpectedly right at the end of my PhD has been utterly devastating. I have never experienced grief like it. Glen was one of the most incredibly kind, thoughtful, wise, gracious human beings I have ever met, and I am privileged to have known him. I know he would be extremely proud of my achievements.

I dedicate this body of work to Glen and all the incredible women who took part in this research and kindly told me their stories. The participants’ collective stories revealed the insidious nature and pervasiveness of trauma in our society. Their experiences, along with the

midwives who took part, are the foundation of this body of work and I am eternally grateful to you all.

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My studentship was originally match-funded between Bournemouth University and an NHS Trust in the South of England, where I also worked as a midwife for the duration of the programme. Due to the impact of the COVID-19 pandemic and experiencing some personal issues along the way, I was not able to submit my PhD on time, and so I applied for a competitive research fellowship. In 2022, the Iolanthe Midwifery Trust awarded me the Iolanthe Midwifery Research Fellowship. The fellowship provided me with financial support during the final stages of writing up this thesis, and I am eternally grateful to the trustees who have continued to support and guide me. I want to extend my deepest gratitude to all of my funders for the opportunity to complete this PhD.

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To my colleagues at ORCHA Health and especially to my fellow Clinical Leads. I joined ORCHA Health as one of the Maternity and Women's Health Leads in 2020 alongside Dr Fatima Ahmed. Over the next few years, we went on an incredible journey together through the world of digital health. Working with an industry partner alongside my PhD and work in the NHS opened my eyes to what could be achieved through cross-industry partnership. ORCHA Health was co-founded by Liz Ashell-Payne, who worked in the NHS as a speech and language therapist before founding ORCHA. Liz and the wider executive team have provided me with countless opportunities for personal and professional growth whilst I have been on this journey. I am a much better practitioner for being part of the ORCHA family, thank you.

To Maggie, my mentor and friend. Thank you for accepting my request for mentorship via the NHS Leadership Academy, back in 2019. I have always been an advocate for mentorship and coaching, but I did not expect such a wonderful friendship to blossom. Without your encouragement, constructive feedback, support, and guidance, I would not have had the courage to apply for the role I am now in.

As Devon's first Consultant Midwife at University Hospitals Plymouth NHS Trust, I want to thank everyone who contributed to my selection process and for putting your trust and faith in me. I have been welcomed into the team with open arms, and I am delighted to be working alongside you all to improve perinatal health inequalities in the local area. A special and sincere thanks goes to Charlotte Wilton – Head of Midwifery and Susan Wilkins – Director of Midwifery, for welcoming me into the senior leadership team. I am thrilled to have been given the opportunity to work with you both, and to utilise my experiences to help bolster Clinical Academic opportunities for other midwives in the South West Peninsula, thank you.

My final thanks goes to the person I was and the person I now am as I complete my PhD. I thought I knew who I was when I started this journey back in 2017 but in reality, I knew very little about myself. I have persevered, despite the challenges, and it is finally time to start the next chapter in my life.

Conducting qualitative research on the topic of social inequalities and discovering that many women who took part had also experienced trauma in their lives, triggered my own fractured memories of difficult experiences I have had over the course of my life. These experiences impacted the way I was in relationship with other people and with myself. During the data collection and analysis phase of this research I started to remember things from my childhood that made me feel disconnected from myself. With the help of an incredible therapist, who I have been working with for a few years now, I have been able to work through my own traumas and start to integrate these experiences. This healing journey, like many others, will be a lifelong journey, but I certainly understand more about myself. I also have a better awareness of what I still need to work on. It is a constant evolution, navigating this sometimes cruel but beautiful world, and I am so grateful to be able to finally experience the fruits of my labour after seven-eight years of dedication to this body of work.

Chapter 1. Introduction to the thesis

This thesis explores the social complexities that twenty-three perinatal women faced during the COVID-19 pandemic and their maternity care experiences at an NHS Trust in the South of England. In addition, the research explores the experiences of thirteen midwives working in a Midwifery Continuity of Care (MCoC) model designed to provide enhanced continuity for women facing additional complexities, to better understand how MCoC midwives tackle health inequalities as part of their public health role. Examining these domains provided evidence about the specific social complexities women faced during the pandemic, the mechanisms and processes that underpin evidence on the improved outcomes for women receiving MCoC, and the evolving public health role of NHS midwives.

A Constructivist Grounded Theory was conducted between 2020-2021 and involved a discursive process of comparative data collection and analysis, coding textual passages to identify categories/themes, memo writing to document analytic decision-making, and eventual theoretical conceptualisation.

In this thesis I refer to 'perinatal women', 'mothers', and 'women' and 'women's health', but I recognise not everyone who is pregnant or giving birth will identify as a woman or a mother, and as such face additional structural inequalities and discrimination that are beyond the scope of this PhD.

1.1 Presentation and navigation of chapters

This thesis provides a comprehensive illustration of the research background, methodology, methods, ethical considerations, and research findings. This thesis then critically analyses the research findings in the context of existing literature, articulates original contributions to knowledge, and closes with a conclusion and recommendations for future research and practice.

Chapter 2 provides the background of the research area and the existing evidence base.

Section 2.2 outlines the motivations behind this doctoral study, while sections 2.3-2.11 identify gaps in current understanding that warrant further investigation. The chapter concludes with section 2.12, which sets the stage for Chapter 3.

Chapter 3 presents a scoping review conducted prior to the COVID-19 pandemic, to investigate the relationship between the social determinants of health and perinatal health inequalities. This review, covering literature from 2008 to 2019, was essential for identifying the research gap and justifying the need for this doctoral study. The decision to limit the review to evidence prior to the pandemic, was both methodological and driven by the COVID-19 pandemic's

impact on women's experiences. The chapter also includes a discussion on the implications for the proposed study and the originality of the research and concludes in section 3.7.

Chapter 4 outlines the methodological assumptions of the research, beginning with an exploration of the philosophical perspectives that guided the development of the study. Discussion then turns to focus on the principles of Constructivist Grounded Theory and its suitability for this research. The chapter also provides a preamble on the activities undertaken which led to the development of the final empirical study, 'The Mi-CARE Study'.

Chapter 5 builds on the previous chapter by detailing the research design, ethical considerations, and development of the research protocol, which received ethical approval from the Health Research Authority and Health and Care Research Wales. An adapted, peer-reviewed version of the research protocol, published in *European Journal of Midwifery*, is also included.

Chapter 6 contextualises the findings presented in Chapters 7 and 8. This chapter begins with an overview of the political landscape in England during the decade preceding the COVID-19 pandemic, followed by a detailed examination of the health inequalities in the city where this study was conducted. The chapter concludes with an overview of the participants and guidance on interpreting the findings in the subsequent chapters.

Chapter 7 presents the first of two findings chapters, detailing the main theoretical categories that emerged from interviews with twenty-three women and thirteen MCoC midwives. This chapter mainly focuses on interviews with women. Interviews explored women's daily lives and their maternity care experiences during the pandemic. Midwives experiences are also woven into the narrative where it added value to the story telling.

This chapter also explores the category, '*sucking it up and getting on with it*' a survival-based mechanism that women in the study appeared to develop in response to their experiences of trauma prior to becoming pregnant and/or during the perinatal period. The cumulative impact this had on the context and conditions of women's lives, health, and wellbeing are also explored. Findings revealed a mix of human survival, hope, joy, and triumph amidst adversity, the compounding effects of intergenerational trauma and structural inequalities, as well as the additional inequities women and children faced during the COVID-19 pandemic.

Chapter 8 builds on the previous chapter by integrating the experiences of women and midwives together, focusing on how MCoC midwives responded to the levels of trauma and the wider social determinants of health that women faced. In this chapter the category, '*we're only really scratching the surface of the complexities women face*' is presented, which demonstrated the significant challenges MCoC midwives faced trying to tackle widening

inequalities. Efforts to address perinatal inequalities in the NHS were hindered by poor data collection, analysis, and evaluation mechanisms, digital literacy, ineffective partnerships with stakeholders, and a lack of midwifery presence and decision making at strategic level.

Midwives are well-positioned to influence public health strategy and interventions in their local communities, but face challenges with representation within the wider public health workforce.

Chapter 9 is a critical analysis of several key areas that emerged from the findings and discusses these within the context of the existing evidence base. Most of the literature discussed in this chapter was published after 2020, which contextualises findings from the study in relation to the impact of the COVID-19 pandemic.

Chapter 10 concludes the thesis and presents the contributions to knowledge that emerged from the research. The strengths and limitations are also discussed as well as recommendations for policy, research, and practice.

Chapter 11 presents the appendices and also includes the reference list.

1.2 Situating the researcher in the thesis

At the start of a Constructivist Grounded Theory, it is important for the researcher to position themselves within the context of their research to aid reflexivity, transparency, and rigour (Charmaz and Mitchell 1996; Charmaz 2006, 2014a). In this section I share some personal reflections to demonstrate how I have influenced the co-construction of knowledge and how this research has influenced and shaped me over the last seven years.

I am a 38-year-old, cis-gendered¹, White, married female, from a working-class family. I am deeply empathic and believe wholeheartedly in the transformative nature of human-connection. My personal and professional priority is to bring my true self to my work and to create safe, non-judgmental spaces where trust can develop, and relationships can grow. At times, my PhD journey has been incredibly challenging. I often experienced low self-esteem and questioned my capabilities. However, through these experiences, I have gained profound insights into the human condition, who I am as a person, and I am extremely proud of what I have achieved despite the challenges I have faced.

Achieving a PhD is not something my inner child would have thought possible - I grew up in a small market town in the East of England in a dysfunctional family. As a young girl growing up, I thought the Academy was for other people, not for people like me. However, I always had big dreams, and my imagination gave me hope of what I might one day achieve.

My mother and father both come from families affected by intergenerational trauma. They married in the early 1980's when they were young adults. I was born in 1986, and they divorced when I was about five years old and my brother James, was three years old. This sent shockwaves through our family and especially for my mother, who had always dreamed of having the 'perfect' family. She, like the women in my study *'sucked it up and got on with it'*, but the cumulative damage from her own childhood traumas and the divorce from my father, took their toll on her health and wellbeing.

Unfortunately, my brother and I did not see our father much during our childhood and I always felt like a part of me and who I was, was missing. I often felt rejected and sad as a child - knowing my father had two other children (my half-brothers) who I did not have much of relationship with. Unsurprisingly, this sense of loss and grief for the family I did not have, had a

¹ Cisgendered (from the Latin *cis-*, meaning "on the same side as") refers to individuals whose gender identity aligns with the sex they were assigned at birth (Aultman 2014). That is, a cisgender person's gender is "on the same side" as their birth-assigned sex, in contrast to a transgender person, whose gender identity differs from their assigned sex (ibid). This term emerged from transgender activist discourses in the 1990s as a way to challenge the assumption that being cisgender is the default or "normal" state, and to promote more inclusive language in discussions of gender identity.

lasting impact on me and my identity. However, in the lead up to my wedding, my father and I rekindled our relationship.

A few years after my parents' divorce, my mum unfortunately married a violent and abusive man. I hold empathy towards her for this decision, as I know she longed for us to have a secure family unit. However, this man was coercive, controlling, abusive, and neglectful towards me and my brother and I still find it difficult to comprehend how she stayed for so long. Most of the time I did not feel safe at home, but as a child, like some of the women who took part in my study explained about their childhoods, I had nowhere else to escape. In the 1990's it was fairly easy for these experiences to go under the radar – children were seen and not heard.

Luckily for me, my brother, and my mum – she divorced him when I was about fourteen years old and we spent a few years together, just the three of us – I remember these years fondly, I felt safe. I guess you could say I am conflicted when I say this, but my stepfather died within a few years of their divorce, and I felt absolutely nothing due to years of his abusive and toxic behaviour.

My mum was finally lucky in love when she eventually met her third husband, my stepfather Dave – a gentle and kind soul – they are still married to this day.

Somehow, I did fairly well at school and after a brief stint at art college after finishing my A-Levels, I turned to the world of healthcare. I did not always want to be a midwife, but I knew how much I enjoyed caring for others and I marvelled at everything to do with pregnancy. I eventually put-all-the-pieces-of-the-puzzle-together and spoke to a local community midwife about the profession before applying to university. I was lucky enough to secure a place at university on my first attempt, and at the age of nineteen I started to study for a bachelor's degree in midwifery.

I am now 38 years old, and I have experienced nearly twenty, incredibly rewarding years in the NHS. I am eternally grateful for the career I have had so far - and the community of supportive people I have met along the way - who have each cultivated and supported my growth. Most notably Janet Driver, previously Head of Midwifery at North West Anglia NHS Trust, where I worked at for eight years after I first qualified as a midwife. Janet always supported my interest in clinical research, which every few years, took me away from clinical practice so I could focus on the various Clinical Academic Training fellowships (funded by the National Institute for Health and Care Research) I completed before my PhD.

I also want to express my sincerest thanks to Tara Pauley, Head of Midwifery at Luton and Dunstable NHS Foundation Trust - we embarked on our research careers together at North West Anglia NHS Trust and she has always been a dear friend and confidant.

I knew early in my midwifery career that I wanted to pursue a clinical academic career and work in continuity models of midwifery care, as they both aligned with my values, professional curiosity, and commitment to working with people in their local communities. I worked in a continuity model of care early in my midwifery career and once again during my PhD journey. During these experiences, I became deeply aware of the impact of the Social Determinants of Health (SDoH) on inequalities. I cherished the relationships I developed with colleagues and the women and families I cared for and was also acutely aware of my impact on women's maternity experiences and outcomes. Sometimes we forget amongst the many roles, responsibilities, and demands placed on us in the NHS, the most powerful intervention is who we are, what we say, how we act, and what we bring of ourselves to each interaction we have with a family. However, being attuned to a woman's needs in times of adversity, whilst working in a complex healthcare system, has at times led to vicarious trauma and burnout.

Akin to the midwives in my study, I have also felt fatigued, and brow beaten by the 'system' within which midwifery practice exists in England. I welcome the evidence presented in this thesis and strive to build psychologically safe, trauma-informed services that address the root causes of inequalities as a core function of equitable care. The evidence in this thesis demonstrates that relational approaches and interventions grounded in social justice can meaningfully contribute to building a more equitable and healthier society.

My midwifery philosophy aligns with the biopsychosocial model of health and disease², seeing health and wellness of women and children as the bedrock of a fair and prosperous society. I have always embraced the mantra '*prevention is better than cure*', favouring to work in primary care and midwifery-led settings and being committed to challenging the status quo.

My political and feminist values have always fuelled my altruistic and socialist desire to collaborate with system partners, including getting involved in local and national politics to advocate for a fairer society. I hope that within my lifetime, the evidence on the SDoH and trauma-informed care will be the lens through which our society operates and through which our health and care services are delivered. Perhaps one day, the political choices of the elite will prioritise care and compassion over neoliberalism and greed. Until then, we must continue to fight the good fight together.

² The biopsychosocial model conceptualises health and illness as the product of a dynamic interaction between biological, psychological, and social factors. It challenges the reductionist biomedical model by recognising that health outcomes are shaped not only by physical processes but also by mental states, social environments, and cultural contexts (Bolton and Gillett 2019).

I hope you enjoy reading this research as much as I have enjoyed living and breathing it over the last seven-eight years.

Chapter 2. Background of the research

2.1 Introduction

This chapter provides the contextual foundation for the research by critically examining the existing evidence base. Section 2.2 outlines the motivations underpinning this doctoral study. Sections 2.3 to 2.11 identify key gaps in current knowledge that form the focus of subsequent investigation. Finally, Section 2.12 concludes the chapter and offers a transition into Chapter 3.

2.2 The state of inequalities in England and their impact on women and children

England is an unfair nation, with deep-rooted inequalities that are showing no signs of improvement in 2024. Imagine a working-class family in the early 2020s being no better off in relative terms, than a family at the beginning of the 20th century (Dorling 2024). This may sound absurd, but it reflects the reality of millions of children and their parents living on the lowest incomes in England. British social scientist, Danny Dorling published a book towards the end of 2024 exploring this very subject, presenting the evidence behind such staggering statistics (ibid). Dorling's book, which critically examines the lives of seven imaginary children representing the median of seven different income brackets - from the poorest to the wealthiest households - explores how 21st century England has the fastest-rising levels of child poverty in Europe and the consequences of this on the life chances of children in England (ibid). A call to action, Dorling states the case for cross-party action to address the growing inequalities families face (ibid).

In the decade before the COVID-19 pandemic struck the United Kingdom (UK) in 2020, a deep-seated malaise in the health and social care system, coupled with years of austerity and funding cuts across public services, widened the gap between the richest and poorest families (Dorling 2024). During the COVID-19 pandemic, the cumulative impact of regressive funding cuts under successive Conservative Governments (which hit poorer areas more), associated with austerity, shone a stark light on the ingrained and insidious health inequalities experienced by the poorest families in England (Goldblatt 2024). For the first time in recent history, data from the Institute of Fiscal Studies showed that worsening health inequities contributed to a reversal in life expectancy for women living in the 10% most deprived areas across England (ibid). The UK also saw a resurgence of Victorian childhood diseases such as scarlet fever, whooping cough, rickets, and scurvy, caused by a combination of nutritional deficiencies and vaccine hesitancy in poorer communities (UK Health Security Agency 2019; Guglielmi 2022). Data also indicates that austerity-related economic adversity and cuts to public services has negatively affected the height of five-year-olds in England since 2010,

compared to other European countries—a direct consequence of household disposable incomes being lower than they were eighteen years ago (Marmot et al. 2020a; Marmot 2023).

Children in England are also more likely to fall behind in terms of school readiness compared to their peers in other European countries (Chzhen et al. 2018). A global survey found that over a third of UK primary school professionals believe most children are not developmentally ready when they start school. UNICEF's report '*An Unfair Start*', highlights significant educational inequalities in the UK, ranking it poorly among forty-one other high-income countries (ibid). Literacy and numeracy levels among English school pupils are also lower compared to other member countries in the Organisation for Economic Co-operation and Development (OECD) countries (Child of the North and Centre for Young Lives 2024).

Respectively, inequities in perinatal health outcomes also continue to persist in the UK (Knight et al. 2023). Birth data from England, Scotland, and Wales (April 1 2015 to 31 March 2017) showed the incidence of pre-term birth, admission to neonatal units, and stillbirth were higher for babies born to women from Global Ethnic Majority (GEM) backgrounds such as Black and Asian women, compared to White babies (Jardine et al. 2021; Knight et al. 2023). Whilst neonatal mortality rates are, on average decreasing, 2019 data show the risk of stillbirth and perinatal mortality remains disproportionately high for babies born to women living in the most deprived areas (Draper et al. 2022). Perinatal mortality risk has also been shown to be higher for babies of Black and Asian heritage in the UK relative to babies of White ethnicity (Draper et al. 2021; Knight et al. 2023). These findings were also corroborated in Watson (2024), which found an association between austerity-related economic adversity and a rise in adverse birth outcomes in the UK, such as pre-term birth and low birth weight. Moreover, data from '*The National State of Patient Safety 2024*' report (Illingworth et al. 2024), published towards the end of 2024, demonstrated an increase in the rate of stillbirths in England. In the period between 2013-2020, whilst the rate fell by 18.4%, from 4.6 to 3.8 per 1,000 births, by 2021 this figure rose to 4.1 – an increase of 8% on the previous year. From an intersectional perspective, the evidence discussed here, demonstrates the cumulative impact of disparities in outcomes, such that there is an increased risk of perinatal mortality in babies from GEM backgrounds whose mothers also live on the lowest incomes (Knight et al. 2023).

Data also continue to highlight significant inequalities in maternal outcomes. According to the latest report from MBRRACE-UK, covering the period 2020-2022 - the period when this doctoral study was conducted - disparities in maternal mortality rates persist (Felker et al. 2024). Women of Black ethnicity are still significantly more likely to die during pregnancy or

within six weeks postpartum, with a mortality rate 2.9 times higher than that of White women (ibid). Women of Asian ethnicity, face a mortality rate 1.7 times higher than their White counterparts (ibid). Furthermore, women living in the most deprived areas are also 2.2 times more likely to die in pregnancy or shortly after compared to women in the least deprived areas (ibid). Nine percent of women (26/275 women) who died in the period 2020-2022, were known to face multiple and severe disadvantage, including mental health conditions and the number of women with social services involvement has risen to 22%, which is the highest proportion since reporting began (ibid). The authors' note that widening socioeconomic inequalities impact women's ability to travel to appointments, take time off work, and access digital maternity records. Moreover, it is highly likely the number of women experiencing multiple disadvantage is underreported, as social risk factors are among the most inconsistently and poorly documented data points in maternity records. The authors' warn that health inequalities will continue to deepen, unless the SDoH that drive these disparities are placed at the core of all maternity policy in the UK (ibid). To identify solutions and drive forward actionable change, Felker et al.(2024) recommend commissioners and local maternity and neonatal systems across England, explore alternative methods and locations for delivering care, while incorporating community advocacy and actively involving community voices in service development. Similar findings were echoed in the '*National State of Patient Safety 2024*' report (Illingworth et al. 2024), which found between the periods of 2011-2013 and 2017-2019, whilst maternal deaths remained relatively steady, following several years of continual decline, between the periods 2017-2019 and 2020-2022, the maternal death rate (including women who died due to complications of COVID-19), increased from 8.8 to 13.4 deaths per 100,000 maternities – a statistically significant increase of 52.3% (ibid).

The recognition of such disparities, alongside successive failings in NHS maternity care at University Hospitals of Morecambe Bay NHS Foundation Trust (Kirkup 2015), Shrewsbury and Telford Hospital NHS Trust (Ockenden 2022), East Kent Hospital's University Foundation Trust (Kirkup 2022), the ongoing review of maternity services at Nottingham University Hospital's NHS Trust (Ockenden 2024), and the national review of maternity services in England (Care Quality Commission 2024), have all driven renewed commitments to improve NHS maternity services. However, as the evidence discussed suggests, more targeted and sustained commitments are required to address entrenched and persistent perinatal inequalities.

2.3 Violence against women and girls

Violence against women and girls (VAWG), an umbrella term used to cover a wide range of gender-based forms of abuse, is a pervasive public health issue and violation of women's human rights, with significant physical, mental, sexual, and reproductive health sequelae (World Health Organization 2021, 2024d). According to the World Health Organization (WHO), approximately 1 in 3 women globally have experienced physical or sexual violence at some point in their lives (ibid).

In the UK, 20% of women have experienced sexual assault (Office for National Statistics 2018). In a sample of 22,419 UK women, 99.3% reported that they had been subject to sexual harassment, sexual assault or rape (Taylor and Shrive 2021). Research from the Office for National Statistics, indicated that over one million violent crimes against women and girls were recorded in England and Wales in 2023, accounting for 20% of all police-recorded crime issues (Office for National Statistics 2023). This figure likely underrepresents the true scale of VAWG, as it is estimated that over 75% of domestic abuse incidents go unreported in the UK (ibid).

There are also well-documented links between socio-economic deprivation and rates of VAWG. Structural inequalities including misogyny and racism create gender inequality, which exacerbate the impact of social disadvantage, financial inequity and marginalisation; all of which heighten VAWG (UN Women 2021; World Health Organization 2021). Evidence demonstrates that women also experience higher rates of Adverse Childhood Experiences (ACEs), sexual abuse, human trafficking, and mental health issues (Sperlich and Seng 2018; Vaswani 2018; Aberlour et al. 2019; Whitaker et al. 2021). Moreover, data also indicate that women are twice as likely as men to develop posttraumatic stress disorder (PTSD), due to the nature of gender-based violence (Olf 2017; Goldstein et al. 2021). From this standpoint we can assume that many women entering pregnancy will have experienced trauma. The psycho-social-emotional impact of trauma has been shown to negatively impact women's engagement with maternity services, increases the chance of adverse birth outcomes, lower rates of breastfeeding initiation, and increases the chance of attachment-related complications in the postnatal period (Goldstein et al. 2021; Benzakour et al. 2022; Dagher and Linares 2022; Reno et al. 2022 (Isobel, 2023 #3797).

The COVID-19 pandemic exacerbated VAWG further, with lockdown measures increasing women's exposure to abusive partners and limiting access to support services (World Health Organization 2021; Psarros et al. 2023b; World Health Organization 2024d). Economic

instability caused by the COVID-19 pandemic, also increased the prevalence of VAWG as more women were exposed to violence in the home but had limited financial resources in which to escape (Galbally et al. 2022; Fletcher et al. 2023). The pandemic not only intensified violence but also exposed and exaggerated structural inequalities, reversing progress on gender equality (Marmot et al. 2020b). In the aftermath of the pandemic, international data suggests that VAWG continues to escalate, with devastating consequences on women and children's life chances (UN Women 2021). There are only six years left to achieve gender equality and fulfil the commitment of the *2030 Agenda for Sustainable Development* (UN General Assembly 2015). If current trends continue, more than 340 million women and girls are predicted to still live in extreme poverty by 2030 (UN Women 2023). No country across the globe is within reach of eradicating intimate partner violence (ibid). As long as workplace discrimination, unemployment, conflicts, displacement, inadequate access to healthcare, and disparities in unpaid care and domestic work for example persist, VAWG is predicted to increase with grave consequences (UN Women 2021; Agenda Alliance 2023; Goldblatt 2024).

Addressing VAWG therefore requires a multifaceted approach that includes robust legal frameworks, adequate funding for support services, and comprehensive public health education to tackle misogyny and toxic masculinity in society (Centres for Disease Control and Prevention 2024; Hayvon 2024; World Health Organization 2024d). It is crucial to tackle the root causes of VAWG, such as gender inequality and socio-economic deprivation, to create a safer and more equitable society for women and girls. Continued investment in prevention and support services, alongside efforts to alleviate poverty, are essential steps towards reducing the prevalence of VAWG in society.

The evidence presented here implies that a substantial number of women experience sexual violence and assault before pregnancy, experiences of which will likely remain with women and could impact women's health and birth outcomes, including the potential for re-traumatisation in the perinatal period due to the sensitive and intimate nature of giving birth and receiving care from multiple often unknown healthcare professionals.

2.4 Defining poverty

This doctoral study originally sought to focus on the impact of socio-economic inequalities on perinatal health and the public health role of caseloading midwives, however, as [Chapter 7](#) and [Chapter 8](#) will reveal, the SDoH intersected with multiple forms of gender-based trauma and discrimination. These overlapping domains exerted a cumulative and pervasive influence on

women and their babies across the lifecourse. The perinatal period emerged as a distinct phase during which multiple forms of oppression and inequality converged.

This section will explore definitions used to describe socioeconomic inequalities, including poverty, and how poverty impacts health and wellbeing. [Section 2.3](#) will discuss the wider SDoH.

Definitions to describe and measure poverty and low-income are used interchangeably and capture the range of circumstances and factors that contribute to wellbeing. Both concepts are socially constructed and are interpreted differently by individuals, families, and communities; shaped by the influence of both direct and indirect lived experiences (Lister 2021). Poverty is best understood as a function of social, economic, and political structures and process, which create and perpetuate an unequal distribution of resources both within and in a global context, between societies (ibid). The concepts will be used interchangeably in this thesis to describe the situations where women have insufficient resources to meet their own needs and those of their families (Social Metrics Commission 2018). Needs are individually determined but encompass women's material needs (i.e. housing and food) and their personal needs (i.e. relationships, health and future prospects) over the perinatal period (ibid).

There is no single, universally accepted measure of what constitutes a 'low-income', and concepts such as 'poverty' and 'inequality' are measured in numerous ways (Adams and Levell 2014; Social Metrics Commission 2018). 'Relative' and 'absolute' low-income are two commonly used terms, which are measured before or after housing costs are deducted (ibid). Relative low-income describes households with income below 60% of the median income in that year, whereas absolute low-income, describes households with income below 60% of (inflation-adjusted) median income (ibid).

The UK's official source of poverty estimates originate from the 'Households Below Average Income' statistics, produced by the Department for Work and Pensions (2016). In 2020, estimates demonstrated that 10.5 million people, around one in six people in the UK, live on a relative low-income before housing costs, rising to around 13.4 million, around one in five people, once housing costs are adjusted for (McGuinness 2017; Francis-Devine 2020). These figures include 2.8 million children, nearly one in five children, living in low-income households before housing costs, and 3.9 million children after housing costs (Marsh et al. 2018). The charity, Child Poverty Action Group, recommends calculating levels of poverty after housing costs, as this can provide a more accurate measure of household income (Howes 2019).

In 2023, the median disposable income before housing costs was £34,500 (Department for Work and Pensions 2024). For the poorest fifth of the population, this figure was significantly

lower at £16,400, while the richest fifth of the population reported a median disposable income of £68,400 (ibid). After accounting for housing costs, the median household disposable income fell to approximately £29,000 (Department for Work and Pensions 2024). This drop in income disproportionately affects lower-income households, who are more likely to experience higher rental costs and utility bills, with the poorest fifth seeing their income fall to around £13,000 (ibid). In contrast, the richest fifth of the UK's population experience a more modest reduction in income after housing costs, to £60,000 (ibid). These figures highlight the uneven impact of housing costs, which place far greater financial burden on those with the lowest incomes, exacerbating socioeconomic inequalities further and limiting opportunities for upward social mobility (Marmot et al. 2020a; Marmot et al. 2020b; Department for Work and Pensions 2024).

In its annual survey, The UK Committee for UNICEF (UNICEF UK) warned that mounting debt, poor mental health, and expensive and unavailable childcare was placing children's futures at risk, with 87% of respondents (2892 parents of children under 5 years), reporting that they were worried about their children's future life chances (UNICEF UK 2024b). Moreover, the children's charity reported that parents of young children - particularly those in lower income households - are not getting the support they need to give their children the best start in life and called on the Government to do more for families and commit to a National Baby and Toddler Guarantee (UNICEF UK 2024a). Joanna Rea, Director of Advocacy for UNICEF UK reported:

"this is the moment to start making the UK one of the best places to raise a child and reverse the years of underinvestment and austerity which contributed to the UK having the highest increase in child poverty of any rich country. With a quarter of parents borrowing money to pay for the essentials for their children – supporting them must be an urgent national priority for the new Government", (UNICEF UK 2024b).

Traditionally, studies of poverty and deprivation have focused on entrenched socio-economic disadvantage, using measures like the Indices of Multiple Deprivation (IMD). The IMD is a measure used in England to assess the relative deprivation of small population areas and is based on the concept that deprivation consists of more than just poverty (Ministry of Housing 2019). Poverty typically refers to the lack of sufficient income to meet basic needs, while deprivation encompasses a broader absence of essential resources and opportunities (ibid). The Index of Multiple Deprivation (IMD) combines a variety of indicators that reflect various aspects of deprivation, grouped into seven domains: income, employment, education, health, crime, barriers to housing and services, and the living environment. Each area in England is ranked from most to least deprived based on these combined factors. These seven domains

are weighted and merged to produce an overall IMD score. The IMD helps local authorities and the wider health and care system to identify areas that may need targeted support and resources to address social and economic inequalities.

Families may also experience poverty suddenly and temporarily, yet even short-term poverty is linked to both immediate and long-term health risks, including increased morbidity and mortality (World Bank Group 2022). Research on this topic often explores the impact of 'economic shocks' - such as the global crisis triggered by the COVID-19 pandemic - and the consequences of temporary, rather than persistent, poverty. It also considers how individuals and families may 'fall into poverty' due to events like job loss, bereavement, illness, or the reduction of income, whether from employment or social support systems (Bufe et al. 2022). For example, during the COVID-19 pandemic, many households faced widespread job losses, benefit freezes, and economic downturns (World Bank Group 2022; Psarros et al. 2023b). These sudden drops in income forced families to deplete savings, increase unregulated debt, and in many cases, fall into poverty (Psarros et al. 2023b; Eliason et al. 2024). The pandemic-induced economic crisis revealed and intensified pre-existing inequalities, with disadvantaged populations suffering disproportionate income losses (Tinson 2020). This has long-term implications for social mobility and economic recovery, as those who fall into poverty may find it difficult to regain financial stability (ibid).

The health implications of economic shocks can also be profound. The cumulative impact of stress caused by the experience of poverty, increases inflammatory responses in the body, leading to increased risks of metabolic disorders, autoimmune disease, gastrointestinal disorders, psychiatric disorders and so on, and worsening living conditions (Crear-Perry et al. 2021; Maalouf et al. 2021; Davie 2022; Wood et al. 2023). The COVID-19 pandemic highlighted the disproportionate impact of poverty, with individuals from socioeconomically disadvantaged groups experiencing significantly higher rates of illness and mortality (Agbai 2023; Reece et al. 2023). Women from the most deprived households also experienced significantly higher rates of perinatal morbidity and mortality (Brown et al. 2022; Eliason et al. 2024). According to MBRRACE-UK, women living in the most deprived areas had maternal mortality rates more than twice as high as those in the least deprived areas (Knight et al. 2023). Additionally, babies born to women in deprived areas were twice as likely to be stillborn and had a 73% excess risk of neonatal death, compared to those born to women in the least deprived areas (ibid).

Addressing the impact of economic shocks requires comprehensive policy responses. Social safety nets, such as unemployment benefits and emergency financial assistance, are crucial in mitigating the immediate effects of income loss and deepening injustice (World Bank Group 2022). Additionally, policies aimed at reducing inequality, such as improving access to healthcare and education, can help build resilience against future economic shocks (ibid). The COVID-19 pandemic underscored the need for robust social protection systems to support populations during times of crisis.

2.5 The Social Determinants of Health

The SDoH describe a range of intersecting social, economic, and environmental factors that shape differences in health and health outcomes between population groups (Wilkinson and Marmot 1999; Commission on Social Determinants of Health 2008; Marmot et al. 2010; Marmot et al. 2020a), such as the contexts and conditions in which people are born, grow, work, live, and age (World Health Organization 2024b). The SDoH expose the root causes of ill-health and challenge vitriolic stereotypes about poverty which intersect with other determinants such as culture, disability, gender, income, race, religion, sexuality, which cumulatively affect health and wellbeing (Marmot 2015; Crisp 2020). According to data from the WHO, the SDoH are estimated to account for between 30-55% of health outcomes (World Health Organization 2024b). This highlights the considerable influence of social and economic conditions on health outcomes - often surpassing the impact of clinical care or individual lifestyle choices. Addressing the SDoH is fundamental to improve health and reducing longstanding inequalities, which requires action across all sectors of society (World Health Organization 2024b). Michael Marmot's principles of social justice are rooted in the idea that health inequalities are largely driven by the SDoH and that addressing these requires systemic change. In his influential work, particularly the '*Marmot Review: Fair Society, Healthy Lives*' (Marmot 2010), Marmot outlines key principles that reflect a social justice approach to health equity:

1. Give every child the best start in life
2. Enable all children, young people, and adults to maximize their capabilities and have control over their lives
3. Create fair employment and secure work for all
4. Ensure a healthy standard of living for all
5. Create and develop healthy and sustainable places and communities

6. Strengthen the role and impact of ill-health prevention
7. Tackle discrimination, racism, and their outcomes
8. Pursue environmental sustainability and health equity together.

Socioeconomic disparities are also evident in incidences of non-communicable diseases and morbidity. For example, low socioeconomic status is associated with a higher prevalence of obesity, cardiovascular diseases, type 2 diabetes, chronic respiratory diseases, and premature death (Sommer et al. 2015; Marmot and Bell 2019; Macias-Konstantopoulos et al. 2023). In 2020 the publication of *'Build Back Fairer: The COVID-19 Marmot Review'* (Marmot et al. 2020b), outlined the detrimental effect of years of austerity on health inequalities within the context of the pandemic. The report demonstrated that pre-existing social and economic inequalities led to higher mortality rates among disadvantaged groups (ibid). Pandemic containment measures, such as lockdowns, exacerbated mental and physical health outcomes, particularly for children and young people, and deepened existing inequalities. The review emphasised the strong link between the economy and health, advocating for multi-sector action and increased public health investment to address these disparities. Finally, it called for long-term, equity-focused policies to build a fairer society, and underscored the need for comprehensive strategies, grounded in the principles of social justice, to mitigate the pandemic's impact on population health (Marmot et al. 2020b).

2.5.1 The Dahlgren-Whitehead model

The Dahlgren-Whitehead (1991) rainbow is an eminent public health model for determining the origin of health inequalities, which conceptualises the relationship between the individual, their environment, and health (figure 1). Developed in 1991 by Göran Dahlgren and Margaret Whitehead, the model places individuals at the centre of a series of interconnected layers that influence health. These layers include individual lifestyle factors, social and community networks, living and working conditions, and broader socioeconomic, cultural, and environmental contexts. The model advocates for cross-sector collaboration as a cornerstone of a population health approach. This shift moves beyond the traditional medicalisation of health in contemporary society – including representatives from the Voluntary, Charity, and Enterprise (VCSE) sector, as well as and local authorities – all of whom play a vital role in promoting community health and wellbeing (Dahlgren and Whitehead 1991; Jones Linda and Douglas Jenny 2012).

The model not only facilitates the exploration of the relative impact of different determinants but also underscores the complexity of their interrelationships. By mapping these interactions,

it supports a more nuanced understanding of how structural and social factors contribute to health inequalities, thereby informing both research and policy development. The model has also informed the development of various hypotheses concerning the SDoH, examining their relative influence on different health outcomes and illustrating the complex interactions among these determinants (Marmot et al. 2020a; Marmot et al. 2020b; Eliason et al. 2024; Poku-Amanfo E et al. 2024).

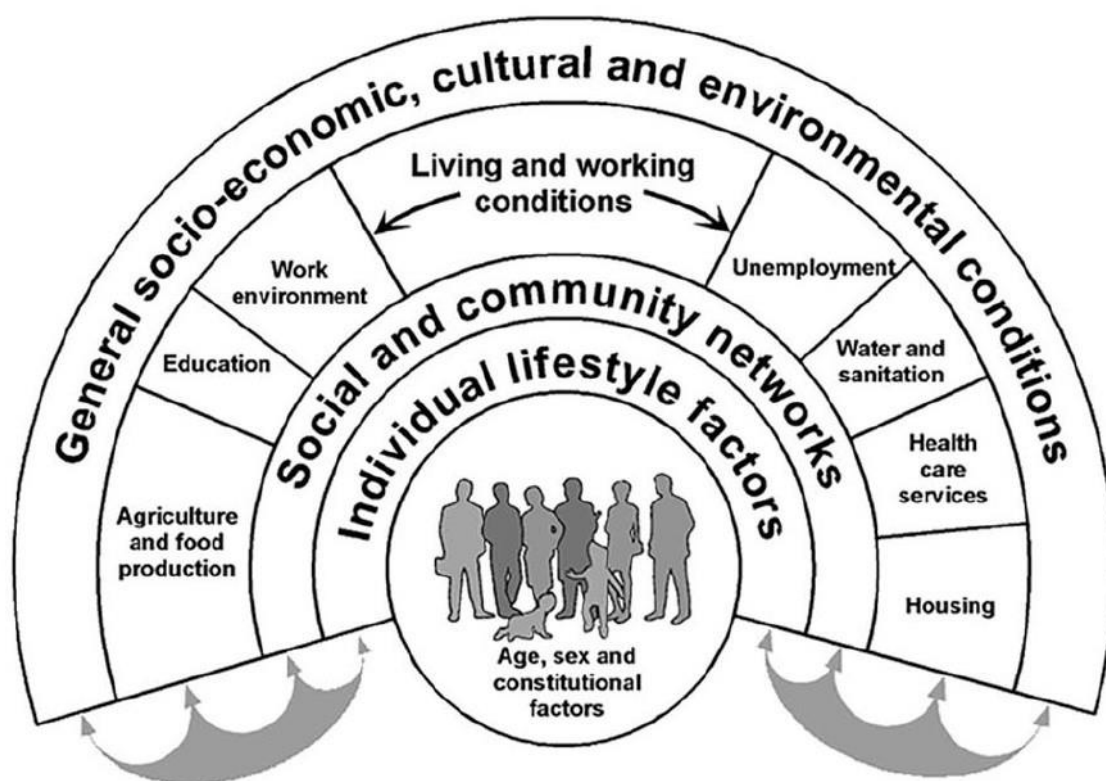


Figure 1. The Dahlgren-Whitehead rainbow of the Social Determinants of Health - Dahlgren and Whitehead rainbow model cited by Dyar, O.J. et al 2022. CC. by 4.0

Given the inextricable link between maternal and infant health, this model is a useful resource in terms of generating effective maternity policy and delivery of equitable care (NHS England and Improvement 2021a, 2021b; NHS England 2023e, 2023d).

2.5.2 The impact of neoliberalism on health inequalities in England

Neoliberalism is an ideology characterised by market-driven policies, deregulation, and a reduction in state welfare provisions and has impacted progress on addressing health inequalities (Collins et al. 2015; Monbiot and Hutchinson 2024). In the UK, neoliberalism gained momentum in the 1980's during the Thatcher Government (Bayliss et al. 2024). What followed was previously unthinkable privatisation of core public utilities such as water, rail, and the post office, and the belief that state intervention in the form of social welfare,

hampered efficiency and growth (Friel et al. 2021). Privatisation and market-driven policies disproportionately affected marginalised communities, leading to reduced access of equitable services for those in greatest need (Bayliss et al. 2024). The result as we now know, was a steady increase in alienation between the richest and poorest, civil unrest, and widening inequities (Monbiot and Hutchinson 2024). Margaret Thatcher famously stated that “*there is no such thing as society, there are individual men and women, and there are families*” (Thatcher 1987). This has since become symbolic of the shift away from collective policies toward market-driven approaches, including the weakening of trade unions, the rise of the gig economy, and a focus on individual autonomy rather than social cohesion (Monbiot and Hutchinson 2024).

The emphasis on individual responsibility and market forces continues to expand social injustices (Bayliss et al. 2024; Monbiot and Hutchinson 2024). As a consequence of the commodification of healthcare under Thatcherism, a two-tier healthcare system exists (ibid). For example, during the COVID-19 pandemic, the unprecedented strain on NHS resources led to increased reliance on private healthcare services. Meanwhile, individuals living in poverty experienced worsening health outcomes, often accessing care later and in a poorer state of health (Moynihan et al. 2021).

Productivity in the NHS also declined far more significantly during the COVID-19 pandemic, and remains below productivity levels recorded in 2019 (NHS Providers 2024). Outpatient appointments and primary care services saw significant reductions in usage, with outpatient appointments falling by over 40% and overall healthcare services by 37% (NHS Digital 2021a). The pandemic also deeply affected the psychological wellbeing of NHS staff. NHS Practitioner Health, which treats health and social care professionals with mental health and addiction issues, saw a significant increase in people accessing their services during the pandemic (NHS Practitioner Health 2024).

The pernicious effects of neoliberalism have also seen a rise in marketisation and managerialism in the NHS. The implementation of the internal market system introduced competition in the NHS and a focus on financial targets, performance indicators, and cost-cutting measures, often at the expense of patient safety and quality (Humber 2017; Monbiot and Hutchinson 2024). Managerialism, characterised by top-down management practices, focuses on efficiency and prioritises financial performance over clinical expertise and care; further undermining the core principles of the NHS (ibid). In 2024, the publication of the *Independent Investigation of the National Health Service in England* (Darzi 2024), provided an

assessment of the issues facing the NHS in terms of patient safety, access, quality, and performance. The Darzi Review, as it was more commonly known, highlighted how excessive managerialism has led to constant reorganisation, creating a fragmented management structure that undermines effective leadership and decision-making (ibid). The report also criticised the Health and Social Care Act (Anon. 2012) as being disastrous for NHS governance, causing instability and inefficiencies across the system. Additionally, Darzi noted that austerity, the COVID-19 pandemic, and the cost-of-living crisis, were effectively reversing the NHS's efforts to improve health outcomes, placing ever increasing and unrealistic demands on the health service (Darzi 2024). Moreover, the NHS's constitutional standards -central to the social contract between the health service and the public - came under sharp criticism for failing to meet expectations, raising concerns about accountability and the erosion of public trust (ibid). The focus on performance has resulted in a narrow pursuit of targets at the expense of patient care, contributing to long waiting times, variable quality of services, and record levels of negligence claims, especially in maternity services (NHS Providers 2024). The Darzi review also highlighted the alarming rise in perinatal mortality rates since the pandemic, growing complexity of care needs, ongoing workforce shortages in maternity, and the troubling reality that recommendations from numerous inquiries have not been adopted (Darzi 2024). Collectively, these challenges significantly constrain the ability of maternity services to address and reduce health inequalities, limiting their potential to deliver equitable care and improve outcomes for marginalised populations.

A significant consequence of neoliberal policies has been the chronic underfunding of maternity services (Collins et al. 2015; Taylor et al. 2022). This has contributed to a national shortage of over 2500 midwives in England, at the same time as NHS England focused on wide-scale implementation of MCoC models (NHS England and Improvement 2021a, 2021b; Royal College of Midwives 2024). Furthermore, safety and quality of care has been compromised. Despite NHS Trusts being held accountable for meeting national targets and standards (Public Health England 2021; Puthussery et al. 2022), women are now facing longer wait times to access services. Access to antenatal education has also declined, with provision significantly disrupted during the COVID-19 pandemic (Adesanya et al. 2022; Lokugamage et al. 2022; Royal College of Midwives 2024).

Working in high-pressure, under-resourced environments is widely recognised as a contributing factor to poor workplace culture, which in turn undermines the quality and safety of patient care (Sabitova et al. 2020). Heightened levels of chronic stress can lead to occupational burnout, sickness, and poor health, which in turn can lead to a loss of staff and

valuable resources to the NHS (ibid). Chronic stress and poor working conditions also contribute to an increased allostatic load, which can exacerbate health issues for both midwives and women and is particularly relevant in maternity settings where demands are high and resources are limited (Hunter et al. 2018a; Manthorpe and Baginsky 2023{Hunter, 2019 #4738}).

While the pernicious effects of neoliberalism remain in healthcare, alternatives that prioritise the core values of the NHS and oppose neoliberal policies are possible. Approaches such as the SDoH and models of maternity care such MCoC, are necessary to challenge and reshape the prevailing ideology that impacts health and prosperity (Allen et al. 2018; Marmot et al. 2020a). As we have discussed in [Section 2.3](#), the SDoH approach to population health focuses on the cultural, political, and structural challenges that impact collective wellbeing, equality, and social justice (Allen et al. 2018; Friel et al. 2021). Addressing inequalities on a population level requires a re-evaluation of neoliberal policies and a renewed commitment to social welfare and population health interventions (Sanderson et al. 2021; Srof 2022; Hayvon 2024). Embedding a SDoH approach in maternity care, as opposed to the risk-adverse, medical model that dominates maternity care in England, are essential to mitigate the adverse effects of neoliberalism (Marmot et al. 2020a; Smith et al. 2020; Srof 2022).

2.6 Maternity policy context

The National Maternity Review, *Better Births* (NHS England, 2016), set out a renewed vision for maternity services across England. This was further reinforced by the Department of Health's, *Maternity Action Plan* (2016) and *Safer Maternity Care – Next Steps Towards the National Maternity Ambition* (Department of Health, 2017). To deliver this vision, NHS England initiated a comprehensive maternity and neonatal transformation programme. These reports highlighted persistent inequalities in perinatal outcomes among GEM women and those from the most deprived communities in the UK. To address these issues, the government launched the Maternity and Neonatal Safety Improvement Programme in 2021 (NHS England 2021b), with ambitious targets to reduce inequalities. This strategy is a key element in NHS England's *Health Inequalities Action Plan* (NHS England 2018) and the *Core20PLUS5* initiative (NHS England 2021a), which both aim to reduce health disparities at national and system level.

In 2019, The *NHS Long Term Plan* (2019) pledged to make MCoC the default model of maternity care in England by March 2023. This initiative was initially prioritised for women from some GEM backgrounds and those living in the most deprived areas, aiming to address the most significant health inequalities (NHS England 2019). However, the actual rate of

women receiving MCoC in the lead up to the pandemic varied significantly due to wide variation in implementation (Sandall et al. 2016b; McCourt et al. 2023; Gillibrand et al. 2024; Middlemiss et al. 2024; Sandall et al. 2024).

Following successive inquiries into failings by NHS maternity services (Kirkup 2022; Ockenden 2022), NHS Trusts were advised to review and, if necessary, suspend their MCoC provision (NHS England 2022). In September 2022, NHS England advised that maternity services were no longer required to meet specific targets for MCoC and recommended that providers should only continue to provide MCoC where safe staffing levels were maintained (ibid).

Notably, the NHS Trust where this doctoral research was conducted, continued to support their MCoC model. The three community-based teams had demonstrable evidence of sustainable impact across the local system. Moreover, the MCoC caseloading teams were already prioritising the care of women from GEM backgrounds and those living in the most deprived areas. As an indirect consequence of this strategic decision, the research presented in this thesis was still able to proceed, providing unique insights into how MCoC models continued to operate during the COVID-19 pandemic and their impact health inequalities.

Whilst the removal of targets was understandable given the impact of the pandemic on the NHS, the decision raised important questions about how the evidence base had been interpreted in different contexts (Rayment-Jones et al. 2022; McCourt et al. 2023; Rayment-Jones et al. 2023). Independent evaluations of the implementation of MCoC within England noted that insufficient attention to the core aspects of the intervention, such as institutional and organisational barriers, centrality of on call working arrangements, variable clinical supervision for MCoC midwives working with social complexity, midwives being regularly called into maternity units during escalation, and alignment with professional values of midwifery, all contributed to the wide variation in successful implementation (McCourt et al. 2023; Gillibrand et al. 2024; Middlemiss et al. 2024). Literature also highlights several factors contributing to the inconsistent success of MCoC across the NHS. These include insufficient attention to the political and structural contexts in which MCoC models are introduced, a lack of application of implementation science methodologies in both rollout and evaluation, and the absence of a strategic midwifery presence (McCourt et al. 2023; Gillibrand et al. 2024; Kuipers 2024; Middlemiss et al. 2024) .

The removal of targets during the COVID-19 pandemic also prompted concerns that MCoC models had become an easy target of neoliberal forces in order to centralise resources, cut costs, and drive attention away from years of austerity (Kirkham 2024). With the evidence on

the impact of MCoC being so strong, this also has broader implications for research, education, and policy aimed at address health inequalities (NHS England 2021a).

Published in 2021 by NHS England, the *CORE20PLUS5* is a national approach to inform action to reduce health inequalities at both national and system level. The target population, the 'Core20', includes the most deprived 20% of the population, identified using the IMD (NHS England 2021a). Prioritising the needs of the most deprived communities targets resources and interventions to those most in need. The 'PLUS' component includes population groups that experience inequities in health access, experience, and outcomes, such as people experiencing homelessness, drug and alcohol dependency, migrants, Gypsy, Roma and Traveller communities, sex workers, people in contact with the justice system, victims of modern slavery, and other socially excluded groups (NHS England 2021a).

The final part of the *CORE20PLUS5* initiative sets out five clinical areas of focus, including maternity. These areas are part of broader actions for Integrated Care Boards and Integrated Care Partnerships to drive system change and tackle health inequalities (NHS England 2021a). Delivery and governance is managed by national programme of work, such as the Maternity Transformation Programme (NHS England 2016b, 2016a), where national and regional teams coordinate local systems to achieve programme aims. The *CORE20PLUS5* framework highlights the significance of MCoC, while also emphasising that its sustainability within the NHS is contingent upon adequate staffing levels (NHS England 2021a).

The *Women's Health Strategy for England (2022)*, launched during the term of the Johnson Conservative Government, while ambitious in its scope, has so far fallen short in addressing women's health inequalities (Bagenal et al. 2022). Despite its commitment, the strategy has been criticised for lacking concrete measures to tackle the root causes of women's health disparities, such as ways to address the conditions for good health and improve access to quality healthcare for underserved communities (Bagenal et al. 2022; Womersley et al. 2022; Witt et al. 2024). The emphasis on expanding women's health hubs is praiseworthy, but the strategy has not sufficiently addressed the systemic issues that contribute to poor outcomes, particularly among vulnerable populations (ibid). Furthermore, pledged improvements in maternity care, including specialist services and neonatal capacity, are yet to be realised (Wickens and Jefferies 2022; Womersley et al. 2022), leaving significant gaps in support for pregnant women and new mothers (NHS England 2023e). Overall, while the strategy sets a positive direction, its implementation and focus on the SDoH require substantial development in order to achieve meaningful progress on population health.

In 2023 NHS England published the *Three-year delivery plan for maternity and neonatal services* (NHS England 2023e), which built on previous policy aimed at improving safety, personalisation, and equity in maternity and neonatal services. The plan emphasised that improving equity involves implementing MCoC, particularly for women from GEM communities and those living in the most deprived areas, but providers should only consider roll out of MCoC in line with principles around safe staffing published the year before (NHS England 2022). The plan also included specific targets, such as improving neonatal cot capacity by 2025 and confirming that all Integrated Care Systems (ICS) must publish equity and equality plans that address their communities' most pressing needs (NHS England 2023e).

Moreover, publication of the *Priorities and operational planning guidance 2024/25* (NHS England 2024b), highlighted the continued and collective focus on improving quality and safety in line with the *Core20PLUS5* (NHS England 2021a). The guidance underscored the requirement for system partners to reduce inequalities but made no further recommendations about the scaling up of MCoC due to persistent and chronic workforce pressures in maternity services.

Given this context, implementing a population health approach in maternity care policy necessitates a seismic shift - from the dominate medical and risk management model of pregnancy and birth to a more holistic perspective that grasps the impact of the SDoH on perinatal health and wellbeing. For instance, we can hypothesise that issues such as housing, heat, and food insecurity contribute to stillbirth rates and non-communicable diseases, particularly in areas of high deprivation. Aligning maternity care policy with a population health approach would mean integrating SDoH as core components of the delivery of maternity care alongside considerations of physical health.

Whilst healthcare alone cannot fully mitigate the state of health inequalities in England, MCoC models are in a unique position to challenge neoliberal ideologies by delivering care to those with greatest need in community settings, close to where women live, which creates greater access and engagement in health and opportunities for behaviour change (Naughton et al. 2024; Sandall et al. 2024; World Health Organization 2024c). This can be actualised through the principles of Proportionate Universalism (Marmot et al. 2010; Marmot et al. 2020a), which emphasise equitable resource distribution based on the level of need of each individual woman and family (NHS England and Improvement 2021b). By the very nature of being involved throughout the perinatal journey and embedding a large majority of care in community and primary care settings, midwives have an important part to play in laying the foundations of good

health for women and their babies in the first 1001 days (WHO Regional Office for Europe 2021; World Health Organization 2024c).

2.7 The Core Competency Framework

Improving professional training in maternity and neonatal care has been recommended in Parliamentary reports and public enquiries into maternity services in England. The *Core Competency Framework Version 2* (CCFv2) for midwives, published by NHS England in 2023, outlines essential training and competency standards across maternity and neonatal services (NHS England 2023a). The framework aims to standardise training, focusing on key public health priorities such as smoking in pregnancy, fetal growth restriction, fetal monitoring, management of emergencies, and measures to reduce unwarranted variation in care. By ensuring all midwives meet core requirements, the CCFv2 seeks to address significant areas of harm and enhance the quality of care provided to women and their babies (NHS England 2023a).

Although the CCFv2 is designed to drive improvements in maternity care, its implementation and impact - particularly on performance and the reduction of health disparities - have not yet been evaluated (Whybrow 2024). Although some basic measures are monitored (e.g. number of staff attending training), there is no built-in evaluation tool. As a result, there is no national-level oversight to monitor how the framework is being delivered or its impact on organisational, team, and individual skills and knowledge (Whybrow 2024). Some critiques of the CCFv2 exist, such as concerns that a 'one-size-fits-all' approach could overlook local variation in patient demographics, practices, and pathways, and that focusing on achieving minimum standards might not be enough to drive significant improvements in care quality and health outcomes (ibid).

While the framework has the potential to improve training and care standards, it is challenging to measure its direct impact on health inequalities without longitudinal studies. To address this gap in knowledge, 'The Core Study', funded by the National Institute for Health and Care Research (NIHR), will evaluate the CCFv2 during 2024-2026 (Whybrow 2024).

2.8 Public health in midwifery

The way in which midwives engage with the SDoH as a pillar of their professional practice is also not fully understood (Fernandez Turienzo et al. 2021). The scope of MCoC midwives' public health role varies greatly and expectations about the requisite competencies, skills, and knowledge midwives need to influence public health and strategic decision making in their local contexts is a matter of ongoing debate within the field of professional practice development (Stamps 2023).

In 2024 and in light of rapidly changing global contexts and increasing medical and social complexity, the Nursing and Midwifery Council (NMC) – the regulatory body for UK nurses, midwives, and nursing associates - updated the *Standards of proficiency for midwives* (Nursing and Midwifery Council 2024). Originally published in 2019, the updated standards included a renewed emphasis on contemporary issues in public health and the role of the midwife. The standards indicated that in order to tackle health inequalities the midwifery profession needed to be ready to respond to the changing needs of diverse communities, supported by agile health and care systems (ibid). Midwives were also noted to play a significant role in population health through quality and safe practice (Nursing and Midwifery Council 2024). The standards stipulate that midwives will, alongside multiple intersecting domains:

“make an important contribution to population health and understand social and health inequalities and how to mitigate them through good midwifery care” - (Nursing and Midwifery Council, 2024 p.5).

As previously evidenced in research by Fernandez-Turienzo et al. (2021), Griffiths (2013), and Rayment Jones et al. (2019), good quality, safe midwifery care goes beyond providing traditional, routine clinical care, to encompassing an active participation in addressing the wider determinants of health.

The *Framework for Quality Maternal and Newborn Care* (QMNC) published by the WHO in 2016, is crucial to our understanding of what constitutes quality and safe care (World Health Organization 2016). Based on evidence from the *Lancet Series on Midwifery* (Renfrew et al. 2014), the QMNC framework outlines essential components of midwifery care, including education, health promotion, assessment, screening, and care planning. Facilitated by safe, effective, timely, efficient, equitable, and people centred care (World Health Organization 2016), the QMNC emphasises the importance of supporting physiology, preventing complications, and providing timely, effective management when complications arise. By adhering to the QMNC framework, healthcare providers can improve perinatal health outcomes, reduce mortality rates, and ensure that care is respectful, continuous, and personalised (ibid). However, what this means more specifically for MCoC midwives working in deprived communities in England, a country with the fastest rising levels of child poverty in Europe in the 21st century, has not been fully delineated in the evidence.

The research discussed in this thesis addressed this gap in knowledge, by exploring what actions MCoC midwives take to address the SDoH affecting women living in deprived communities and women’s experiences of these. Moreover, this research identified underlying mechanisms that

contributed to improved outcomes, as well as those that had unintended or unexpected consequences for public health, to inform future research, policy, and practice.

2.9 The roots of Continuity of Care in healthcare

The concept of continuity of care, rooted in primary care, refers to care provided over a period of time by the same care provider(s) (Saultz and Albedaiwi 2004; Saultz and Lochner 2005). It encompasses informational, management, and relational continuity, aiming to enhance personalisation and integrated care (Freeman 2006; World Health Organization 2016). Haggerty (2003) defines continuity of care as involving informational continuity, which concerns the timely availability of information; management continuity involving communication of information across institutional and professional boundaries between professionals and patients; and relational continuity which constitutes an ongoing therapeutic relationship between a healthcare professional and patient (ibid).

Continuity of care between primary care professionals, such as General Practitioners (GPs) and their patients, is associated with better patient outcomes, including diagnostic accuracy (Starfield 2009), improved patient satisfaction (Paddison et al. 2015), reduced emergency department visits (Nyweide et al. 2013), fewer hospital admissions (Pourat et al. 2015; Barker I et al. 2017), better co-ordination of care (Khatri et al. 2023), reduced mortality (Dyer et al. 2022), and lower overall costs to health services (Khatri et al. 2023).

Continuity of care is also fundamental in the context of end-of-life services, as it ensures people receive consistent, personalised, and compassionate support during their most vulnerable moments. Research in this space has shown that continuity of care can lead to better symptom management, improved patient and family satisfaction, and reduced hospital admissions (Devery et al. 2022). It also facilitates better coordination among integrated teams, ensuring care is aligned with individual needs (ibid). Moreover, continuity of care can help mitigate the emotional and psychological stress experienced by patients and their families (Van Den et al. 2022).

In the context of maternity care, where continuity is also known to improve outcomes and care experiences (Rayment-Jones et al. 2023; Sandall et al. 2024), MCoC models vary in their implementation depending on national and contextual factors. To have the greatest impact on perinatal health inequalities, models must include the provision of maternity care by one or a small team of midwives, usually up to eight, across the entire perinatal journey, including the ante-, intra-, and postnatal periods (NHS England and Improvement 2021c; Sandall et al. 2024).

Some MCoC models provide care to a defined group of women by a team of midwives sharing a caseload, often referred to as 'team midwifery' (Leavy and Leggett 2022) or 'midwifery group practice' (Hewitt et al. 2023). In these models a woman will usually have a named, lead midwife, but will also likely receive care from a number of other midwives in a team who provide cover for time-off and to provide backup support for other midwives in a team.

Other models, often termed 'caseload midwifery', aim to offer greater relational continuity by ensuring women receive their ante-, intra-, and postnatal care from one midwife or a second practice partner (Homer 2019; McCourt 2006).

In some mixed-risk, community-based models, care is targeted in areas of high deprivation in partnership with the wider multidisciplinary team (Rayment-Jones 2021). In other risk-based models, midwives provide care to women with medical or obstetric risk factors as part of a wider specialist team (Fernandez Turienzo et al. 2023). Community-based, mixed-risk models that target care in the most deprived communities, have been shown to have the greatest impact on population health (Homer et al. 2017). This thesis focuses on care provided to women in specific areas of deprivation in an urban context in the south of England.

Relational continuity in the context of maternity, refers to a continuous process of ante-, intra-, and postnatal care and includes the coordinated oversight and seamless progression of personalised care, rather than fragmented care events (Dahlberg 2013; Haggerty 2003). The longitudinal nature of maternity care provides a unique opportunity for midwives to build an attuned relationship with women based on trust, reciprocity, and respect, as highlighted by Feeley's concept of 'skilled heartfelt practice' (Feeley 2023a, 2023b). An attuned relationship can also improve midwives' ability to identify subtle nuances in the context of women's lives and their behaviour, providing a safety net for perinatal wellbeing and improving outcomes (McInnes et al. 2020). Moreover, it has been argued that neither management nor informational continuity can ever compensate for the lack of a therapeutic relationship built over time (Guthrie et al. 2000; Berg et al. 2006; World Health Organization 2016).

Mechanisms shown to improve outcomes in maternity and primary care include care providers taking greater responsibility and autonomy, which has been found to increase women's confidence in their care provider (Abbott et al. 2016; Kuipers 2024). This can lead to a positive psychology, where women feel more open to disclose the issues affecting them, which in turn can lead to reduced stigma and discrimination, and improved engagement and referral to specialist services (Fernandez Turienzo et al. 2021; Rayment-Jones et al. 2022; Stoodley et al. 2023). Furthermore, it is hypothesised that lower intervention rates observed in MCoC models

may be linked to the increased agency experienced by women and midwives, with these effects being influenced by the context of the settings in which the model of care exists (Royal College of Midwives 2018; McCourt et al. 2023).

National evaluations of the implementation and sustainability of MCoC in the NHS have also found this model of care to lead to enhanced co-ordination and navigation of maternity care, greater advocacy, timely action of investigations, and greater adherence to interventions (Mccourt et al. 2023; Gillibrand et al. 2024). Moreover, MCoC can facilitate more opportunities for midwives to connect women to grassroots services and improves opportunities for health behaviour interventions compared to standard maternity care (Naughton et al. 2024; Talbot et al. 2024).

2.10 Midwifery Continuity of Care models – latest Cochrane evidence

In 2024, the latest Cochrane review on MCoC was published by Sandall et al. (2024). The review found that women receiving MCoC compared to other models of maternity care were less likely to experience caesarean sections and instrumental births. When compared to other models of care, MCoC models also increased the rate of spontaneous vaginal births and reduced episiotomy rates (ibid). Women receiving MCoC also reported higher satisfaction with their care. Return on investment was also noted in the antenatal and intrapartum periods compared to fragmented models of maternity care (ibid). However, in contrast to findings noted in the previous Cochrane review (Sandall et al. 2016a), the updated review found no significant differences in adverse outcomes as a result of women receiving MCoC, such as pregnancy loss at or after 24 weeks gestation, preterm birth, and neonatal death. The authors noted the certainty of some findings varied due to the possible risks of bias, inconsistencies in reporting, and imprecision of some estimates in studies synthesised in the review (Sandall et al. 2024).

The latest review also built on recommendations from the previous review, calling for more research to understand the impact of MCoC on women with social and medical risk factors in different contexts, and to explore the implementation and scaling up of MCoC models in low- and middle-income countries (ibid). Overall, the updated review supports consensus that MCoC models can lead to better outcomes for women and their babies but noted that further, quality evidence is required to better understand the underlying social mechanisms which lead to improved outcomes, those that have unintended consequences, and how midwives experience feel working in continuity models of care to better understand how to support sustainable implementation (Sandall et al. 2024).

2.11 What mechanisms are known to impact improved outcomes in women and babies at greatest risk of poorer outcomes?

The aim of MCoC is to reduce disparities in service provision, delivery, and health outcomes by tackling issues within health and care systems, such as systemic barriers to care, social injustices, and women's unmet psychosocial needs (Frank et al. 2022; Rayment-Jones et al. 2023; Stevenson et al. 2023). Despite the global body of evidence on MCoC, there is still a lack of qualitative research that has specifically explored the underlying social mechanisms through which MCoC models can achieve better outcomes for specific groups in different contexts (Sandall et al. 2024). Whilst the body of knowledge indicates MCoC models positively impact perinatal outcomes for underserved populations (Fernandez Turienzo et al. 2021; Rayment-Jones et al. 2021a; Rayment-Jones et al. 2021b; Rayment-Jones et al. 2022), many studies have been conducted outside of the UK context (Cibralic et al. 2023; Lawal et al. 2023; Dube et al. 2024; Hu et al. 2024).

For example, a Grounded Theory study conducted in New Zealand by Griffiths et al. (2013), examined the underlying mechanisms impacting the effectiveness of midwifery care provided to women living in areas of high deprivation. The core theoretical framework "*staying involved, because the need seems so huge*" (Griffiths et al. 2013, p.222), explained the significance of the attuned midwife-woman relationship and the level of commitment midwives working in a midwifery group practice model, dedicated to meet women's needs (ibid). Midwives provided what Griffiths coined as being "*total midwifery care*" (Griffiths et al. 2013 p.223), which extended beyond the provision of routine care, to include an emphasis on addressing the wider determinants of health. Midwives in the study identified that women living in areas of socioeconomic deprivation had additional requirements and felt that because of the complexities women faced, midwives who worked primarily with more affluent women were usually not keen to commit to becoming involved. This meant that women considered to be more difficult were often referred on to the midwives in this study for their midwifery care. Routine clinical care alone was unable to address the social complexities women faced. Midwives were unwavering in their support, often going above and beyond their duties and often without remuneration. Midwives provided advocacy, support, and navigation of the maternity care system. Sometimes midwives described using their own transport to help women attend appointments with wider system partners, as women struggled to attend appointments due to inadequate public transport. Some midwives also reported buying material goods for women and providing help in women's homes. Participants in this study believed their support enhanced women's lives, increased engagement, and impacted

outcomes, hence, *“staying involved because the need seemed so huge”* (Griffiths et al. 2013, p.223).

In 2019, Griffiths completed her PhD, expanding on the work described above (Griffiths 2019). In this study, Griffiths explored how women living in areas of high socioeconomic deprivation in New Zealand accessed and engaged with midwifery care. Using a Constructivist Grounded Theory methodology, Griffiths conducted 24 interviews with 11 women and 10 community Lead Maternity Carer midwives across three North Island cities. Findings revealed that accessing midwifery care was complex, shaped by inconsistent availability and location of midwives. Women often had to navigate competing priorities and unstable conditions, which risked them missing important aspects of care. The maternity system offered limited and shifting support, and midwives had to adapt their practices to keep women engaged. Effective relationships between women and midwives were key to maintaining engagement and ensuring continuity of care. Midwives played a crucial role in advocating for women, helping them negotiate a fragmented healthcare system. However, sustaining these relationships required considerable time, energy, and resources, which were not always available. When complications arose, women were caught between a system that segmented care episodes, and a midwifery model focused on continuity. Midwives had to negotiate solutions to support women within these constraints, highlighting systemic gaps and the importance of relational care.

Both studies by Griffiths et al. (2013) and Griffiths (2019) are among the few qualitative research studies to examine the specific strategies midwives use to address the SDoH, along with the outcomes of these actions. The research outlined in this thesis builds on Griffiths’ important body of work, by examining the collective experiences of midwives and women, but in a UK context. Moreover, the examination and evaluation of MCoC models designed to reduce health inequalities is vitally important as it remains a key public health priority in the UK.

In the UK, more recent programme of research conducted by Rayment Jones et al. (2021; 2021a, 2023) and Fernandez-Turienzo et al. (2019b; 2021) have developed our understanding of the social processes and mechanisms underpinning MCoC models implemented in the NHS. In the body of work by Rayment Jones (2021) and Rayment Jones et al. (2021a, 2023), researchers examined the effectiveness of two specialised models for women with social risk factors in areas of high deprivation in London. Using realist evaluation, an approach used to evaluate how complex interventions like MCoC models work, for whom, and in what

circumstances, researchers examined one community-based team and one hospital-based team. Findings revealed that a complex, interconnecting web of system resources and individual response mechanisms worked behind the scenes to influence the quality of the care women experienced and their birth outcomes. The quality of the midwife-woman relationship enabled midwives to guide women through an unfamiliar maternity care system. Midwives working in the community-based model were more attuned to women's psychosocial needs, which was facilitated by the option of flexibility and place of appointments. This included seeing women in their own homes to develop a better understanding of the context and conditions of women's lives. Midwives were able to act quickly on clinical findings and professional curiosities and had an in-depth knowledge of community assets (such as the VCSE sector and faith-based organisations). Interesting mechanisms were also identified in the care of women with social care involvement. Midwives revealed multiple strategies in communication and advocacy to help women regain trust in the system. Women responded with increased feelings of safety and trust in their maternity care, which in turn increased the likeliness of disclosure, improved help-seeking behaviours, and positive behaviour change. This in turn improved engagement with services, which created more opportunities for women to form supportive social networks. Recommendations from the programme of research included the need for future studies to examine the complexity of mechanisms underpinning community-based care, and how these might lead to improving equity in different contexts (Rayment-Jones 2021; Rayment-Jones et al. 2021a, 2023).

A pilot hybrid implementation-effectiveness randomised controlled trial conducted by Fernandez Turienzo et al. (2019a; 2020; 2023), compared the outcomes of a specialist, hospital-based, MCoC model for women at increased risk of preterm birth with women receiving standard maternity care, in a deprived area of London. Findings from the intervention group, developed specifically for the trial, showed no statistically significant difference in the primary outcomes of timing and appropriate interventions for preterm labour and birth in comparison to standard care. Conversely, implementation outcomes included high fidelity with MCoC, acceptability, and sustainability for maternity services. Qualitative interview data showed that women in the intervention group were satisfied with various aspects of their care, including the trusted relationship they developed with their midwife. Midwives reported that the model was worth implementing, despite initial challenges and concerns about burnout.

Although a pilot trial with limited power in which to draw generalisable conclusions, the lack of trend for most outcomes indicated that for women at increased risk of preterm birth, the

specialist model of care did not show promise of impact to justify a larger trial with these outcomes in this population. The study also highlighted the importance of implementation science in this context, to facilitate the identification and evaluation of factors likely to affect implementation of complex interventions. The authors recommend that further research should investigate whether hypothesised mechanisms—such as increased trust and engagement, improved care coordination, earlier referral, and continuity of midwifery care—can benefit disadvantaged communities, including women facing complex social factors, in various contexts and settings, where there is currently little evidence.

In 2021, evidence from both programme of research were integrated into maternity policy in England (NHS England and Improvement 2021b), therefore demonstrating the significance of research which asks different questions of complex interventions, such ‘how’ and ‘why’ improvements in outcomes are seen in different contexts and under which conditions. Thereby informing implementation of effective and sustainable models of maternity care through the integration of qualitative and quantitative evidence (Symon et al. 2019).

2.12 Utility of attachment theories in the context of Midwifery Continuity of Care

Western attachment theories, theorised by developmental psychoanalysts in the 20th century, such as John Bowlby and Mary Ainsworth (Ainsworth 1969; Ainsworth and Bell 1970; Bowlby 1975, 1982), are also interesting frames of reference in the context of this research, that could further explain how the midwife-woman relationship operates in MCoC models.

Childhood attachment theories describe the impact of the interpersonal bond between a child and its primary caregivers (most notably the mother-infant relationship), that serves to protect infants from harm (Bowlby 1982, 1988). Attachment styles are developed based upon the cumulative effects of successful or failed interactions with primary caregivers to meet an infant’s needs (ibid). An infant’s experience of their caregiver’s attunement to their needs - that is, the caregiver’s responsiveness and sensitivity to the infant’s emotional state - helps form internal representations of identity and relationships with self and others, known as the ‘Internal Working Model’ (IWM) (Piaget 1964; Young 1964; Bowlby 1982). The IWM consists of conscious and unconscious assumptions that influence how a person perceives and interacts with others in future relationships (Bowlby 1982) . Moreover, a key function of the IWM is the development of a person’s identity of themselves as worthy of love and protection and is inextricably linked with experiences in infancy. The formation of a secure attachment base and IWM, where a child feels safe and knows how it feels to trust their caregivers, is a critical aspect of human development, including the development of self-efficacy and self-esteem

(Pressley 2023). Furthermore, a secure attachment base and IWM is associated with positive outcomes across the lifecourse such as, increased educational success, adaptive socio-emotional function in adulthood, lower risk of morbidity, and increased life satisfaction (Bowlby 1988; van der Kolk 1998; Grafft et al. 2023).

Conversely, an insecure attachment, where a child does not feel safe and does not have their needs met, impacts on a child's sense of self as worthy of love and protection, and is associated with multiple co-morbidities in adulthood such as poor mental and physical health (Felitti et al. 1998). Difficulties with emotional regulation, complicated adult relationships, and increased levels of substance abuse, antisocial behaviour, and criminality are also associated with ACEs (Marmot et al. 2010; van der Kolk 2014; Wood et al. 2023). Poor attachment experiences in childhood have also been shown to adversely affect perinatal health and outcomes, demonstrating the cumulative and weathering impact of adversity across the lifecourse (Frederickson et al. 2024)

Ongoing interpersonal interactions are said to be the relational-living-out of the IWM, whereby the intentions and motives of others are interpreted implicitly and impact the way people form attachments in adulthood (Bruschweiler-Stern et al. 2007). The same principles can also be applied to how adults interact and respond in a therapeutic relationship (Pressley 2023), such as how a woman can be in relationship with their midwife. The principle of the IWM and attunement, alongside midwives' assumptions, values, and biases, may also provide an explanation of a casual mechanism that leads to improved outcomes in the context of MCoC.

2.13 Conclusion

This chapter explored the pressing issue of widening health inequalities and the state of these disparities in the UK - in an era of post-COVID-19, cost-of-living-crisis recovery. It has examined the state of perinatal health inequalities and the significant role of the SDoH, particularly the increase in trauma and VAWG, and the profound impact of gender-based violence on health and society.

This chapter has also discussed the detrimental effects of neoliberal policies on the NHS, emphasising how a SDoH approach could counteract neoliberal narratives about poverty and help reduce health inequalities, though it requires political commitment for widespread societal change.

Moreover, this chapter has explored the maternity policy context before, during, and after the COVID-19 pandemic, the roots of continuity and the evidence base for MCoC models, and the widening public health role, responsibilities, and education of midwives. While existing

research highlights the positive outcomes associated with MCoC, there is a lack of UK-based qualitative research that explore the specific actions taken by MCoC midwives which may contribute to improved perinatal outcomes, as well as the mechanisms that could lead to unintended consequences. This gap highlights the need for methodologies that develop theoretical perspectives to understand how and why MCoC is an effective intervention across different contexts, aiding in its implementation and evaluation.

Furthermore, this chapter has presented ideas about the utility of attachment theory, which could explain the midwife-woman relationship, contingent on systemic and contextual factors. However, there remains uncertainty about the lived experiences of perinatal women living in areas of high deprivation, necessitating a deeper understanding of the SDoH impacting their lives.

To address these gaps, the following chapter will present a scoping review of the pregnancy and postnatal experiences of women living in areas of high deprivation, in high-income countries, prior to the COVID-19 pandemic. The scoping review further illuminated the SDoH affecting women and their babies and identified gaps in the evidence which set the foundations for this doctoral research.

Chapter 3. A scoping review exploring the pregnancy, postnatal, and maternity care experiences of women living in areas of socioeconomic deprivation in high-income countries

3.1 Introduction

This chapter presents a scoping review that explored the interplay between the SDoH and perinatal health and wellbeing in high-income countries (Arksey and O'Malley 2005). The scoping review was completed in 2019, prior to the COVID-19 pandemic, in preparation for the empirical work and provides a snapshot of relevant issues between 2009-2019.

The decision to present the scoping review as a standalone piece of work and not to update evidence beyond 2019, was twofold. Firstly, the decision was methodological. Updating the literature beyond 2019 would have grossly influenced my engagement with the process of emergence to understand what was important to participants within their contexts and would have impacted the final theory; a central methodological principle of Grounded Theory (GT) research. Secondly, the decision was based on the impact of the COVID-19 pandemic and how this global health challenge impacted on women's experiences.

Although the following manuscript was prepared for submission to a peer-reviewed journal, it remains unpublished. This was a consequence of multiple compounding factors caused by the pandemic, which impacted my capacity. However, the review was crucial at the time to identify gaps in current understanding and provided a foundation on which to justify the need for the research discussed in this thesis. Subsequently, the scoping review presented in Sections 4.2-4.6, includes evidence published between 2009-2019.

Evidence published between 2020-2024 is then revisited in Chapter 10 to contextualise and critique the empirical findings in the context of the COVID-19 pandemic. Supplementary information about the publication is included in [Appendix 1](#). Implications for future research, policy, and practice are presented in Section 3.6.6, before Section 3.7 brings the chapter to a close and provides justification for this doctoral study.

3.2 Exploring the impact of socioeconomic deprivation on women's health during the perinatal period and their experiences of care

Despite the presence of resilient and comprehensive healthcare systems in high-income countries, the pregnancy and birth outcomes for women and babies from low-income backgrounds remain significantly worse compared to those from higher-income groups (United Nations Population Fund 2017; Knight et al. 2018; Women Political Leaders Global Forum 2018). A pervasive social gradient in perinatal health exists, whereby the lower a woman's

socioeconomic position, the more likely they are to experience poor health, adverse pregnancy and birth outcomes, and diminished opportunities throughout the lifecourse (Marmot et al. 2010; Adena and Myck 2014; Women's Budget Group 2018). Intergenerational poverty, where deprivation persists across generations of the same family, also perpetuates a cycle of disadvantage (Woodward et al. 2013; Metzler et al. 2017).

The environments in which individuals live, grow, work, and play have a direct impact on health and well-being (Dahlgren and Whitehead 1991). In high-income countries, which possess the political, economic, and taxation measures to eradicate poverty, widening disparities seen between the life-chances of different income groups are not the result of individual behaviours or biological factors, but are significantly influenced by political ideologies and policies which can either reduce or exacerbate health inequalities (Marmot et al. 2010; Collins et al. 2015; Humber 2017).

While epidemiological data is vital to shape health policies and target interventions at a population level (World Health Organization 2015; Lehtonen et al. 2017), this data cannot fully capture the human experience of poverty behind the reported statistics. The lived experiences of women living in areas of high deprivation have historically been underrepresented in research (Cheng 2014; van der Graaf et al. 2018), which impacts progress on the development of effective policies and interventions to tackle poverty.

Complex healthcare interventions, such as such MCoC models, are known to improve care experiences and birth outcomes, by providing more personalised care to smaller groups of women (NHS England 2016b; Sandall et al. 2016b; Homer et al. 2017). International research has demonstrated that MCoC models can reduce incidences of pre-term birth, fetal growth restriction, and birth-related interventions, while also increasing rates of spontaneous vaginal births and breastfeeding (Tracy et al. 2013; Rayment-Jones et al. 2015; Sandall et al. 2016a; Jepsen et al. 2017). Relational continuity helps foster trust in the midwife-woman relationship and facilitates a better understanding of the SDoH impacting women's lives, which in turn helps midwives connect women with specialist services in their communities (Balaam M and Thomson G 2017; Everitt et al. 2017; Origlia et al. 2017).

MCoC models are particularly beneficial for underserved communities experiencing intersectional discrimination, such as low-income families, adolescents, GEM women, displaced women, non-native speakers, and survivors of violence and abuse (de Groot et al. 2016; Balaam M and Thomson G 2017; Homer et al. 2017). In 2010, the National Institute for Health and Care Excellence (NICE) published clinical guidance titled *Pregnancy and Complex*

Social Factors: A Model for Service Provision (2010), which offered recommendations for improving maternity care for women facing social complexity in England. These included the development of coordinated and seamless care pathways - an approach aligned with the aims of MCoC models.

Listening to and responding to women's experiences is central to designing and delivering quality, targeted interventions aimed at reducing inequalities (Hunt 2001; Pope and Bloom 2016; Sigurðardóttir et al. 2019). To develop our understanding about the value of MCoC and the underlying mechanisms associated with reported positive outcomes, it is essential to understand what psychosocial issues women face and what they value from their maternity care.

Exploring women's daily activities, routines, thoughts, and feelings provided a snapshot into the challenges women faced during the perinatal period and revealed how women coped with making decisions about their lives.

3.3 Research questions

The following research questions guided the review process:

1. What are the pregnancy, postnatal, and maternity care experiences of women from low-income backgrounds living in high-income countries?
2. What are the SDoH impacting women's lives and experiences in these contexts?

3.4 Aims

The review aimed to explore:

- The nature and scope of existing research on the pregnancy, postnatal, and maternity care experiences of women from low-income backgrounds, living in high-income countries;
- Implications and directions for this doctoral research study.

3.5 Methods

This review was conducted in alignment with two frameworks, as neither independently fulfilled the aims of the scoping review. The frameworks which guided the review were the Preferred Reporting Items for Systematic Reviews and Meta-Analysis, extension for scoping reviews (PRISMA-ScR) (Tricco et al. 2018) and Arksey and O'Malley's framework for scoping reviews (2005).

Scoping reviews facilitate the exploration of broad research questions by mapping the knowledge base of a specific topic from all forms of evidence (Peterson et al. 2017). Although

not as comprehensive as a systematic review, a rigorous scoping review following a recognised framework, is considered to offer an advanced level of evidence synthesis, compared to a standard review of the literature (Peterson et al. 2017). An assessment of methodological quality is not within the remit of scoping reviews therefore limitations will exist, curtailing the transferability of evidence (Peterson et al. 2017). However, given the potential for methodological heterogeneity in the evidence, a scoping review was deemed the most appropriate means of collating and synthesising the available literature to reveal current narratives and highlight directions of this doctoral study.

3.5.1 Review protocol development and registration

A protocol was drafted using the PRISMA extension for scoping reviews framework (PRISMA-ScR) (Peterson et al. 2017). The final protocol was developed using the PRISMA extension for scoping reviews and then registered on the Open Science Framework website (Clayton et al. 2019).

3.5.2 Identifying concepts for the search strategy

There is limited guidance available for the development of search terms for scoping reviews (Cooke et al. 2012). However, initial concepts were defined using the 'SPIDER' search strategy tool (Sample, Phenomenon (I), Design, Evaluation, Research type), developed by Cooke et al. (2012). After a preliminary search was undertaken via an online bibliographic database (which yielded a vast amount of irrelevant studies), it was necessary to adapt the strategy to produce more specific and sensitive results. A revised concept map using the Population, Concept and Context (PCC) framework, advocated by the Joanna Briggs Institute (2015), was developed and applied to all subsequent searches ([Appendix 1](#)).

Additional concepts were added to the strategy as I became sensitised to the literature. The population, 'pregnant OR postnatal' women, and concept, 'lived experience' were easily defined, but the context, 'low-income OR poverty' was challenging due to the way in which socio-economic inequalities are described in the literature. Concepts required careful consideration and adjustment so that the search remained sensitive and specific to the review question.

3.5.3 Eligibility criteria

In order to be considered for screening, publications needed to meet the inclusion criteria detailed in Table 2.

Table 2. Scoping Review - Eligibility of papers

Concept	Inclusion criteria	Exclusion
1.Population	Perinatal women from low-income backgrounds in high-income countries. The perinatal period includes the ante/intra/postnatal period.	Women outside of the perinatal period.
2.Concept	Perinatal and maternity care experiences. Evidence which explores multiple and cumulative disadvantages caused by poverty. Women's accounts of the SDoH impacting their lives.	Studies on other people – women's partners, family, friends, healthcare professionals and so on.
3.Context	Evidence explores concepts of low-income/poverty on women's experiences. Definitions related to 'low-income' are multiple, varied and used interchangeably. Related search terms will be used. Research in high-income countries (The World Bank Group 2018)	Studies which explore concepts of low-income/poverty in women's lives outside of the perinatal period. Research conducted in low- and middle-income countries.
4.Language	Published in English language only	Published in languages other than English, due to lack of translation resources.
5.Other	All methodologies. Peer-reviewed and non-peer reviewed grey literature between 2009-2019.	Research prior to 2009, to ensure the evidence is contextually relevant. Expert opinion pieces, websites etc.

3.5.4 Information sources and search strategy

A systematic strategy was employed to identify relevant sources of information. The search strategy was drafted, performed, and then refined through discussion with an academic librarian. Keyword searches (title and abstract) were performed using the search strategy ([Appendix 1](#)) in Bournemouth University's (BU) own iteration of the EBSCO Discovery Service

tool. This enabled simultaneous and systematic searching of multiple bibliographic databases including: CINAHL, Cochrane Review, Education Research Complete, Internurse, MEDLINE, PsychINFO, Scopus, SocINDEX and Web of Science. Truncations and Boolean logic operators were applied to the keyword searches, as well as proximity indicators. Limiters were then applied at the end of searches, in line with the inclusion and exclusion criteria.

Subject heading searches were then performed in five bibliographical databases to yield additional sources of evidence: Medline via EBSCO, BNI, CINAHL via EBSCO, PsychINFO via EBSCO and SocINDEX via EBSCO. All databases were searched from January 2009 to August 2019. The last search was performed on the 31st August 2019. In each of the databases, subject headings were 'exploded', which revealed additional search terms, specific to the index logic of each database. Exploded terms were then combined with Boolean operators, which yielded additional sources. The final subject heading search performed in CINAHL via EBSCO can be found in [Appendix 1](#).

Database searches were also supplemented with keyword searches in Google Scholar, which identified some additional grey literature. Search alerts were created in EBSCO, which triggered weekly automated emails with new sources. All search results were exported from EBSCO into the referencing management system, Endnote™ X9. Duplicates were then removed in a timely manner for the next stage of the review.

3.5.5 Screening and selection of sources of evidence

The process of screening and selecting articles followed the process recommended by Tricco (2018) and Arksey and O'Malley (2005). First, titles and abstracts of sources were evaluated. Secondly, potential texts were obtained electronically through institutional subscriptions. Full texts were then saved to Endnote™ X9 and reviewed against the eligibility criteria. Irrelevant articles based on a review of the full text, were then discarded.

Bi-directional searching developed by Hinde (2015), was also conducted. This facilitated a loop-based process of screening reference lists for interesting and relevant articles, obtaining these articles, and repeating the process until no additional relevant sources were identified. Forward citation searches of key authors and papers were also performed in Scopus®.

3.5.6 Data charting

A data charting template was developed in Microsoft™ Excel with reference to the research questions, based on the Critical Appraisal Skills Programme (CASP) checklists for qualitative and mixed methods research (Critical Appraisal Skills Programme 2017b, 2017a). The final template was adapted after an initial review of three full-texts and updated in an iterative process. The template captured relevant information on methodological characteristics of each study, salient information to describe women's experiences, and themes arising from preliminary review of the articles. The charting template can be found in [Appendix 1](#), which details information collated from the studies.

3.5.7 Review and synthesis of results

Studies were reviewed in order of publication date. Studies were then grouped together depending upon the age of participants and the country of origin. Studies were read a number of times to develop theoretical sensitivity.

3.6 Findings

3.6.1 Study selection

A total of twelve studies are included in the final synthesis. [Appendix 1](#) presents the PRISMA diagram (Moher et al. 2009) of studies included in the review and those that were excluded.

3.6.2 Study characteristics and categories

Most studies were conducted in the United States of America (USA) (n=6), the UK (n=5), and Canada (n=1). Findings are presented in narrative form (Peters et al. 2020) and are organised under the following categories in relation to the research questions:

- women's pregnancy and maternity care experiences;
- women's experiences during the postnatal period.

3.6.3 Overview of findings

The review found that women's pregnancy experiences were impacted by multiple personal and structural influences, including their social milieu, their immediate physical environment, where they lived, and their social networks. These dimensions had both positive and negative consequences on their wellbeing and experiences. Moreover, women's lives were directly affected by the wider socio-cultural-political contexts of the countries they lived in. These structural mechanisms impacted opportunities, and the resources women could access, including opportunities for education, employment, childcare, housing, and social welfare.

Maternity care, which encompasses both health and social care and more widely, and support from community and faith-based organisations, revealed opportunities to make a positive impact on women's health and experiences. However, services and healthcare professionals were largely considered to be ill-equipped to address and advise women on issues like housing and income. Women expressed an interest in this being part of their maternity care and wished for healthcare professionals, namely a known midwife, to be involved in these determinants. The following section summarises the results of the studies in more detail, before going on to draw conclusions and making recommendations for future research.

3.6.4 Women's pregnancy and maternity care experiences

Six of the twelve studies by Psarros et al. (2018), Bragg (2018), Birtwell (2015), Bloom (2013), Raymond (2009), and Katz (2018), examined the impact of living on a low-income and the measures women took to meet their daily material needs. The majority of the studies were conducted in the UK (Raymond, 2009; Birtwell et al. 2015; Bragg et al. 2018; Psarros et al. 2015), and the remaining two studies were conducted in the USA (Bloom et al. 2013; Katz et al. 2018). Additionally, the evidence explored women's care experiences, which included interactions with maternity services, wider health and social care organisations, the Voluntary, Community, and Social Enterprise (VCSE) sector, and faith-based organisations. All of the studies were conducted in urban areas of economic deprivation, and most women described their lives being directly affected by their household incomes.

The studies revealed the experiences of women from diverse, low-income backgrounds. In addition, the study by Psarros et al. (2018) included women from Gypsy, Traveller, and Orthodox Jewish communities. This provided a valuable window of opportunity to better understand the experiences of women from seldom heard communities, such as these (Knight et al. 2018). Only two studies in the review had a sample of predominantly Caucasian women (Bloom et al., 2013; Birtwell et al., 2015).

Four of the six studies used qualitative methods (Raymond 2009; Birtwell et al. 2015; Feldman 2016; Psarros et al. 2018), however only one study followed a specific methodological framework. Using interpretative phenomenology (IPA), Birtwell et al. (2015) explored how women made sense of their self and their perinatal experiences. The other three studies adopted Sandelowski's (2000), Qualitative Descriptive Analysis (QDA) design (Raymond 2009; Feldman 2016; Psarros et al. 2018).

The other two studies used mixed methods (Bloom et al. 2013; Katz et al. 2018). Bloom et al. (2013), combined measures of stress exposure before and during pregnancy with a qualitative

exploration of women's experiences and their coping mechanisms. The study reported that women's (n=24) levels of stress were twice as high as the American average, half of the women had symptoms of clinical depression, and most women displayed symptoms of post-traumatic stress. Women in Bloom et al. (2013) faced housing and job insecurity, neighbourhood deprivation, food insecurity, and social isolation. Some women in the study developed maladaptive coping mechanisms as a result of the multiple disadvantages they faced, such as self-harming, dietary and sleep disorders, and substance misuse. Conversely, other women discussed using multiple, self-sustaining strategies to combat their levels of stress, such as help seeking and making meaningful connections with other women.

Similar findings were echoed in Katz et al. (2018). In their sample of 892 participants, most women reported a high-level of stress, anxiety, and antenatal depression. Women completed a questionnaire about their quality of life and unmet material needs such as, food and housing insecurity, lack of clothing, poor access to a mobile phone, and a lack of affordable public transport to attend their maternity appointments.

Similar recommendations were described in both studies. Investment in SDoH education for healthcare professionals was considered a priority to improve awareness of structural inequalities and to equip staff with the skills and knowledge required to actively engage in tackling the root causes of inequalities. Both studies also suggested co-locating maternity services with services such as housing associations, law-firms, and food banks in order to address women's needs as they are identified and to prevent the worsening of preventable inequalities (Bloom et al. 2013; Katz et al. 2018). Moreover, maternity services should identify new ways to deliver care, such as the provision of group antenatal care, so that women have opportunities to build social connections with each other (Hunter et al. 2018b; Wiggins et al. 2018).

For women in Psarros et al. (2018) and Feldman et al. (2018), maternity experiences were negatively impacted by the UK's immigration process. Some women reported being in legal disputes related to NHS maternity care charges, language barriers, and having access to little or no income. Experiences like these increased women's risk of exploitation, violence, racial discrimination, and social isolation. In addition, some women reported having poor diets, living in unsanitary conditions, and being moved without little warning as part of the UK's dispersal programme. Women also described finding it difficult to engage with mainstream maternity care because of financial barriers, racism, and misconceptions about immigration.

Women in both studies also described experiencing prejudicial care from some healthcare staff, especially if they did not speak English. In addition, women described holding different cultural values about pregnancy and maternity care to the culture in the UK, and frequently reported NHS care to be confusing. For some women from countries where midwifery was not a recognised or established profession, seeing a midwife rather than a doctor left them feeling as though they were receiving sub-standard care. This led them to believe antenatal care was not important, which increased the chance of disengagement from services. Conversely, for women from countries with poor healthcare infrastructure, women felt the quality of maternity care they received from the NHS was exceptional, which increased engagement (Psarros et al 2018; Feldman et al. 2018).

In Birtwell et al. (2015), researchers in Scotland explored the experiences of eight women enrolled in an antenatal parenting programme, designed to explore attachment, attunement, infant development. The study also provided a rich analysis of the meaning of becoming a mother and women's relationship with themselves. Participants regarded pregnancy as reparative and provided an opportunity for them to develop a highly valued self. Women reported feeling able to connect with what being a mother meant to them in addition to the issues they faced. The authors suggest that pregnancy can also be experienced as a 'normalising event' (ibid, pg. 232), providing women with an opportunity to develop more positive representations of the self, which may be helpful for women to move away from past experiences and may also be protective for future mother–infant relationships. The researchers conclude that pregnancy can therefore act as a critical period for intervention for women who have experienced multiple disadvantage (Birtwell et al. 2015).

3.6.4.1 Women's daily lives

Across the six studies, women reported difficulties meeting their physical and emotional needs. Participants described the impact of being in insecure and low-paid work and/or receiving low welfare benefits, feelings of social isolation, and the impact of food and housing insecurity. Evidence suggested that women in employment also experienced workplace discrimination. It was common for women across the studies to report having been refused time off to attend antenatal appointments, despite this being a legal entitlement (Berdy et al. 2017; Bragg et al. 2018). Some employers also refused to perform risk-assessments, which put women and their babies at higher risk of injury and forced some women to go on sick leave or take early maternity leave. In essence, some women were at the mercy of their employers. Women also had limited support from human-resource departments due to the nature of

their precarious employment, or union representation in which to challenge this form of gender-based, workplace discrimination. Across the studies, women did not feel healthcare professionals were in a position to support them to challenge their employers. Instead, some women reported having to seek advice through trade unions (if they could afford to be members) or the VCSE sector.

In UK studies by Bragg et al. (2018) and Bloom (2013), findings revealed that some women were subjected to emotional and financial control by male partners, who restricted their agency and autonomy. Women in receipt of welfare benefits also reported these were not routinely paid to their own bank accounts. Instead, benefits were often paid to individual 'households' accounts, which often meant male partners received this income (Psarros et al. 2018).

Women's experiences were further exacerbated by a lack of social housing stock and poor-quality housing in the private sector. In Psarros et al. (2018) and Bragg et al. (2018), women reported living in overcrowded, poor-quality housing, living in hostels, being homeless, and being subjected to dispersal programme. Health problems were common in pregnancies exacerbated by damp and mould. Women discussed the respiratory and skin conditions they faced along with the difficulties of sharing communal bathrooms in houses of multiple occupancy, which meant personal hygiene could be a problem. These issues affected women's health and urinary tract infections were reported. These cumulative issues created hazardous environments and caused preventable health inequalities for women and their babies.

Trying to maintain a healthy diet and lifestyle was also hard for women. Evidence demonstrated that women frequently used food banks or relied on family and friends to feed them. Women also regularly skipped meals or went without meals so their other children could eat. In addition, there was an over-abundance of fast-food chains in their neighbourhoods, which meant poor quality food was more accessible.

Government-backed food vouchers schemes to help low-income families purchase healthy food were discussed in studies by Bragg (2018), Psarros (2018), and Bloom (2013), however evidence demonstrated the complexity of the schemes. Women described difficulties accessing the schemes due to the application process requiring confirmation from a healthcare professional. In addition, women faced multiple barriers when trying to use the vouchers, including finding it difficult to find shops close to home that accepted the vouchers and limits on what they could buy with the vouchers.

Nevertheless, women in the studies had an awareness of other avenues of support to help them and also discussed how they coped with daily stressors. Some women reported watching TV, reading, and exercising at home. However, the most meaningful resource were the friendships they had with other women (Raymond 2009; Bloom et al. 2013; Birtwell et al. 2015). In Raymond's (2009) study, some participants also reported smoking to help relieve stress, despite to associated risks. Additionally, women in the study reported 'self-silencing' (pg. 44) as a form of coping, whereby they denied their own feelings and needs in order to please their partners, or as a strategy to maintain their relationships while keeping open the possibility that their relationships might improve (Raymond 2009). Theorist Dana Jack first described the process of self-silencing (Jack 1991). According to Jack's model, depressive experiences in women are intricately linked to fears of abandonment, which can result in poor self-esteem and a lack of agency and autonomy.

3.6.4.2 Experiences of maternity care

Across all of the included studies, a dichotomy existed in women's care experiences. Women received maternity care within a variety of different care models. Continuity of care, whereby women received care from a designated midwife or group of midwives, universal maternity care where women had a named midwife, but who would also see a number of different midwives, and hospital-based care, where women received care from obstetricians, midwives, and other specialists across the multidisciplinary team. For some, maternity care was a source of support and guidance, whereas for other women their experiences were tarnished by fragmented and poor continuity of care (Bragg et al. 2018), transient living situations, and mental ill-health (Psarros et al. 2018). Women also experienced barriers to accessing care, such as the proximity of health centres or hospitals where their antenatal care was often carried out (Birtwell et al. 2015).

Human factors, such as judgemental and unhelpful staff, poor relationships between women and midwives, and a lack of interpretation services were also apparent across the studies. Women revealed that they were unlikely to disclose issues when interactions with healthcare professionals focused on risk, concentrating on their physical health, rather than a holistic review of the context and conditions of their lives (Bragg et al. 2018). In Raymond's (2009) study, women referred to being treated like a 'walking womb' (pg. 45) and a 'baby carrier' (p. 45). In addition, one participant in Bloom et al. (2013) pointed out that healthcare professionals often had different agendas in their appointments:

"[they] didn't want to know these things...they are like technicians, concerned with the body when you are pregnant and nothing else" (p.7).

In contrast, other women across the studies reported how positive the midwife-woman relationship was. Being given the opportunity to build a trusting relationship with a known midwife or small number of midwives enabled some women to feel comfortable enough to disclose information about their lives (Raymond, 2009). Continuity of care with a midwife meant women were more likely to feel they were being listened to when they did share information. They also reported their concerns were more likely to be validated and their needs addressed to a higher degree (Bloom et al. 2013; Birtwell et al. 2015; Feldman 2016). Not having to repeat their stories to multiple people and not feeling judged were identified as being imperative for women to feel safe (Bragg et al. 2018).

Across all of the evidence, the VCSE sector often provided women with material and emotional support. Working in collaboration with the VCSE sector was considered to be one of the most effective ways for maternity services to help tackle the root causes of preventable health inequalities (Raymond 2009; Bragg et al. 2018; Psarros et al. 2018).

Recommendations across all six studies supported the exploration of new, innovative models of care, including group antenatal care. Commissioners and providers of maternity care should therefore collaborate with women and the VCSE sector to implement, sustainable, specialist models of care, with clear pathways for evaluation and improvement.

3.6.5 Women's experiences during the postnatal period

Six of the twelve studies in the review also explored the postnatal experiences of women (Landy et al. 2009; Mollborn and Jacobs 2012; Lee King 2014; Suplee et al. 2014; Anwar and Stanistreet 2015; Keefe et al. 2018). Compared to the studies focusing on women's pregnancy experiences, only one study was conducted in the UK (Anwar and Stanistreet, 2015). The other five studies were conducted in Canada (Kurtz Landy et al., 2009) and the USA (Keefe et al. 2018; Lee King 2014; Mollborn and Jacobs 2012; Suplee et al. 2014).

Two studies explored the lives of young women (Anwar and Stanistreet, 2014; Mollborn and Jacobs, 2012). In Lee King's (2014) study, interpretation services were used to explore cultural differences in postnatal experiences of English, Spanish, and Hmong speaking women living in the USA. Interpretation services were offered in Suplee et al's. (2014) study but were declined by the women in their sample. The remaining studies by Anwar and Stanistreet (2014), Mollborn and Jacobs (2012), Kurtz Landy et al. (2009), and Keefe et al. (2018) explored the experiences of women whose first language was English and who engaged with health services or religious centres in their local communities.

Four of the six studies used QDA (Landy et al. 2009; Mollborn and Jacobs 2012; Lee King 2014; Anwar and Stanistreet 2015), instead of claiming a particular methodological approach. Mixed-method studies by Suplee et al. (2014) and Keefe et al. (2018) triangulated interview data with demographic data (Suplee et al. 2014), and depression scores using the Edinburgh Depression Postnatal Scores (EDPS) (Keefe et al., 2018), with limited integration of these into their results or discussion. This lack of integration creates incongruence between the aim and design of the studies, which both aimed to illuminate women's experiences.

3.6.5.1 The experience of young mothers in the postnatal period

The postnatal period is a time of major transformation. For young women, this can be further complicated by additional complexities. Two of the six studies focused on women below the age of twenty (Mollborn and Jacobs 2012; Anwar and Stanistreet 2015). Both studies aimed to delineate the experience of young motherhood, to reveal how women negotiated their identities as mothers and coped with the additional strains of being a young mother.

Women were aware of the negative depiction of young motherhood within popular culture. For the women in Anwar and Stanistreet's (2014) study, there was acknowledgement of the judgement and scrutiny imposed upon them by British society. They described how the media contributed to the narrative of young mothers being deviant, especially when it came to the subject of welfare benefits. However, women in Anwar and Stanistreet's (2014) study reported that their reliance on the benefit system was only ever intended to be a temporary measure, as they hoped to return to education or employment when their children were older.

Young women found the postnatal period especially challenging due to such things as housing insecurity, receiving unwelcoming and unkind remarks from strangers, and insufficient financial support from the benefits they did receive. Women therefore relied on their immediate family members and services like Family Hubs, to help them meet their baby's material needs. Women often sacrificed their own needs to meet their baby's needs, as one woman in Anwar and Stanistreet's (2014) study described:

"I have found it really hard especially as I don't have much money, I am counting the pennies to buy nappies and clothes, and all the money I have goes on him" (pg. 271).

Although young women in the studies were subjected to public scrutiny, women discussed receiving good support from their communities. Participants did not report social isolation, although they recognised this was a possibility for other women in their position. For them, young motherhood was often the norm in their communities. This social norm positively contributed to their sense of self and their role within their communities (Mollborn and Jacobs

2012; Anwar and Stanistreet 2015). These findings challenge the dominant narrative that being a young mother is a negative experience and calls to question policy that has historically been aimed at reducing teenage pregnancy.

Participants in Mollborn and Jabobs (2012) reported different experiences within their communities. Women (n=52) from diverse ethnic backgrounds were recruited from a school for pregnant teenagers and a health centre providing public funded antenatal care. Participants reported experiencing disapproval from their families and judgement from wider society, which chastised young motherhood. Due to a lack of social welfare, participants also felt isolated and described being unable to afford clothes and nappies or nutritious food. Participants also revealed they had limited access to reliable childcare and found it difficult to travel to school and/or their place of work due to inadequate public transportation.

Across both studies, women reported considerable strength and resilience in the face of multiple disadvantage, utilising their schools, community organisations, health providers, and their social networks to help them meet their material and emotional needs. Women felt strongly that being young did not affect their ability to be mothers, but rather the experience helped shape their coping mechanisms.

3.6.5.2 The experiences of adult women in the postnatal period

The experiences of adult women above the age of twenty years were explored in studies by Kurtz Landy et al.(2009), Keefe et al.(2018), Suplee et al.(2014), and Lee King(2014). Rather than spending time recuperating from childbirth, establishing infant feeding, and adapting to new family life, women in these studies were more likely to report returning to work within weeks of giving birth. Women described the level of financial stress they were under since taking their maternity leave, which ultimately forced them to return to work prematurely. Some women in the studies reported doing 'cash-in-hand' work or accepting financial gifts from their families just to survive. Any additional income they made was kept 'off-the-record' as this would affect any maternity benefits they did receive.

Financial and emotional support received from male partners was inconsistent across the studies. For some participants this was a result of a lack of paternity leave, difficult relationships, or other cultural factors, which suggested fathers played an absent role in parenting. For some women this contributed to depression and social isolation, whereas for others it encouraged them to seek out help and resources within their local communities. Women also recounted having to travel to multiple local organisations in order to obtain basics

such as food and shelter for their families, however poor travel infrastructure often made this difficult.

Single mothers and women with limited social support networks, faced additional discrimination and isolation. Where possible they spoke to family and friends over the phone, online, or attended community organisations to form connections with other women.

Participants across the studies were acutely aware of the impact of stress and sleep deprivation on their health and wellbeing. Few women reported having enough time to engage in health promoting activities, but for the women who did, they took regular exercise, kept themselves busy at home, or found comfort in their spiritual and religious beliefs (Keefe et al. 2018; Lee King 2014). However, women in Suplee et al. (2014) study reported taking minimal amounts of exercise as they felt unsafe in their neighbourhoods. Some participants in Kurtz Landy et al. (2009) also discussed taking anti-depressants and smoking in order to cope.

Women also reported diverging opinions about their reproductive health following the birth of their babies. In the study by Lee King (2014), women expressed frustration about the timing of their pregnancies but were unable to access long-acting contraception due to multiple access barriers within their local health system. Similar findings were echoed in an earlier study, by Kurtz Landy et al. (2009). In order to obtain contraception women had to travel to health facilities that were not easily accessible, making it inconvenient. Access to contraception was further exacerbated for women from cultural and religious communities, which did not agree with using contraception (Kurtz Landy et al. 2009; Lee King 2014). Women were therefore more likely to have short pregnancy intervals and unplanned pregnancies, which impacted their health and wellbeing and exacerbated the inequalities they already faced.

3.6.5.3 Interaction with services during the postnatal period

All women in the six studies reported varying levels of service utilisation and information seeking during the postnatal period (Landy et al. 2009; Mollborn and Jacobs 2012; Lee King 2014; Suplee et al. 2014; Anwar and Stanistreet 2015; Keefe et al. 2018). Women received most of their information about infant and self-care from their peers and family members, rather than healthcare professionals (Lee King 2014; Anwar and Stanistreet 2015; Keefe et al. 2018). When women received information from healthcare professionals, it focused mainly on identifying signs of postnatal depression, and also on health promotion such as exercise, nutrition, and smoking cessation. Women reported healthcare professionals rarely enquired about the context of their lives and when they did, healthcare professionals seemed unaware of the breadth of community support available, and conversations were sometimes culturally

insensitive (Lee King 2014). Equally, women found it difficult to share personal information with professionals they did not know for fear of judgement (Suplee et al. 2014).

Women valued holistic support programme provided by the VCSE sector, compared to those provided by healthcare services. Women appreciated being able to address their material needs, whilst also being able to access advice about welfare, housing, finances, education, and employment (Anwar and Stanistreet 2015). Opportunities to develop parenting skills and develop support networks were also highly valued by women in all contexts. Barriers to the use of community-based organisations were similar to those expressed by women in the antenatal period. Low utilisation of services were linked to limited options for childcare, poor transportation links, and women receiving judgemental or discriminatory care (Lee King 2014; Anwar and Stanistreet 2015; Keefe et al. 2018).

3.6.6 Implications and directions for future research, policy, and practice

The body of evidence discussed in this review revealed that women had a high level of unmet needs, regardless of which country they lived in. These findings demonstrate the ubiquity of global socioeconomic inequalities and highlight some of the consequences on women's health and wellbeing and their experiences of pregnancy and early motherhood. Women's lives appeared to be complicated by multiple forms of disadvantage prior to their pregnancies. The additional pressure of pregnancy increased levels of stress, anxiety, and depression. Some women found attending antenatal appointments a challenge due to multiple competing factors beyond their control. Pregnancy is considered a critical window of opportunity for services to impact the context and conditions of women's lives by making services accessible and inclusive (Hodgins et al. 2016; Koblinsky et al. 2016; Weeks and Temmerman 2016), however evidence in this review suggested this was not the reality for many women across the studies.

This review also found a degree of heterogeneity in the way studies reported how socioeconomic deprivation impacted women's experiences. Some evidence provided rich descriptions of women's experiences, whereas other evidence neglected to provide detailed information about the reality of women's lives. In order for models of maternity care, especially models based on continuity of care for women and babies at increased risk of poor perinatal outcomes, it is essential that models are grounded in cultural sensitivity and what is important to women in different contexts. Future research would benefit from a renewed focus on the contemporary challenges affecting women, particularly the SDoH impacting women in the UK today. Exploring how women navigate these issues and the influence this has

on their engagement with, and experiences of maternity care could offer valuable insights to improve perinatal health inequalities.

3.6.7 Strengths and limitations

This review aimed to provide an overview of evidence published between 2008-2019 that explored the pregnancy, postnatal, and maternity care experiences of women living in socioeconomically deprived communities in high-income countries. The review focused on how the context of women's lives affected their health, wellbeing, and care experiences, and also has implications for maternity care research in the UK. It is imperative for specialised MCoC models based in areas of high deprivation to respond to women's needs at pace, which can only occur if our understanding is grounded in the experiences of women who live in areas of high deprivation themselves.

This review explored the evidence of twelve studies which met specific inclusion criteria from an international and UK perspective, revealing limits in our current knowledge of the realities women face during the perinatal period. However, the evidence base is growing, meaning that our understanding of contemporary issues is continually expanding.

All studies were conducted in urban, Western contexts, and so the experiences of women who live in rural contexts, and those living in the Global South were not included. All studies highlighted a strong association between conditions of deprivation and health inequalities and call to attention the social injustices experienced by women as they navigate pregnancy and motherhood whilst living on a low-income.

Despite the evidence largely exploring the perspectives of English-speaking women, most study participants were from GEM backgrounds. This a notable strength of the review, as the experiences of women from GEM backgrounds have historically been neglected, compromising how maternity care is developed and ultimately delivered within different healthcare systems. Moreover, this review is a call-to-action for policy makers, commissioners, and providers of maternity care to develop sustainable, equitable, and culturally sensitive models of care, in order to tackle avoidable differences in health outcomes.

There are some factors which could have led to the omission of relevant studies in this review. Searches were conducted between January 2018 and August 2019, therefore more recent studies have not been included. Studies that were not published in English and those which did not directly refer to 'low-income' or 'socioeconomic deprivation' were also excluded, which may have resulted in the exclusion of evidence which tacitly discussed these issues. Future reviews would benefit from broadening the scope of evidence to address this. In addition, the

review was conducted by one reviewer (PhD student), which increased the risk of confirmation bias. It is usually prudent to involve a team of at least two reviewers to maximize the triangulation of evidence (Arksey and O'Malley 2005; Peters et al. 2020). However, the reviewer took several steps to mitigate the potential for bias, including publication of the review protocol with the Open Science Framework, engaging with the methodological literature on scoping reviews, and peer review by an academic advisory team. These steps provided a framework to guide the reviewer.

3.6.8 Conclusion

The findings of this review offer valuable insights and generate discussion around the SDoH impacting women during the perinatal period. The findings corroborate and expand upon existing research, emphasising the need for a holistic approach to perinatal care. Exploring how screening for the SDoH is conducted internationally, it is evident that midwives play a crucial role in identifying and addressing the wider determinants of health. Cross-cultural variations in midwifery practice and healthcare systems were evident, and these differences can compound women's experiences, especially when they face access and engagement barriers. Many women may not feel safe to disclose the issues they face due to fear of judgement and distrust of professionals. Continuity of care by a known midwife, or a small, consistent team, is crucial for fostering rapport and trust - key foundations for understanding women's lives and delivering care that meets their individual needs.

In conclusion, this scoping review underscores the importance of a holistic, integrated approach to maternity care that goes beyond addressing women's physical health needs. It calls for healthcare providers and professionals to actively engage with the evidence on the SDoH, to challenge structural inequalities, and to work collaboratively across systems and organisations. The implications for practice are significant; highlighting the need for training and education about the SDoH, and the need for cohesive and accessible services that support and empower midwives to be active agents within the field of public health.

3.7 Justification for the proposed doctoral study

This scoping review and evidence presented in Chapter 3, has provided an overview of some of the social complexities perinatal women faced in the decade prior to the COVID-19 pandemic - the point at which this study was designed. Evidence strongly indicated that the SDoH impact perinatal health and women's maternity care experiences. Understanding the lived experiences of women and midwives in England, will provide sociocultural and political

nuances relevant to MCoC models operating in the NHS, and therefore sets the scene for the rationale of this study.

Research that centres women's experiences and examines how the SDoH are addressed within MCoC models is both timely and relevant. This focus aligns with current healthcare policy in England, where tackling health inequalities remains a key priority (NHS England 2021a; Department of Health and Social Care 2022; NHS England 2023e; Department of Health and Social Care and Department for Education 2025). The primary aim of this study was to explore the social complexities women encountered during the perinatal period and their lived experiences of these challenges. Additionally, the research investigated the perspectives of midwives working within an MCoC model in a city in the South of England, to understand whether—and in what ways—MCoC midwives contribute to tackling perinatal health inequalities. By examining these domains during the COVID-19 pandemic, the study provided evidence on the social challenges women and their families faced, the mechanisms through which MCoC models may improve outcomes, and the evolving public health role of midwives working in these models of care.

The research was informed by the following research questions:

1. What SDoH impact the lives of perinatal women living in areas of high deprivation, and how do they manage these?
2. What do MCoC midwives know about the SDoH impacting the lives of women and babies living in deprived areas?
3. How do MCoC midwives address the SDoH and tackle perinatal health inequalities?

Additional objectives and outcomes for the research are detailed in the published research protocol in [Chapter 5 - Section 5.4](#), and again in the NHS research protocol, in [Appendix 2](#). Chapter 4 will now present the methodological assumptions of the research, before exploring the development and conduct of the study in Chapter 5.

Chapter 4. Methodological assumptions of the research

4.1 Introduction

This chapter presents the methodological assumptions of the research. First, an exploration of the philosophical perspectives that underpinned the research and guided my development as a researcher will be presented, before moving onto a discussion about the principles of Grounded Theory research and its utility in view of the aims and objectives of this doctoral study ([Section 4.5-4.6](#)).

Initially, a preamble is provided about the activities I conducted during the design and development of the research - which culminated in the final empirical study, titled 'The Mi-CARE Study'. The research protocol, approved by the Health Research Authority (HRA) and Health and Care Research Wales (HCRW) is provided in [Appendix 2](#) and an abridged version is presented as an integrated, peer-reviewed publication in [Chapter 5 - Section 5.4](#) (Clayton et al. 2022).

4.2 Relativist ontology

This research is underpinned by my relativist ontological perspective about the nature of reality. Like Creswell (2003) asserted, it is essential to discuss ontology prior to explicating the epistemological perspectives that underpinned this research. As much as it informs us about the stance of the researchers' philosophical assumptions, it also assists others to make informed decisions about the utility of this research; thereby contributing to a fair evaluation of the knowledge generated (Creswell and Creswell 2018).

I believe that reality is subjectively interpreted and is contextually orientated (Benton and Craib 2001). Relativists ascribe a greater meaning to the influence of emotions and sociocultural and political frames of reference and presume individuals make decisions in complex ways (Benton and Craib 2001). A relativist ontology embraces the complexity and individuality of human experience and does not seek to provide a universal explanation but rather offers interpretations of the human experience under examination (Moon and Blackman 2014).

4.3 Constructivist epistemology

Epistemology is concerned with all aspects of validity, scope, and methods of acquiring knowledge; insofar as what constitutes knowledge, how knowledge can be produced or acquired, and how the extent of its applicability to the real world can be determined (Carter and Little 2007; Moon and Blackman 2014). Epistemologically, I orient myself with the notion that knowledge is contextually created. This world view is known as interpretivism/constructivism.

Constructivists reject the idea that truth is waiting to be discovered. Instead, truth or meaning are the result of our engagement with and reflection on our own realities and interactions with one another (Crotty 1998). Human life is essentially a life of meaning making, communication, and reflection on our experiences and actions (Metz 2022). Reality is then reconstructed through engagement with the research process. This epistemological position assumes that different individuals construct meaning about the same phenomenon in multiple ways; experiences of which are based upon language, culture, history, and social perspectives (Creswell and Creswell 2018). In the context of this research, knowledge was co-constructed through the interactions and relationships I established with participants and the analytical procedures I engaged in. For example, I am a woman, a midwife, and I am also yet to become a mother – these personal attributes, experiences, and my professional identity shaped how I engaged with participants, both as an insider/outsider, and with the research process itself. My preconceptions about the research topic were challenged and laid bare in the practice of reflexivity. I wrote multiple reflective memos about my preconceptions and my influence on the co-construction of knowledge. Continuously questioning my assumptions, I was able to challenge my influence on the research process and critically analyse my preconceptions from multiple perspectives.

4.4 Intersectional feminist theory

Throughout this research I was also influenced by intersectional feminist epistemology - which subverts knowledge created by traditional hegemonic forms of knowledge, including that of the positivist and feminist movements of the 1970's (Hill Collins and Bilge 2016). Intersectionality first emerged from the influential work of the Combahee River Collective in 1977 (Guy-Sheftall 1995), a group of Black feminists who analysed and articulated the simultaneous impact of sexism and racism on their lived experiences. By the time Kimberlé Crenshaw, a legal scholar, coined the term 'intersectionality' in 1989, the groundwork for this concept was already deeply embedded in the social and historical politics of Black communities in the USA (Crenshaw 1989). Crenshaw's work built on critical race theory and Black feminist thought, offering a framework that recognised lived experiences without reducing individuals to a binary identity (ibid). Intersectionality theorises that social identities are shaped by interconnected social processes and structures, influenced by both time and place (Crenshaw 1989). Historical violence and systematic discrimination has led to startling inequities experienced by marginalised communities, such as women from the global south, women from GEM backgrounds, and communities living in poverty (Burger et al. 2021; Adkins-Jackson et al. 2022; Hayvon 2024). Essentially, intersectionality illuminates how various systems of oppression and privilege interact to shape the unique experiences of individuals and their communities.

The principle of intersectionality is inherently tied to the pursuit of social justice due to its roots in Black feminism (Carastathis 2016). Although originally coined within legal discourse, the concept has found application across various fields, including social sciences, health, humanities, and business (Hill Collins and Bilge 2016). Within each discipline, intersectionality serves as a valuable framework to conceptualise and contextualise the effects of cumulative and systemic forms of inequality and discrimination on people's lived experiences. More recently, intersectionality has gained traction in health sciences, becoming a critical paradigm for understanding the complexities of health inequities (Ajayi et al. 2024; Hayvon 2024). This perspective is considered to lead to the production of knowledge, which can inform policy change and create more impactful knowledge that brings about more meaningful change and social justice (Eric-Udorie 2018; Baird 2021; Hoang and Wong 2022).

I understood intersectionality to be a critical constructivist paradigm that aligned with the principles of ConGT by drawing attention to how multiple systems of oppression, power, and privilege intersect to shape women's lived experiences (Hill Collins and Bilge 2016; Kassam et al. 2020; Hayvon 2024). Intersectionality was therefore an important conceptual lens for this research. The literature informed my interpretation of findings, particularly in recognising how intersecting factors such as gender, class, race, and disability shaped women's experiences (see [Chapter 7](#)) (Hoang and Wong 2022). It also guided my understanding of power dynamics within maternity services and among stakeholders, emphasising how these dynamics are embedded in historical, gendered, and cultural contexts relevant to perinatal health (see [Chapter 8](#)) (Bowleg 2012; Snell-Rood et al. 2021; Hayvon 2024). Furthermore, [Chapter 9](#) discusses the ways in which trauma intersects with gender, race, and class to shape perinatal health and wellbeing, and critically explores strategies for maternity services to mitigate widening inequalities in England

4.5 Grounded Theory

This doctoral study was informed by an approach of Grounded Theory (GT) that is founded on a constructivist epistemology. GT research examines process, structures, and meaning within human behaviour and interactions in an attempt to make sense of or interpret them from multiple perspectives (Denzin and Lincoln 2008). The benefit of GT is that it can be used where comparatively little is known about a subject, as the purpose is exploratory rather than explanatory (Lathlean 2010). GT is also useful when attempting to explore an experience or situation in depth, taking account of contextualised knowledge and intersectional complexity (Gerrish and Lathlean 2015).

Glaser wrote:

‘if there is virtually no work in the area or just the barest of straight descriptions, then grounded theory opens up the area with relevant concepts and hypotheses and has many directions and leads for future research’ (Glaser 1992b, p.32).

Glaser and Strauss pioneered GT in the 1960's (Glaser and Strauss 1967), by combining their expertise in qualitative and quantitative sociology to articulate a new system of inquiry and marking a move away from traditional hypothetico-deductive methods that dominated research at the time (Loonam 2023). Glaser and Strauss (1967), developed systematic inductive and abductive strategies which facilitated the development of theories that were grounded in participants data rather than a researchers' *a priori* knowledge assumptions. Moreover, they proposed specific components that defined a GT as including concurrent data collection and analysis, where the researcher collects and analyses data simultaneously (Glaser and Strauss 1967; Glaser 1978). GT research utilises deductive, inductive, and abductive reasoning in the generation of theory. Glaser described these forms of logic as conceptualisation, theoretical coding, and theoretical sampling (Glaser 1992b). Induction is always the first step of GT analysis and begins with reasoning from observed facts and assumptions in the data, to more abstract general ideas. This occurs when the researcher codes and analyses data from one case and then compares it with codes from another, identifying commonalities and the clustering of codes to define a concept (Glaser and Strauss 1967; Glaser 1998).

Coding raw data produces what Glaser termed, substantive codes. The word substantive refers to human experience that is perceived to exist in participants' reality through implicit meaning and explicit language (Glaser 1998). The researcher collects and examines the raw data and uses the logic of induction to identify substantive codes and then compares further cases and clusters them together to indicate concepts, which are a higher level of abstraction (ibid). Employing abduction, the researcher infers relationships among concepts to create interrelated hypotheses. Glaser proposed that deduction guides the researcher back to the field to discover more ideas and connections from data. According to Glaser:

“deductive work in grounded theory is used to derive...where to go next for which comparative group or subgroup, in order to sample for more data to generate the theory” (1978).

Thus, deduction points to the most appropriate avenue for further investigation and subsequently fills gaps in a theory.

Unlike other research methods, the foundational process of GT is conceptualization, which is grounded in empirical data and clarified through the process of constant comparison. Through constant comparison, concepts are clustered by similarity. Concepts emerge as the analyst goes back and forth in an iterative process of constantly comparing the empirical data and writing conceptual memos (Glaser and Strauss 1967; Glaser 1998). This method increases formal abstraction and corrects for poor data, as it brings each concept into closer grounding (ibid). In this way abstract concepts derived from empirical data form the building blocks of theory. Abduction is the type of explanatory reasoning that creates theory (ibid). Through inference, abduction connects concepts to arrive at the best explanation of a phenomenon. This process is ubiquitous in daily life and is fundamental to GT. Glaser used the phrase 'theoretical coding' when referring to abduction. Unlike other research methods that identify and describe themes, abduction (through theoretical coding) moves GT further, producing abstract and explanatory integrated hypotheses (Glaser 2005b). In GT, deduction is used to complete a theory. Unlike other methods that employ deduction to verify a preconceived theory or hypothesis, theories emerge directly from the data (ibid). Therefore, in GT, deduction is not predetermined before a study begins (Glaser 1998). Each type of logic described here is indispensable to GT methods, but especially to Glassarian GT. These processes allow the researcher to adjust their data collection around their emerging findings.

In the years since Glaser and Strauss' (1967) seminal study, iterations of GT research have developed. The catalyst for Glaser and Strauss' divergence was Strauss' collaboration with Juliet Corbin and the publication of their book on GT titled, *'Basics Of Qualitative Research'* (1998). This prompted Glaser to publish *'Emergence vs Forcing: Basics of Grounded Theory Analysis'* (1992b), in which he asserted that Strauss and Corbin misinterpret the method by encouraging users to force findings from the data, rather than allowing them to simply emerge. From Glaser's perspective, emergence is an essential element to ensure that theory is grounded in the data. Moreover, Glaser's stance is that by the application of GT principles – such as constant comparison and coding and analysing – categories and their properties will emerge. Glaser posits this as a fundamental difference between GT and other qualitative research methods (Glaser 1992b). Glaser further elaborated that Strauss and Corbin's approach, whilst describes a legitimate way of conducting qualitative research, cannot be considered GT (ibid).

This methodological division opened up opportunities for other epistemological orientations in GT, such as Constructivist GT (ConGT), espoused by Kathy Charmaz (2006; 2010; 2014a). ConGT informed the conduct of this study and is discussed in detail in [Section 4.6](#). However,

this can be problematic for novice researchers, who must arrive at their own conclusions about which GT approach is suitable, and which approach orients with their own philosophical perspectives. Despite their differences, GT approaches share the fundamental aim of developing theory to explain processes associated with a specific phenomenon (Birks and Mills 2015). In the context of this study, ConGT was chosen for its congruence with the aims and objectives of this research and guided my development as a novice researcher.

4.6 Constructivist Grounded Theory

Constructivist Grounded Theory (ConGT) is rooted in pragmatism, symbolic interactionism, and constructivism (Charmaz 2006, 2014a). ConGT is a suitable methodology for research which aims to critically analyse complex social phenomena and provides a methodological framework on which to generate rich, innovative, data-driven theory in areas which lack explanatory theory (Bryant 2019). ConGT aims to describe '*what is going on*' by examining the contextual factors and nuances of human behaviour and social interaction, as well as exploring how individuals and groups might construct meanings and experiences with the world (Rodner 2019). Similar to the Straussian model, but in contrast to the Glassarian method, ConGT invites researchers to engage with the extant literature on a substantive area under investigation prior to undertaking fieldwork (Charmaz 2014a, 2017a). Charmaz invites researchers to reflect on their own assumptions and influence on the construction of knowledge; a practice known as reflexivity (ibid). Charmaz also suggests, rather than data providing a direct window into truth and reality, reality is co-constructed and influenced by cultural and socio-political contexts (Charmaz 2006).

A central theme in ConGT is the treatment of data and its analytical outcomes. The underlying assumption is that the interaction between the researcher and the participant generates the data (Charmaz 2016a). To produce rich, contextually specific data, Charmaz advocates for the inclusion of descriptions of the situation, the interaction, and a general perception of the interview process.

Two original core principles of GT are to limit exposure to literature prior to beginning the research and not to integrate *a priori* conceptual or theoretical frameworks into the process (Glaser and Strauss 1967). To approach GT research in this way is considered by Glaser (1998), as a method to minimize bias in analytical processes. However, an *a priori* grounding in the literature has been recognised as being virtually inescapable, since all researchers hold their own values base and experiences and will have some level of exposure to literature (Charmaz 2014a; Nagel et al. 2017). According to Gibson and Hartman (2014), this helps researchers to loosely explore the structure, processes, and mechanisms in the situations being studied.

Charmaz (2006) also acknowledges that researchers cannot be impartial, but rather they are influenced and shaped by their own experiences with the world, experiences which will inherently influence their research endeavours, making research and theory a co-production. Charmaz (2006) wrote:

“[researchers] are not passive receptacles into which data are poured [so that] neither observer nor observed come to a scene untouched by the world. Researchers and research participants make assumptions about what is real, possess stocks of knowledge, occupy social statuses, and pursue purposes that influence their respective views and actions in the presence of each other” (p.15).

In this sense researchers are not value free, but rather shaped by their positionality and the participants’ throughout, making research and theory a co-production. Moreover, Nagel et al. (2015), contend that GT researchers engage in meaningful reflexivity and cannot account for subconscious influences associated with *a priori* exposure to literature and experience. In the context of this doctoral study, reviewing the extant literature on the SDoH and midwifery practice was fundamental to identify gaps in knowledge. Moreover, this process provided the rationale for the study, facilitated the development of a research protocol, and contributed to the study receiving ethical approvals from the HRA and HCRW.

The core design features of ConGT and how these were applied to this study are discussed in detail in [Sections 5.5-5.8](#). However, it is worth briefly noting that the design features of ConGT include the simultaneous use constant comparative methods for data collection and analysis, alongside memo-writing, theoretical sampling, and theoretical sensitivity (Charmaz 2006, 2014a). These steps are repeated until the emergent theory robustly conceptualises the research phenomenon (Glaser 1978, 1998, 2014). Data coding in ConGT research involves the pivotal link between collecting data in the field and developing an emergent theory to explain the data. This process involves two major phases of coding, known as initial and focused coding (Charmaz 2014a). Initial coding begins when the first piece of data has been collected. Initial coding can entail line-by-line labelling and is particularly well suited for data collected through interviews and observation (ibid).

I acknowledge that my own experiences and the existing literature shaped the design and conduct of this research, however I remained open to new analytical lines of inquiry throughout. To my astonishment, the process of emergence led this research on an unexpected analytical turn, which completely transformed lines of enquiry and in the process, transformed me as an individual. How I applied these methods will be discussed in Chapter 5 - Sections 5.6-5.7 and again at the end of the thesis in Chapter 10, where I reflect on the emergence of the main category.

4.6.1 Selecting data collection methods

Among the various data collection methods available, interviews are a favoured approach for many GT researchers, including Charmaz (2006; 2012; 2016b, 2017a). Notwithstanding, GT research also supports the use of both quantitative and qualitative data collection methods (Birks and Mills 2023).

Conducting interviews facilitates the exploration of experiences, perspectives, and meanings embedded in human experience (Charmaz 2014a; Charmaz and Thornberg 2020). Unlike surveys or secondary data, interviews capture the depth, nuance, and context of participants' stories. This rich qualitative data is essential for theory development. Moreover, interviews prioritise focus on participants' voices, enabling researchers to delve into meaning making, contradictions, and unexpected insights (Charmaz and Belgrave 2019). By actively engaging with participants in conversation, researchers gain access to tacit knowledge and subjective interpretations that other methods cannot (Hoare et al. 2012a).

ConGT involves an iterative cycle of data collection, coding, and theory refinement, and interviews can facilitate the constant comparative process by allowing for follow-up questions - probing deeper into emerging themes (Birks and Mills 2015). Researchers can also adapt their approach based on initial findings, ensuring a dynamic exploration of concepts.

Theoretical sampling, a core principle of the GT method, involves the purposeful selection of participants based on concepts that emerge during data analysis (Birks et al. 2019; Conlon et al. 2020). Interviews support this process by enabling researchers to strategically recruit subsequent participants who are most likely to offer deeper insights into developing codes and categories. This targeted approach supports theory development by refining categories and relationships between codes (Draucker et al. 2007). Furthermore, GT strives for theoretical saturation, where categories are sufficiently developed such that, no new concepts emerge through the ongoing, concurrent processes of data generation, collection, and analysis (Birks and Mills 2023). As a result, interviews offer unique advantages to GT research. They provide rich, context-specific data, prioritise participant perspectives, provide a powerful tool for uncovering the underlying structures and processes that shape human experience with the world, and align with the iterative nature of theory building - which this research sought to develop.

Semi-structured interviews were selected as the preferred method of data collection based on the aims of the research, and in view of insights and suggestions obtained from public engagement sessions during the design phase of the study ([see Section 5.2.1](#)). Semi-structured

interviews were selected over structured or unstructured interviews, as they were considered most suitable for facilitating constant comparative analysis and supporting the process of emergence (Glaser 1992b). Semi-structured interviews also supported the development of more focused questions during advanced stages of comparative analysis.

My original intention was to conduct in-person interviews and observations in the field, but due to COVID-19 pandemic restrictions, I had to amend various components of the research design. The study amendments required to complete this research are discussed in detail, in [Section 5.5.3](#).

4.6.2 Strengths and weaknesses of Constructivist Grounded Theory

A major strength of GT research is that it is a substantiated method of formulating theory and has the ability to move data from description to a conceptual and theoretical level (Birks and Mills 2023). Moreover, GT can be used when little is known about a subject or participant group (Charmaz 2017a). Another notable strength of GT is its self-correcting nature. If the essential elements of GT are consistently applied, any errors in the data collection and analysis process are expected to be eliminated over time (Birks and Mills 2023).

The most frequent problem encountered by GT researchers is their conscious and unconscious unwillingness to let go of assumptions. By holding on to preconceived ideas, the researcher will ultimately have difficulty trusting emergence from the data, which inhibits the achievement of a theoretical conclusion (Glaser 1992b). Moreover, GT can be daunting for the novice researcher, as researchers often lack confidence in knowing if they are using the method accurately until they are often immersed in the research process (Charmaz and Thornberg 2020). These situations arise from differing beliefs about the use of GT methods. In my experience, having a supervisory team experienced in qualitative research and GT was advantageous, as they provided support and guidance on navigating the complexities I faced with using the method. Fortunately, ConGT appeared to be a flexible method with a set of guidelines, rather than prescriptive rules, and so provided some flexibility in how I could choose to apply the methods' guidelines. In my experience, my concerns about using ConGT were overcome by having regular supervision with my supervisory team, who were skilled at keeping me focused and accountable.

4.6.3 Suitability of Constructivist Grounded Theory for this research

Transformative research approaches are essential for exploring issues of social justice, such as avoidable perinatal health inequalities, particularly those that account for the underlying socioeconomic and political mechanisms affecting the lives and wellbeing of women and their babies (Kennedy et al. 2018). Realist and critical research theorists argue that the types of questions traditionally posed by funders and researchers are ill-suited to examining complex systems of maternity care, such as MCoC models, and the structural inequalities that shape women's lives (Chalmers 1991; Kennedy et al. 2018; Russell 2021). Instead, they advocate for research that engages with social contexts to better understand the processes and structures that prevent or enable sustainable change - which are essential for impact and the translation of research into real-world, clinical practice (Chalmers 1991; Kennedy et al. 2018; Russell 2021). The principles of GT research not only support critical inquiry, but also resonate with midwifery philosophy, particularly in valuing the midwife-mother relationship, co-construction of knowledge, and mutual understanding (Prussing et al. 2024).

4.7 Conclusion

This doctoral study explored the lived experiences of women and midwives, with careful attention to the sociopolitical and economic contexts that shaped those experiences. The research questions were inherently feminist in nature, specifically, by examining the contexts and conditions of women's lives during the perinatal period. Additionally, I explored how the inequalities women faced and how the evidence of the SDoH was acted upon within a MCoC model, in an effort to tackle widening perinatal health inequalities in the UK.

Relativist ontology and constructivist epistemology provided valuable perspectives on reality and knowledge. Relativist ontology acknowledges that reality is context-dependent, shaped by cultural and historical factors. It emphasises multiple viewpoints and the relativity of truth. Meanwhile, constructivist epistemology focuses on how knowledge emerges through language and interpretation, highlighting individuals' active role in shaping understanding and meaning making. Both paradigms challenge traditional notions of objectivity, inviting critical engagement with evolving ideas about reality and knowledge.

Therefore, ConGT and midwifery woman-centred philosophy are complementary and provided a comprehensive and suitable methodological framework upon which to address the research aims and objectives.

Chapter 5 builds will now turn to explicating the research design, ethical considerations, and development of the research protocol, which received NHS ethical approval from the Health

Research Authority and Health and Care Research Wales. An adapted, peer-reviewed version of the research protocol, published in *European Journal of Midwifery*, is also included.

Chapter 5. Development and conduct of a Constructivist Grounded Theory study in the NHS

5.1 Introduction

In the previous chapter I presented the theoretical and methodological principles that underpinned this research. This chapter will now turn to explicating the research design features, ethical considerations, and development of the original research protocol for 'The Mi-CARE Study' ([Appendix 2](#)). An adapted version of the research protocol was also developed for publication ([Section 5.4](#)). The published manuscript was peer-reviewed and published by open-access in *The European Journal of Midwifery*. It also includes details of the study amendments required during the COVID-19 pandemic and also a reflection on data collection and analysis (Clayton et al. 2022). This is followed by a discussion of how I operationalised the conduct of the study in [Section 5.5](#), where I reflect on the considerations of access, informed consent, confidentiality, and anonymity. This section also includes another integrated manuscript, published in *The Practising Midwife Journal* (Clayton C 2022) in [Section 5.5.5](#). This publication reflected on my experiences of conducting and managing research in the NHS during the COVID-19 pandemic.

Finally, whilst data analysis procedures were defined in the study protocol, the ConGT methods of comparative analysis extended beyond those originally described and will therefore be discussed in full, in [Sections 5.6-5.8](#). The analytical procedures performed in NVivo (v12.5) will also be discussed to demonstrate the integrity and transparency of the procedures I employed in the generation of this ConGT.

5.2 Designing research suitable for being conducted in the NHS

This doctoral research was match-funded by BU (managing organisation and Sponsor for the research) and a local NHS Trust. The research was conducted in the NHS and recruited NHS patients and staff. Doctoral research in the NHS requires researchers to develop a research protocol and supplementary study materials and for these to be submitted online through the Integrated Research Application System (IRAS), along with the IRAS application (IRAS- 262369, REC- 20/SC/0183). The IRAS application was then sent to an NHS Research Ethics Committee (REC) for peer-review. The study materials had to satisfy strict research governance criteria required by an NHS REC. The following section looks at how the various study methods were developed during the design phase of the project, prior to receiving Sponsorship from BU, NHS REC approvals, and HRA and HCRW approvals.

5.2.1 Public involvement in the design of the research

Meaningfully curated, public involvement in research was an essential consideration in the design of this research. Effective and purposeful public involvement has been shown to improve all stages of the research lifecycle (Hughes and Duffy 2018). Evidence also demonstrates that involving members of the public in the development of topics, design, research materials, and dissemination, can impact how research is ultimately conducted - especially when seeking to engage with underserved communities, such as perinatal women from socially deprived communities (Tully et al. 2021). Moreover, it highlights the importance of ensuring research is meaningful and beneficial for the target population, while demonstrating a commitment to embedding ethical principles and promoting equality, diversity, and inclusivity. This approach helps prevent the perpetuation of existing inequalities within research knowledge and practice (Hughes and Duffy 2018; National Institute for Health Research and Health and Care Research Wales 2019).

The development of the study protocol was enriched through collaboration with service users from local Family Hubs³, as well as with staff, including staff working at Family Hubs and midwives working at the research site. Targeted public involvement refers to engaging individuals who have lived experience of the research phenomenon, who are invited to contribute feedback on specific aspects of the research. This is usually conducted to inform the research design and provide feedback on research proposals, recruitment, and proposed data collection methods (Hughes and Duffy 2018; Sundaramurthi et al. 2024).

During the design phase of the research, I volunteered at three events for families held at two Family Hubs. Alongside helping staff with the facilitation of sessions, I had discussions with service users about the proposed research. Support and access were approved by the senior management team at the Family Hubs, who I had developed a professional rapport with when I worked as a midwife at one of the Hubs. Figure 2 provides an example of a memo I wrote

³ Family Hubs in England are community-based centres designed to provide integrated services and support for families with children. They aim to offer a range of services, including health, education, and social care, in a single accessible location. The Family Hubs and Start for Life programme, led by the Department for Education and the Department of Health and Social Care, supports the establishment of Family Hubs to ensure families can access the support they need to thrive (Department of Health and Social Care and Department for Education 2025). In the city this study was based in, Family Hubs are organised into three localities: east, central, and west. Each locality has multiple hubs offering services such as, stay and play sessions, breastfeeding support, midwifery services, and wider health and social care advice.

after a 'Weigh and Play' session - where I talked to twelve mothers - and I reflected on how I could improve the study to meet the needs of the local population.

Public involvement in the design of the research

I attended my second 'Weigh and Play' session at the Family Hub today, which I arranged with the senior management team at the centre – they are so supportive of this research. I am also a midwife here, working with the MCoC team based at the centre.

Families attend these sessions to come to see the health visitor, and they can also use the self-weighing facilities to weigh their babies. Families can also stay with their children and play with the toys and books. The staff were keen to share with me the purpose of the sessions - which is to encourage social cohesion and connection as social isolation is a chronic issue in the local area.

I helped out with the session and spoke with twelve women - eight service users and four members of staff. I spoke about the proposed research and gained so much insight from the women on how I could improve the research:

Demographic information about the women

- Twelve women - including two young women below 18 years of age
- Two women had moved to the area from Poland and Slovakia, with another two women having recently moved into the area. The rest had lived in the local area for some time
- Two women reported having mental health conditions without me even asking
- Two women were first time mothers
- Six women were multiparous - one had six children; one had two children
- All women received maternity care from the research site. Some women received their care from the local MCoC team

The main outcomes from this session:

- Equality, diversity, inclusion: Provide childcare, refreshments, travel expenses, and remuneration to facilitate participation
- Flexible location for interviews: Offer home visits for interviews but provide alternatives with covered costs
- Effective communication: Utilise social media to advertise the study and provide updates, alongside other methods like midwives, posters, and text alerts
- Simplify information: Use conversational methods to explain study details, ensuring clarity and accessibility
- Diverse consent methods: Look into how I can make the informed consent process easier. Most women suggested online consent with the option of written or verbal consent. Most women said they did not want to sit and read long forms
- Preferred interview methods: Prioritise 1-2-1, in-person interviews, and offer alternatives such as asynchronous instant messaging on WhatsApp/Facebook™ etc.
- Update on results: disseminate study results through social media and email.

This public involvement session was conducted on the 05/08/2019

Figure 2. Public involvement in the design of the research

In response to the first round of public engagement sessions, I refined elements of the research design and developed study related materials for both participant groups - including refinement of the study title and iteration of the study's acronym. The acronym 'The Mi-CARE Study' and the logo for the study were developed by local graphic designer, based on an iteration of the original PhD title. I chose to develop an acronym and logo in response to public feedback about accessibility, branding, and recruitment. Furthermore, it suited my visual learning style and provided consistent branding for all research advertisements and communications. The graphics for 'The Mi-CARE Study' are located in [Appendix 2](#).

Study materials were once again subjected to peer-review by the local Maternity and Neonatal Voices Partnership⁴, midwifery staff, and three service users of a 'Confidence Building' parenting programme at a Family Hub. The programme was an online, trauma-informed course about the physiological effects of trauma, including how trauma can impact women's self-esteem and confidence as mothers. I helped the facilitator with the session and presented the materials to the group. Three women kindly agreed to provide feedback, which was invaluable to the final iteration of the study documents.

These engagement activities refined and enhanced all aspects of study design prior to submitting the final IRAS application. The final study protocol and supplementary materials are detailed in [Appendix 2](#), and include:

- Recruitment materials - including a social media campaign
- Participant information sheets
- Online consent process
- Interview schedules
- GP letters
- Data management plan

⁴ Maternity and Neonatal Voices Partnerships (MNVPs) are collaborative forums designed to ensure that the voices of women, birthing people, and families are central to the planning, development, and improvement of maternity and neonatal services in England. According to NHS England (2023b), MNVPs bring together service users, healthcare professionals (such as midwives and doctors), commissioners, and other stakeholders to co-produce services that are safe, personalised, and equitable. They are embedded within the leadership structures of provider trusts and feed into Local Maternity and Neonatal Systems (LMNS), which in turn inform Integrated Care Board decision-making.

5.2.2 Development of semi-structured interview schedules

Preliminary interview schedules were developed for both participant groups and were based on my engagement with the evidence, findings from the scoping review, and recommendations from public and staff engagement. These schedules were used in early interviews to frame conversations with participants, but were adapted, tested, and refined over the course of the study as a result of constant comparative analysis and theoretical sampling. [Appendix 2](#) details the initial interview schedules for each participant group and the development and refinement of questions.

5.2.3 Risk management plan

In order to fulfil my professional role and responsibilities as a midwife (Nursing and Midwifery Council 2018), I developed a risk management plan. The risk management plan covered specific safeguarding issues with controls, to demonstrate my integrity and commitment to safeguarding participants and the public. I also included mechanisms to safeguard my needs as an independent researcher during the conduct of the study. The risk management plan can be found in [Appendix 2](#).

5.2.4 Peer review

This doctoral project, part of the Clinical Academic Doctoral (CAD) programme at BU, was initially peer reviewed by the Wessex Integrated Clinical Academic Training Programme. The CAD programme forms part of the NIHR-recognised, Wessex Clinical Academic Pathway, which enabled the research to be adopted on to the NIHR Clinical Research Network (CRN) portfolio ([The Mi-CARE Study - CPMS ID 45534](#)). In theory, portfolio adoption would have provided access to valuable support services from research staff within participating NHS Trusts (National Institute for Health and Care Research 2025). However, due to the COVID-19 pandemic, resources were redirected to priority COVID-19 studies, and no study support was available throughout the lifecycle of this research. As a result, I independently coordinated and managed all aspects of study delivery, including administration, data collection, analysis, incident reporting and management, and monitoring.

The final study protocol was peer reviewed by:

- 1 PhD supervisory team
- 2 Sponsor
- 3 A consultant midwife from the participating research site
- 4 Research Ethics Committee

- 5 Head of Research, Lead Research Nurse, and Clinical Trial Assistant from the research site
- 6 Peer reviewers for *The European Journal of Midwifery*, prior to publication of the adapted research protocol

5.3 Ethical approval

The study received Sponsorship from BU and was granted ethical approval by South Central – Oxford C NHS REC (20/SC/0183; IRAS 262369), on the 29th May 2020 ([Appendix 2](#)). The study then received HRA and HCRW approvals on the 20th July 2020 ([Appendix 2](#)). However, due to the impact of the COVID-19 pandemic on all non-COVID research, local capacity and capability approvals were not granted until mid-October 2020 ([Appendix 2](#)). Recruitment and data collection began in November 2020.

The study protocol was also registered on the [ClinicalTrials.gov](https://clinicaltrials.gov) website - a global register of clinical trials. This was recommended by the HRA to aid transparency and reduce duplication (Health Research Authority 2022).

5.4 Publication in a peer-review journal - The Mi-CARE Study protocol

Clayton, C., Hemingway, A., Hughes, M., Rawnsdon, S. (2022). *The public health role of caseloading midwives in advancing health equity in perinatal women and babies living in socially deprived areas in England*. The Mi-CARE Study protocol. [The European Journal of Midwifery](#). Vol 6, p.1-10. CC BY 4.0.

An adapted version of the approved research protocol was developed for publication and is presented overleaf. This peer-reviewed article also included reflections on areas such as recruitment and data collection. The paper was published in *The European Journal of Midwifery* (Clayton et al. 2022).

The public health role of caseloading midwives in advancing health equity in childbearing women and babies living in socially deprived areas in England: The Mi-CARE Study protocol

Charlotte E. Clayton¹, Ann Hemingway¹, Mel Hughes², Stella Rawnsdon³

ABSTRACT

This article outlines the protocol for a qualitative Constructivist Grounded Theory study, examining the public health role of caseloading midwives working in a continuity model of care in areas of urban social deprivation. The study is currently being conducted in a city in the south of England during the COVID-19 pandemic. Focusing specifically on the Social Determinants of Health impacting women and babies in this context and from the perspectives of women themselves, the study is developing a theoretical framework examining the actions caseloading midwives take in response to these determinants and how these actions contribute to advancing equity and equality for women and babies at increased risk of adverse perinatal outcomes. Examining and integrating the experiences of women and midwives from a Constructivist Grounded Theory perspective, the study findings will inform current NHS maternity policy and contribute to our understanding about the social processes and mechanisms underpinning the known benefits of midwifery continuity of care models in different contexts.

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INTRODUCTION

Living in a deprived area is known to negatively impact on health outcomes and quality of life across the life course^{1,2}. The Social Determinants of Health (SDH), which describe the contexts and conditions people are born, grow, work, live, and age in, are recognized as having a significant impact on health differences seen between the richest and poorest^{3,4}. The SDH intersect with other determinants such as gender, race, disability, and culture, all of which affect differences in health and wellbeing⁵. There are also clear socioeconomic disparities seen in levels of avoidable disease in women, affecting cardiovascular and respiratory health⁶. Life expectancy has also declined for women living in the most deprived areas in England, for the first time in more than a hundred years⁵. Furthermore, the COVID-19 pandemic further amplified historical socioeconomic and racial inequalities throughout the United Kingdom (UK), especially for families from minority ethnic backgrounds and those living in the most deprived areas^{6,7}.

Pregnant women living in the most deprived areas in England are more likely to enter pregnancy with pre-existing co-morbidities such as raised BMI, poor nutrition, hypertension, mental health conditions, learning disabilities, diabetes, and undiagnosed medical disorders⁸. Poor physical health often intersects with other social risk factors as outlined in Table 1, which increase incidences of intervention, adverse perinatal outcomes, and poor experiences of maternity care⁹. In addition, women living in the most deprived areas are 50% more likely to experience a stillbirth or neonatal death⁹, and also have a threefold chance of dying in pregnancy compared to women living in the least deprived neighbourhoods⁹. Babies are also more likely to be born prematurely and with a low birth weight, causing significant health disparities including developmental delay, learning disabilities, lung disease, visual and hearing problems, as well as other health

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complications¹⁰. These factors contribute to increased costs to health and social care systems, economies, and society as a whole¹⁰.

Whilst healthcare can never fully compensate for the impact of socioeconomic health disparities, maternity care provided by the National Health Service (NHS) in the UK, is in a unique position to uncover, understand, and take action on maternal and infant health inequalities¹¹. Individual midwives, maternity services, and maternity systems by the very nature of being involved throughout the pre-pregnancy, pregnancy, intrapartum, and postnatal periods (hereafter referred to as the childbearing continuum), have diverse public health responsibilities which can influence health inequities¹². There is a strong international consensus that continuity of midwife-led care significantly contributes to increased perinatal survival whilst also mitigating against the unnecessary use of medical interventions and resources¹³. In 2015, a seminal Cochrane review by Sandall et al.¹⁴ found Midwifery Continuity of Carer (MCoC) models for women at 'low' and 'high' risk of complications (but not currently experiencing complications), were the only complex intervention associated with a reduction in preterm birth and improved perinatal survival. Women who received planning, organization, and delivery of care by a named midwife or small team of caseloading midwives throughout the childbearing continuum, were on average

24% less likely to have a preterm birth and 19% less likely to experience pregnancy loss before 24 weeks, compared to women receiving standard care, where they were likely to see different midwives at each appointment¹⁴. Women also reported consistently higher satisfaction with their care when receiving care from a known midwife. However, outcomes and experiences of care for 'mixed-risk women' in different contexts, such as women living in deprived areas, and 'why' and 'how' these might be so were not included. Recommendations from the Cochrane review¹⁴ and subsequent international consensus by Kennedy et al.¹⁵, called for research to prioritize asking different questions using established and transformative methodologies which capture the underlying social processes of human interaction that enhance or constrain the wellbeing of women and their families. Moreover, research needs to prioritize what matters most to women and take account of the mechanisms underpinning models of maternity care in different contexts that influence outcomes.

In the study described in this protocol, mechanisms refer to the social processes shaping how MCoC caseloading midwives interpret, respond, and act on the SDH impacting on women's lives. These influence decisions, which in turn can impact health equity in a specific context. Context refers to the environment in which the MCoC caseloading model functions, which influence mechanisms to affect outcomes and experiences. Lastly, outcomes refer to the consequences of the actions in this specific context.

The understanding of mechanisms impacting the effectiveness of MCoC models in different contexts was examined in a grounded theory study by Griffiths¹⁶, which explored caseloading midwives' experiences of caring for women living in areas of high deprivation in New Zealand. The core theoretical framework 'staying involved, because the need seems so huge', explained the significance of the trusting relationship developed between women and midwives and the intensity of involvement required to meet women's needs¹⁶. Midwives provided what Griffiths coined as being 'total midwifery care', which extended beyond the provision of routine clinical care to include a focus on addressing the SDH. Routine clinical care alone was unable to address the social complexities women faced, which included food poverty, housing insecurity, high rents, low-paid insecure work, and so forth. Midwives were unwavering in their support, often going above and beyond their duties. Midwives provided advocacy, support, and navigation for women in the maternity care system, sometimes using their own transport to help women attend appointments with partner organizations such as the police, social care, and housing. Some midwives even reported buying things for women and providing practical help around the house. Midwives believed their support enhanced women's lives, increased engagement, and impacted outcomes: hence staying involved because the need seemed so huge¹⁶. This is one of only a few studies to explore the specific actions midwives take to address the SDH as part of their public health role and explains mechanisms involved in this context which influenced outcomes and women's experiences. However, Griffiths¹⁶ did

Table 1. Summary of social risk factors experienced by some women living in deprived areas, associated with poor perinatal outcomes and experiences of care

Women at increased social risk of poor perinatal outcomes and who particularly benefit from midwifery-led continuity of care^{1-3, 6-9}

Black, Asian, and Minority ethnicity women
Female genital mutilation
HIV positive status
Housing insecurity and homelessness
Non-native language speakers
Not in education, training, or employment
Perinatal mental health conditions
Physical/emotional and/or learning disability
Poverty and deprivation
Refugees/asylum seekers
Sex workers
Single women
Social isolation
Substance and/or alcohol dependency
Travelling community
Victims of domestic abuse, trafficking, modern slavery, war, conflict etc.
Safeguarding concerns
Social service and/or criminal justice system involvement
Young women

not examine the experiences of women receiving care from midwives. The study outlined in this protocol will address this gap, examining the experiences of women and midwives to develop a theoretical framework in a UK maternity context.

Recent research conducted by Rayment-Jones et al.¹⁷⁻²¹ and Fernandez Turienzo et al.²² is at the forefront of developing our understanding of the social processes and mechanisms underpinning MCoC models in a UK context. The influential program of research by Rayment-Jones et al.¹⁷⁻²¹, examined the effectiveness of two specialized models of MCoC for women with social risk factors in areas of high deprivation in London. The research employed realist evaluation methodology, an approach used to evaluate how, for whom, and in what circumstances complex interventions like MCoC model work. The study assessed two place-based MCoC models, one community and one hospital-based team. The research identified a complex, interconnecting web of system resource and individual response mechanisms working 'behind the scenes'²⁰. The quality of the trusting relationships midwives built with women enabled them to guide women through an unfamiliar maternity care system. Midwives working in the community-based model were more attuned to women's wider needs, which was often facilitated by the flexibility and place of appointments. This included seeing women in their own home environments to develop a better understanding of the context and conditions of women's lives. Midwives were able to act quickly on their professional curiosities and abnormal findings and had increased knowledge of locally available support. Interesting mechanisms were also identified when discussing women who had social care involvement. Midwives revealed multiple strategies and resources they used to advocate and help women regain trust in the system. Women responded with increased feelings of safety and trust in their maternity care, improved help-seeking behaviors, behavior change, and disclosure of the social complexities they faced. This in turn improved engagement with services in the local community, which created more opportunities for women to form supportive social networks. Future research, which examines the complexity of mechanisms underpinning community-based care and how they might lead to improving equity in deprived communities is recommended²¹.

A randomized controlled trial (RCT) by Fernandez Turienzo et al.²², evaluated a specialist MCoC model for women at increased risk of preterm birth in London. Findings from the pilot RCT found those accessing hospital-based care in the intervention group were at increased risk of preterm birth compared to women in the standard care group accessing community-based MCoC, demonstrating the protective nature of community midwifery-led care. Recommendations for future research included examining the influence of perceptions of trust, safety, quality, anxiety, stress, coordination, referral, and engagement. Moreover, research should explore the determinants affecting women's lives and the subsequent actions midwives take to address these as part of their public health role.

Evidence from both studies has been integrated into latest maternity guidance in England^{11,12}, demonstrating

the significance of asking 'how' and 'why' improvements in outcomes are seen, thereby informing implementation of effective and sustainable models in NHS maternity services²³. The 'Delivering Midwifery Continuity of Care at full-scale'¹¹ and 'Equity and Equality'¹² strategies build on the commitments of the 'Better Births' report published in 2016²⁴, which aimed to deliver transformation across maternity services in England, to make care safer, more personalized and more equitable. These latest recommendations take account of concerns raised by stakeholders about the challenges of implementation during the COVID-19 pandemic and the need for sufficient resources and support to be successful in delivering MCoC as the default model of care offered to all women²¹. As outlined in the priorities and operational planning guidance for the NHS in 2022/2023, providers across England should put in place the building blocks for a phased implementation of MCoC teams to ensure that most (>51%) women from Black, Asian, and Mixed ethnicity backgrounds and women from the most deprived areas receive MCoC by March 2022. This is with a view to meeting the commitments set out in the NHS Long-Term Plan²⁵, which drew on evidence from Homer et al.²⁷, demonstrating improved outcomes for women from Black, Asian, and Mixed ethnicity backgrounds. The commitment is such that 75% of women from these ethnic backgrounds and those from the most deprived areas should receive MCoC by March 2024²⁶. This calls for care to be universal, delivered at pace, scale and intensity proportionate to the level of disadvantage, which is known as 'proportionate universalism'³. To do this it is essential for maternity services, and at the micro level, midwives, as part of their public health roles, to respond to each woman's unique health and social situation, with increasing support as inequalities increase so that care is personalized and equity and equality is improved¹². The specific actions and mechanisms leading to improved equity for women and babies living in deprived areas are not clearly defined. Moreover, there is a clear need to improve our understanding of the public health role of caseloaded midwives working in these contexts, which the study reported in this protocol aims to address.

The way in which MCoC midwives engage with and take action on the SDH and the demands on their role in different contexts are also not fully understood²⁸. The scope of midwives' public health role is broad, and the demands and expectations placed on their education, knowledge, and skills in health education, health promotion, and health protection are growing²⁹. In 2013 the Royal College of Midwives³⁰ (the professional trade union for midwives and maternity support workers in the UK), contributed to an analysis of the increasing demands on the public health roles of healthcare professionals in the UK. They identified the critical need for midwives to be adequately mandated, trained, and supported by education providers and NHS maternity services to address the SDH as part of their role. Practical steps midwives can take such as gathering data, taking action, providing information, and evaluation were presented, but how midwives achieve this in different contexts is left

open to interpretation. In 2019 the Nursing and Midwifery Council (NMC), (the professional regulator for nurses and midwives in the UK), published the latest standards of proficiency for midwives in light of the changing contexts in which midwives work²⁹. This included a significant focus on their public health contribution. Midwives make a vital contribution to the quality and safety of maternity care and midwives are expected to make an 'important contribution to population health, understand social and health inequalities, and how to mitigate them through good midwifery care'²⁹. 'Good midwifery care', as evidenced by Fernandez Turienzo et al.²⁸, Griffiths et al.¹⁶, and Rayment-Jones et al.¹⁸, goes beyond routine clinical care and highlights the diversification and expertise of midwives within the wider interdisciplinary and multi-agency team.

To raise awareness and refine the scope of MCoC caseloading midwives' contribution to public health, the study outlined in this protocol builds on these critical knowledge gaps. The research is currently taking place in a city in the south of England and is in the process of developing a theoretical framework using Constructivist Grounded Theory (ConGT) methods, to explain the mechanisms/actions midwives take in response to the SDH affecting the lives of women and their babies living in deprived areas. The study is focusing specifically on the SDH impacting women and babies in this context, from the perspectives of women themselves. In addition, the study is examining the public health role of midwives from the perspectives of women and midwives participating in the study. Integrating the perspectives of both women and midwives into the final theoretical framework, will provide information on what affects women most and what matters to them, whilst also understanding how midwives respond to social complexity. Moreover, this research is timely and will inform the implementation and sustainability of MCoC models in different contexts to advance equity. At the time of writing and to the best of our knowledge, this is the first study to develop a theoretical framework to explain this phenomenon by interviewing midwives and women during the COVID-19 pandemic.

METHODS

Constructivist Grounded Theory

This qualitative study is informed by the ConGT approach to grounded theory, developed by Charmaz^{31,32}, and is developing a contextually sensitive theoretical framework informed by the perspectives of women who have received or are currently receiving MCoC care and caseloading midwives themselves. ConGT is suitable for research which aims to develop theoretically generalizable explanations of social processes and mechanisms and provides a framework on which to construct rich, innovative, data-driven theory, grounded in the experiences of participants. Charmaz uses the term 'constructivist' to acknowledge subjectivity and the researcher's own influence and involvement in the construction of knowledge³². As an interdisciplinary team of academic health and social care professionals the reflexive nature of Charmaz's ConGT is fitting.

ConGT is also useful when little is known about an area of

interest and an overt focus on social processes is needed³². The aim of this study is to develop an understanding that is pragmatic whilst being grounded in the social processes identified by participants. The resultant theory will integrate the experiences of women and midwives. Subsequently there are two sets of research questions, outlined in Table 2 and the intended outcomes of the research are outlined in Figure 1.

Co-production

Each stage of the research design was co-produced and refined as a result of a series of engagement and advisory sessions with midwives, stakeholder organizations, user engagement groups, and women living in the study setting. Consulting the expertise of women with lived experience greatly improved the study's overall quality, applicability, internal consistency, and relevance for the local target population.

Research setting

This is a single center study based in a city in the south of England. The study site is an NHS maternity service provider with approximately 5900 births per annum, serving a large multi-cultural, socio-economically diverse childbearing population. Alongside standard maternity care, where women see a number of community and hospital-based midwives throughout the childbearing continuum, the study site has three, well-established mixed-risk, MCoC caseloading teams based in the most deprived areas, which form the focus of this study. At the time of writing, teams provide care based on the presence of known social risk factors as they do not have capacity to provide care to all women living in the deprived areas until more teams are rolled out across the service. These criteria include women from minority ethnic backgrounds. The provider is also the regional tertiary referral center for maternal and fetal medicine.

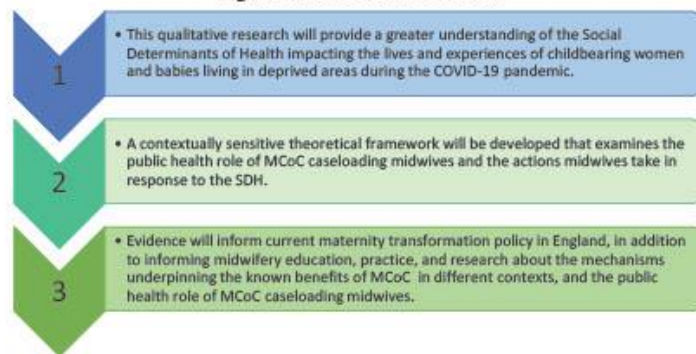
The study has been designed to comply and adapt at pace with local and national COVID-19 restrictions. Data collection methods and access to the field were adapted as appropriate.

Eligibility criteria

Tables 3 and 4 detail inclusion and exclusion criteria for each participant group. Individual eligibility is checked by the research team before proceeding to the consent process.

Table 2. Research questions

Research questions for childbearing women
What social issues impact the daily lives of women and babies living in deprived areas, and how do they manage and overcome them?
What do women perceive caseloading midwives' public health role to be, and how do they experience the care and support they receive?
Research questions for MCoC caseloading midwives
What do midwives know about the Social Determinants of Health impacting the lives of women and babies living in deprived areas?
How do midwives engage with and take action on the Social Determinants of Health as part of their public health role to advance health equity?

Figure 1. Research outcomes

Recruitment of childbearing women and data collection

Recruitment and data collection with midwives and childbearing women is concurrent. Data collection involves conducting semi-structured interviews with both participant groups. Literature available online, including research, reports, policies, and guidance is also being analyzed to assist with theory development.

In order to reach a wide audience, the study has been publicized in partnership with key stakeholders across corporate social media pages. A Facebook™ page has been developed, which is being used to advertise the study and provide a space to post relevant documents, such as

the Participant Information Sheet (PIS) and posters. The Facebook™ page has been used as a form of communication between the research team and potential participants. Women who are interested in taking part contact the research team via private messages on Facebook, via email, or by telephone. The research team then contact potential participants to discuss the study and to confirm eligibility.

Midwives and key stakeholders have been integral to the success of recruitment. Women have been provided with study information packs and those interested in taking part have either contacted the research team or have provided their contact details to staff and the research team have made contact. The lead researcher, CC, has also attended parenting groups facilitated by stakeholders on Zoom™ to inform people about the study.

Interviews are being conducted remotely by CC. The PIS is explicit about CC being a midwife and that she will conduct the research interviews. Interviews are being conducted using video-conferencing software provided by Microsoft Teams™ or Zoom™, via email, WhatsApp™, Facebook Messenger™, or by telephone. Interviews by telephone or

Table 3. Inclusion and exclusion criteria for participants in the 'childbearing women group'

Inclusion criteria
Women who are currently receiving maternity care from a MCoC caseloading team in the study setting
OR have previously received care from a caseloading team within the last five years
AND are aged 16 years or older
AND can speak English
AND can independently provide their informed consent.
Exclusion criteria
Women who have not received care from one of the MCoC caseloading teams
OR gave birth more than five years ago
OR are below the age of 16 years
OR are known by the lead researcher
OR cannot speak English (this is due to a lack of resources to fund translation services)
OR had their maternity care with a different provider
OR lack capacity to provide their informed consent (i.e. women in labor or women with significant learning disabilities requiring a formal mental capacity assessment)

Table 4. Inclusion and exclusion criteria for participants in the 'midwives' group'

Inclusion criteria
Midwives who work in the MCoC caseloading teams in the study setting
OR have previously worked in the local caseloading teams
OR are in senior roles providing wider support to the caseloading teams, including safeguarding, public health, project management, and leadership
Exclusion criteria
Midwives who work in the standard model of maternity care
OR have worked in caseloading teams at different maternity providers
OR are Maternity Support Workers (these practitioners having different professional roles and responsibilities)
OR decline to provide their informed consent

WhatsApp™, have been conducted using a study specific mobile phone. Interviews via all other platforms are being conducted on a study-specific computer provided by Bournemouth University (the study sponsor).

Adopting a flexible approach to data collection was influenced by the public. Women highlighted the importance of being able to choose which platform they completed their research interview on, and whether the interview was conducted via telephone or on a personal computer.

Interviews follow a semi-structured interview guide exploring the context of women's lives. In addition, questions explore women's perception of the midwives' public health role and their experience of care. Through ConGT methods of concurrent data collection, analysis, constant comparisons, and theoretical sampling, new questions are developed and posed during interviews and at subsequent interviews with new participants. Before and after each interview the lead researcher records thoughts and insights in a reflective journal to inform theory development.

Recruitment of midwives and data collection

The study has been advertised using posters throughout the maternity department and discussed at relevant departmental meetings. Recruitment emails have also been sent. Midwives either contact the lead researcher or provide their details and are contacted by the research team.

Interviews are being conducted remotely in a format of the participants' choice, as described above. Interviews follow a semi-structured interview guide exploring midwives understanding of the SDH and their public health role. Prompts and new questions are developed and posed during interviews and at subsequent interviews.

Figure 2 provides a detailed timeline of the recruitment period for each participant group, data analysis, synthesis, and dissemination activities once the final report is complete.

Reflexivity of the study team

Personal and professional identities and philosophies have undoubtedly influenced preconceptions and impact the dynamics of the interview space. They also influence the way in which questions are posed, the information participants feel comfortable to share, data analysis, and the co-creation of knowledge. ConGT emphasizes participants' implicit meanings and researcher's constructions of reality and accounts for the influence of the social contexts in which they are constructed^{31,32}. Moreover, ConGT acknowledges the influence of the researcher and encourages reflexivity. Reflexive memos have been kept to ensure all preconceptions, actions, and interpretations are critically analyzed and peer-reviewed by the supervisory team. This is consistent with the principles of ConGT and upholds transparency, authenticity, and rigor³².

Consent process and confidentiality

Consent is confirmed and documented electronically. Participants complete an online consent form prior to any data collection. They are sent a link to the consent form

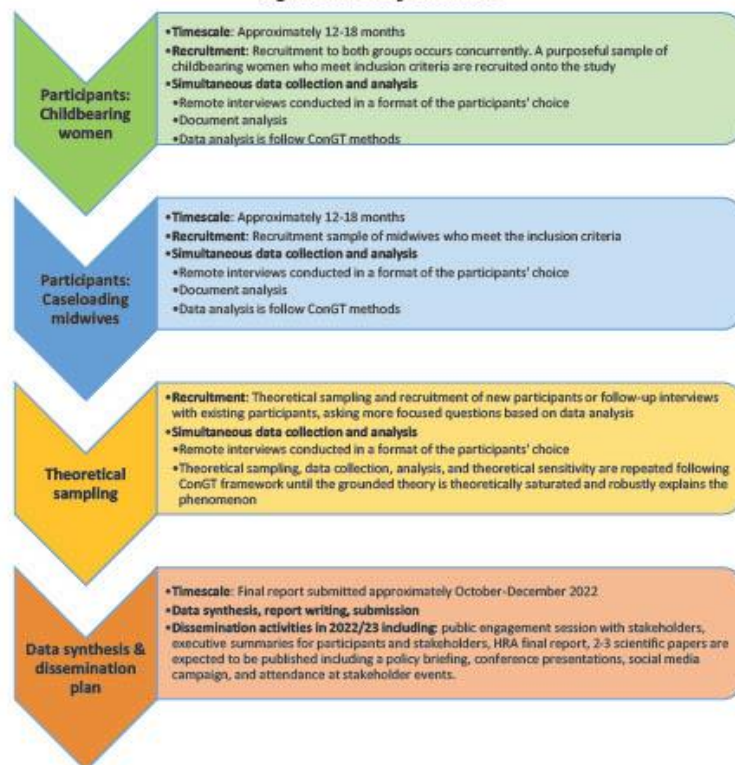
after the research team has confirmed eligibility. The consent form involves a set of simple, self-assessment questions which confirm participants' understanding. Each statement must be answered in order to progress to the next. Participants select either 'yes' or 'no', to indicate their agreement, if they select 'no' to any mandatory statement they will be redirected to the end of the form, which thanks them for their time and provides instructions about exiting the page, thereby declining their informed consent. The end of the form also provides hyperlinks to the PIS and the contact details of the research team. An electronic signature is collected at the end of the form, confirming whether the participant agrees to provide their informed consent or not. An option of 'yes, I do provide consent' or 'no, I do not wish to provide consent' confirms whether they agree to participate or not. Both the HRA and the Medicines and Healthcare Products Regulatory Agency³³, promote the use of e-consent procedures in studies with minimal risk of harm. The consent form supports the following accessibility functions: text-to-speech and adjustable font size, which can be selected by participants to aid understanding and completion of the form. Consent is verbally re-confirmed with each participant prior to any data collection.

All study procedures are compliant with the Data Protection Act³⁴ and the European General Data Protection Regulations (GDPR)³⁵. Each participant is allocated a unique study identifier and a pseudonym, which will be used to protect confidentiality in future publications. Job titles held by the midwives will not appear in final reports to protect confidentiality. Participants' personal identifiable information will be held securely and separately from other study documentation by the study sponsor. Only the research team have access to the complete data set. There are also specific circumstances when the research team are required to share information with other named professionals. For instance, if participants are at risk of harming themselves or others, or if they disclose concerns about the practice of a healthcare professional. The actions required to protect participants' wellbeing are explained in the PIS, the consent form, and re-confirmed at the beginning of each interview. The research team acknowledge this may impact what participants feel comfortable to share and the impact this may have on the development of theory.

Sampling technique and sample size

In the early phases of data collection, a purposeful sampling strategy was employed. Participants were recruited because they were representative of the target population groups. Opportunistic and snowball strategies also identified additional participants³². After an initial period of data analysis, the sampling strategy took the form of theoretical sampling, which is a method unique to grounded theory research³². Theoretical sampling focuses on the generation or collection of data that will theoretically saturate the emergent, core category or categories, and the related themes³². This involves a process of data collection for theory development, whereby the researcher jointly collects, codes, and analyses data, and then decides

Figure 2. Study timeline



what to collect next, how, and what questions to ask future participants.

Sampling will cease at the point we reach theoretical saturation or data adequacy, that is, when categories are robust, rich, and show variation. The resulting theory should be rich, logical, and without gaps in explanation. Practical restrictions impacting sampling and recruitment such as time and financial restrictions may also influence the duration of sampling. However, based on previous reports of GT studies³⁶, we anticipate completing between 20–40 interviews to achieve saturation.

Ethical considerations

This study was granted regulatory and ethical approval on 29 May 2020 by South Central – Oxford C Research Ethics Committee (Ref: 20/SC/0183; IRAS 262369) and received HRA approval on 20 July 2020. There were no substantial changes to the study design reported in this protocol after commencement of the study. The study has also received Sponsorship from Bournemouth University and was prospectively registered on the Clinicaltrials.gov repository on 21 August 2020 (NCT04524286). Data collection was

significantly delayed due to the impact of the COVID-19 pandemic on non-COVID related research activity across the NHS. The study commenced recruitment in November 2020 during the second national lockdown in England.

Participants can withdraw their consent until the point at which data is anonymized, without reason, and their normal care will not be affected. Data will be kept securely on a Sponsor approved device for five years following the end of the study. The PIS is explicit about the use and storage of participants' data in line with GDPR.

Participants are remunerated for their time and contribution to the research by way of a £15 voucher, which is sent electronically or by post after participants complete their interview. This was an important design element, as it is crucial to recognize the value and significance of women's time and contribution to this study. These involvement payments are being met by funds held by the study Sponsor.

The research team have a statutory duty of care to safeguard and protect the public in accordance with their professional code of practice³⁷. A robust hazard log has been developed to mitigate against anticipated and unexpected risks.

Data analysis

Data analysis involves the initial and focused coding procedures developed by Charmaz^{31,32}. Data is initially coded line-by-line using 'in vivo' codes, these are labelled using words or short phrases from the participants own language. Alongside 'in vivo' codes, a comparative study of events occurring across the data is also being conducted. Here, similar events are being compared with one another to look for connections in the data. Data is analyzed for context, compared with one another, and then coded. Coding in this way assists in identifying subtle patterns and properties of the emerging categories. Comparing opposing events in the data provides further theoretical insights.

Focused coding procedures involve making sense of the data by grouping initial codes together into coherent categories. Constant comparison techniques are also being used throughout. Here data and focused codes are compared and contrasted with each other to understand similarities and differences in how participants understand their situations, actions, and social contexts³². Making constant comparisons helps to move beyond description to thinking more analytically and increases theoretical sensitivity. Theoretical sensitivity facilitates insights into what is meaningful and significant for the emerging theoretical framework and also helps to develop the properties and dimensions of categories and subcategories. As our theoretical sensitivity develops, we become better equipped to answer the question: 'What is happening in the data?'.

DISCUSSION

Limitations

Conducting research during the COVID-19 pandemic has created multiple issues and this study is not free of limitations. For example, recruitment so far has been successful but our heavy reliance on digital technologies has created barriers for women who experience digital exclusion. Digital exclusion disproportionately impacts people from low-income backgrounds and restricts equitable access and engagement with research³³. Simultaneously, women accessing maternity services are generally comfortable with technology as it has been part of their adult lives or they are 'digital natives', for whom digital technology has been a normal part of their entire lives³⁹. In addition, public engagement activities concluded this to be an appropriate recruitment strategy, given the circumstances and pressures created by the COVID-19 pandemic.

Additional limitations include that participants are aware the study is examining their local service and this may impact responses. However, during preliminary data analysis, participants revealed positive and negative experiences. To increase rigor these insights will be compared using constant comparative methods to inform theory development. In addition, this study focuses on community-based, MCoC teams in urban contexts. Research examining rural models and innovations in the use of digital technologies with MCoC models should also be conducted as these contexts will reveal additional unique insights.

CONCLUSIONS

With health and social inequities continuing to rise in England, the public health role of MCoC caseloading midwives is an important feature in helping to tackle disparities. The specific actions caseloading midwives take to advance equity in deprived areas is not well defined in a UK context. This study will provide new, mid-level theory from which future research hypotheses can be proposed and tested, in addition to expanding our existing understanding about the mechanisms underpinning the benefits of MCoC in different contexts. This research is timely and will provide important evidence to inform maternity policy, midwifery education, practice, and research.

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PROTOCOL REGISTRATION

Clinicaltrials.gov: NCT04524286. Submitted on 21.08.2020
Protocol version: The Mi-CARE Study, v1.3, 19.03.2021

CONFLICTS OF INTEREST

The authors have each completed and submitted an ICMJE form for disclosure of potential conflicts of interest. The authors declare that they have no competing interests, financial or otherwise, related to the current work. C.E. Clayton is supported by the Clinical Academic Doctoral (CAD) program. The CAD program is recognized and supported by the Wessex Clinical Academic Training Initiative, which is funded by the NIHR Wessex Partnership Scheme.

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ETHICAL APPROVAL AND INFORMED CONSENT

This study was granted regulatory and ethical approval on 29 May 2020 by South Central – Oxford C Research Ethics Committee (Ref: 20/SC/0183; IRAS 262369) and received HRA approval on 20 July 2020.

DATA AVAILABILITY

The data supporting this research are available from the authors on reasonable request.

PROVENANCE AND PEER REVIEW

Not commissioned; externally peer reviewed.

5.5 Ethical and regulatory considerations of the study

To research and write about the impact of deprivation on women's lives and their experiences of receiving MCoC - within the context of the COVID-19 pandemic - while also considering how midwives respond to the SDoH affecting women's lives, requires a sensitive and ethically grounded approach (Edwards and Mauthner 2012; Charmaz 2016a). It is important to keep in mind the ethics of research purpose, roles, conduct, representation, the co-creation of knowledge, as well as the ethics of dissemination (Letherby 2003). Women's lived realities are complex and social and economic inequalities may introduce additional challenges that researchers must be prepared to address in the field.

The safety and well-being of participants and researchers must guide all decisions during the course of research. With standards of feminist research in place (Letherby 2003; Edwards and Mauthner 2012), the process of research has the potential to be transformative and contribute to social change (Maynard 1994). Needless to say, sufficient time, consideration, and resources must be dedicated to ensuring rigorous ethical standards are embedded into the processes of informed consent, voluntary participation, confidentiality, risk management, and mechanisms to attend to the needs of the researcher (Kelly et al. 1994).

A feminist ethics of care is a theoretical perspective that emphasizes the importance of interpersonal relationships and the moral significance of care (Edwards and Mauthner 2012). This approach challenges traditional ethical theories that prioritise autonomy, justice, and rights, arguing that they overlook the responsibilities and values inherent in human relationships (Leavy and Harris 2019). Adopting a feminist ethics of care involves a commitment to reflexivity, empowerment, and reciprocity (Buch and Staller 2007; Ginn and Benzie 2019), by ensuring the research process is not exploitative and that participants are valued and respected (Hesse-Biber 2012). Furthermore, it calls for a dialogic and narrative form of practice, where the researcher is not merely a technical operator but an active participant in the ethical dimensions of the research process (England 1994; Edwards and Mauthner 2012). This approach also reframes our conception of humans as interdependent, advocating for relationality and reciprocity over individual competition (Hesse-Biber 2012). By integrating these principles, researchers can foster a more inclusive and empathic research environment that aligns with the transformative aims of feminist research (Letherby 2003).

The way in which a feminist frame of ethics was operationalised in this study is outlined in the next section.

5.5.1 Sensitivity of the research topic

Women, especially pregnant and postnatal women, are under-represented in research, not because they lack autonomy or capacity, but because of their susceptibility to moral pressure and/or coercion to participate in research, and the potential risks research might present to the unborn or breastfeeding child (van der Graaf et al. 2018). However, inclusion of marginalised groups, as such as perinatal women, can provide vital information on women's health, from their perspectives. This can lead to improvements in prevention, care, and treatment of female only experiences, like childbearing (Smith 2008).

Confidentiality and safety must be given prime importance, with a strong emphasis on ensuring that participation in research does not cause harm or retraumatise individuals. It is essential that participants are also informed of available sources of support, and that interviewers respect their decisions and choices throughout the research process (Reinharz 1992; Wuest 1995; Plummer and Young 2010).

Due to the sensitivity of this doctoral research, the participant information sheet (PIS) contained information about my role to safeguard their wellbeing along with details of local support services that could offer further advice in the event they needed support. Participants' named GPs were informed of their participation in the research via an electronic letter. I closely observed participants wellbeing throughout our interviews, ensuring I responded to participants needs. Participants were also informed that they could stop their interview at any point, and that we would discuss the most appropriate support together.

The sensitive nature of the research topic triggered memories for participant 021, who became visibly upset as she recalled her recent traumatic birth. In the moment itself, I carefully listened to her story and bared witness to her discomfort. We paused the interview for a few minutes, and I reassured the participant that we could stop the interview at any time. After maybe five minutes had passed, she was positive she wanted to continue. Towards the end of our interview, I asked how she would feel about receiving some additional support to help her process her traumatic birth experience. At the time, the research site only offered women and their families a midwifery-led 'Birth Afterthoughts' debriefing service. This was prior to the launch of a specialist, trauma-informed perinatal mental health service a year later. The participant welcomed the support but wanted me to make the referral, as opposed to her making a self-referral:

Interviewer: "Something that you mentioned earlier on...I wanted to follow up with you if that's okay? Locally we offer a birth afterthoughts service, and I noticed how upset you

became when you recalled your birth experience. Would you like me to refer you to this service?”

“Yeah, maybe, from talking to you about it, and that kind of bit of unclear, what felt like really quick to me, maybe I need to figure out whether it was that quick, because you know, your memory is never always accurate, and what changed so quickly. So yeah, I think that maybe worth - I don’t know if they’re doing it now, because of everything but can you check for me?”- participant 021.

Within twenty-four hours I raised an Adverse Event (AE) with the Sponsor and recorded the AE on [EDGE](#) – a cloud-based clinical research management system, which also acted as the study site file. I also informed the research site and alerted the participants’ named GP via secure email. Within a few days the Birth Afterthoughts service contacted the participant to provide her with some additional support. Her GP also contacted her to arrange an appointment.

5.5.2 Power in the research process

Dealing with power imbalances in qualitative research is an on-going process evident in recruitment, ethical considerations, data collection, data analysis, and validation (Plummer and Young 2010). Suggestions have been made about measures to promote reciprocity between researcher and participants, for instance, interviews can be relational through the sharing of personal insights with one another (Lather 1988; Vahasantanen and Saarinen 2012). Other considerations included the use of reflexivity and memoing, where I challenged my preconceptions and how these might have affected the research (Keane et al. 2022).

Contentious debates exist around the ethics of financial payments in research, especially in sensitive research. I deliberated with balancing fair compensation for participants time and expertise, with avoiding introducing undue influence, which could have distorted participants’ judgment and affected the voluntary nature of their informed consent (National Institute for Health and Care Research 2024). Prior to the COVID-19 pandemic, the proposed research design included in-person interviews and reimbursements to cover travel, refreshments, and childcare costs. Financial reimbursements were an important consideration for me to embed in the research design to promote inclusivity and fairness, so that women were not financially burdened by participating in the study and were more likely to be able to attend an interview on their own. I consulted NIHR guidance on financial payments in research (National Institute for Health and Care Research 2024), to ensure participants financial circumstances would not negatively affected by their involvement in the study. Moreover, unpaid labour disproportionately impacts women, and I considered the absence of remuneration to be a potential reinforcement of gender inequality.

All participants received a digital ‘Love2Shop’ voucher up to the value of £15 after the conclusion of their interview. These funds were met by my researcher development fund held at BU.

Whilst financial remuneration may have played a part in the success of my recruitment strategy, participants expressed the value of participating in the research during lockdown. Being able to share their experiences with another person beyond their immediate household and the altruistic benefits of helping others was discussed by five participants, as illustrated below:

“[...]I wasn’t bothered about it anyway, it was more just sharing with and giving the recognition for the midwives that I had” – participant 005

“[...] That’s not, I’m honestly not fussed about it, it’s just nice to be able to talk about the team” – participant 008

“[...] Yeah, that’s fine, I wasn’t even bothered about the voucher I just wanted to help... I think people might just be looking for some human interaction” – participant 012.

5.5.3 Study amendments

When social distancing measures were imposed during the COVID-19 pandemic, aspects of research design were amended. Over the course of the lifecycle of the research, I submitted four amendments for NHS REC approval. I received ethical approval for online recruitment, informed consent, data collection, and the method of reimbursement (Table 3).

Table 3. Study amendments

Amendment No.	Protocol version no.	Date issued	Author(s) of changes	Details of changes made
0	v1.0	14.02.2020	N/A	N/A
1	v1.1	02.07.2020	Charlotte Clayton CI	- The process of informing the named GP about safeguarding issues - Grammatical errors amended throughout study documents
2	V1.2	29.07.2020	Charlotte Clayton CI	- Addition of contextual information about impact of COVID-19 pandemic and social distancing measures - Addition of remote video interviews - Reimbursement for participants, to include a £15 ‘Love to Shop’ voucher, instead of travel and childcare costs
3	V1.3	19.03.2021	Charlotte Clayton CI	- Change of addresses of the PhD supervisory team - Grammatical changes to study documents
4				Change to end of study declaration

5.5.4 Publication in a peer-reviewed journal – methods paper

Pre-print of record. Clayton, C. (2022) *Embracing the rapid acceleration of digital transformation in research during the COVID-19 pandemic*. The Practising Midwife Journal. Vol 24(8), p.8-9. Available at: <https://www.all4maternity.com/embracing-the-rapid-acceleration-of-digital-transformation-in-research-during-the-covid-19-pandemic/>

In this section, the second paper, published in *The Practising Midwife* (Clayton 2021) is presented. In this paper I reflected on being a midwife/researcher and the opportunities and challenges that digital transformation provided me during the COVID-19 pandemic. This article included a discussion on how I approached amending design features to be compliant with COVID-19 restrictions. The article also explored how I operationalised the study in the field, including details of my recruitment and data collection strategies. These details are also discussed in the published research protocol, in [Section 5.4](#). On the 19th September 2024, I received permission from the editorial team at *The Practising Midwife* to include the original submission in the thesis (Clayton and Purdy 2024).

5.5.5 Embracing the rapid acceleration of digital transformation in research during the COVID-19 pandemic. Conducting midwifery research in the NHS as a Clinical Academic Doctoral student.

5.5.5.1 Abstract

The COVID-19 pandemic has transformed every aspect of our lives, including how non-COVID related research was conducted in the NHS during the third national lockdown in 2020. Charlotte Clayton, midwife and Clinical Academic Doctoral student at Bournemouth University, reflects on the dilemma's caused by the pandemic as she prepared to recruit members of the public and midwives to her PhD study in the NHS, and the opportunities it provided both her and the people who took part.

5.5.5.2 Article content

It is difficult to remember life as it was before the COVID-19 pandemic, but I've found a degree of strength from reflecting on what I've learnt and how, as a postgraduate midwifery research student, the pandemic forced me to adapt at pace under the most uncertain circumstances and embrace digital transformation in research. As you can imagine the pandemic impacted on my research in multiple ways, but since November 2020 I have had the privilege of listening to and learning from the experiences of women and midwives in many interviews thanks to the

use of digital technology as a method to collect research data. I therefore wanted to reflect on the opportunities the third national lockdown provided me when I opened my PhD research study 'The Mi-CARE Study'(Clayton 2020; Clayton et al. 2022), to recruitment and data collection in the NHS.

I am an experienced midwife, and I am in the last year of a four-year, Clinical Academic Doctoral (CAD) programme at Bournemouth University. The CAD programme provides midwives with bespoke research training, which includes conducting a piece of independent research whilst also remaining in clinical practice. The CAD programme is part of the NIHR Wessex Integrated Academic Clinical Training Pathway and in my case is coordinated and supported by Bournemouth University (BU) and a local NHS University Hospital, where I am also a midwife(Centre for Midwifery and Women's Health 2021).

'The Mi-CARE Study', which has been adopted onto the National Institute for Health Research, Clinical Research Network Portfolio, is a qualitative study exploring the public health role of caseloading midwives working within areas of social deprivation in city in the South of England, alongside the health inequality and maternity care experiences of women receiving midwifery caseloading care. Through the use of semi-structured interviews with women and midwives, the research is developing theory which seeks to explain how caseloading midwives specifically work to achieve health equity. The research is being conducted in the wake of NHS England's Maternity Transformation Plan (NHS England 2016a, 2016b) and the NHS Long Term Plan(NHS England 2019).

During the design phase of my research, way before the pandemic hit, I had the great fortune of consulting with midwives, Children Centre staff, and the communities they support to determine the best ways to advertise the research and engage with the local community. These insights established that I needed flexible, blended approaches of both digital and traditional methods of recruitment and data collection in order for the research study to be inclusive and appeal to those I was seeking to recruit. In addition, to account for people who might be digitally excluded, I had planned to immerse myself in the local community, working in partnership with the Children's Centres and local midwives to identify potential participants. However, as the pandemic unfolded and social distancing restrictions became the norm, I was unable to conduct any in-person fieldwork. It was at this point that I recognised I needed to adapt the study quickly in order to make any tangible progress. This process took time, lots of reflection, false starts and talking things through with my supervisory team.

I successfully received NHS research ethics approval for the design strategies I developed with stakeholders, which included a study Facebook™ page (@TheMiCareStudy), and social media advertising campaigns. I was fortunate enough for the study to be advertised on multiple stakeholder pages, including the NHS Trusts' maternity services Facebook™ page @_____MaternityService, which reached over 4700 people. I am forever grateful to [removed] – Consultant Midwife Trainees, for their help and support with the recruitment to my study.

I also developed an online consent process, a digital site file for data management purposes, and options for participants to choose how their interviews were conducted including over video conferencing software, WhatsApp, or over the phone. All participants, both members of the public and midwives, received a 'Love2Shop' voucher in recognition of their time and contribution to the research. This was important, as I wished to remunerate participants for taking time to talk to me.

I started recruitment and data collection during the third, national lockdown in November 2020. I learnt how to use new and unfamiliar video conferencing software and soon enough I was attending Zoom sessions with Family Hub staff and local families, Microsoft Teams meetings with my colleagues, and answering swaths of enquires about the study via Facebook™.

I have conducted thirty-two interviews so far, all of which have been conducted over Microsoft Teams, Zoom, or over the phone. For many participants in the childbearing women cohort being able to share their experiences virtually or over the phone, whilst being confined to their homes, provided an opportunity to speak with another adult outside of their household, offered a space for them to share their experiences, and to be actively listened to. Naturally, out of a desire to help others in similar situations, I have found women's motives to take part are altruistic. Whilst participants did receive a voucher in recognition of taking part, this did not appear to be an ulterior motive. One woman alluded to this at the end of her interview with me, *'I wasn't bothered about it anyway, it was more just sharing with you and giving the recognition for the midwives that I had'*. Many other women said similar. It has been an utter privilege to hear their stories, and to better understand the context of their lives in order shape maternity services of the future that seek to achieve health equity.

In the context of my own doctoral research, whilst the COVID-19 pandemic has caused unprecedented challenges, it has provided numerous opportunities to embrace digital transformation and to work smarter. Undoubtably, conducting research interviews virtually

has its limitations; namely causing barriers to participation for people who are digitally excluded. I am fully aware of the implication this will have on inclusivity, and I am disappointed that I have been unable to complete the community engagement work I had planned prior to the pandemic. However, without the use of digital technology I would not have been able to progress with my research nor had such success with my recruitment. I have been able to engage with participants in new ways and learn transferrable skills that will inevitably support my beyond the PhD.

I am forever grateful to all of the partnerships I have developed and the support I have received from staff at local Family Hubs, my midwifery and research colleagues, my PhD supervisory team, and all the wonderful staff in Research Governance, I.T, Faculty Librarians, and Research Delivery at BU.

References

References included in this article can be found in the main reference list at the end of the thesis, in Chapter 11.

5.5.6 Recruitment and informed consent process

5.5.6.1 Recruitment of perinatal women

Recruitment and data collection occurred concurrently with both participant groups. Recruitment strategies comprised of both passive and active methods of advertisement to maximise recruitment. Passive recruitment involves distributing recruitment materials such as adverts and posters with the aim of attracting potential participants (Gelinas et al. 2017). By contrast, active recruitment occurs when research staff interact with people with the aim of gaining interest in the study. This is usually on the basis of knowledge of characteristics that would make potential participants suitable candidates for the research (Gelinas et al. 2017).

Women were primarily informed about the study via social media. This was deemed one of the most effective and accessible ways to communicate with the public from public feedback sessions ([Section 5.2.1](#)) and became even more relevant during COVID-19 lockdowns. A Facebook™ page - @TheMiCareStudy – was co-developed with the social media team at the BU and was advertised in partnership with local stakeholders. The most effective method of advertisement was via the Facebook™ page of the maternity services at the research site - @____MaternityService - which had a following of over 5.5k followers at the time. The study Facebook™ page included information about the study with hyperlinks to the poster, PIS, and online consent form. An example of the social media page is provided in [Appendix 2](#).

Women who were interested in taking part contacted me to express their interest either via Facebook™ messenger, via my University email, or by telephone on a study specific mobile number. Within the first twenty-four hours of the study being advertised via the hospitals' Maternity Service Facebook™ page, I had over one hundred enquiries from interested participants, including women living in other countries who had their babies at the Research Site. As an independent researcher, who was also working as a clinical midwife, following up these avenues of enquiry was time consuming, but nonetheless particularly worthwhile. As I expected from my own experience of using social media and knowledge of the realities of using social media as a research tool (Gelinas et al. 2017), most of the initial public interest was screened and subsequently not eligible to participant. Nevertheless, the conversations I had with the women were fruitful. A number of the women I spoke to also kindly offered to share the social media post within their own networks, demonstrating the power of social media as a communication tool and the impact of human connection on snowball strategies of recruitment

(Gelinas et al. 2017). Even during a global pandemic, women were altruistic in their motives to share their stories.

Women were also informed about the study through online parenting groups organised by the Family Hubs. Posters were also displayed across the Family Hubs, as certain in-person appointments and events continued. Women were also informed about the study by midwives and maternity support workers. Remote site initiation visits were conducted with relevant staff prior to recruitment commencing. Stakeholders were provided with study information packs to provide to potential participants, which included copies of the study poster, summary PIS, and full PIS. Two versions of the PIS were developed to support accessibility. Women who were interested in the study, either contacted me directly, or staff contacted me after gaining women's expressed consent to be contacted. Methods of referral are detailed in Figure 3.

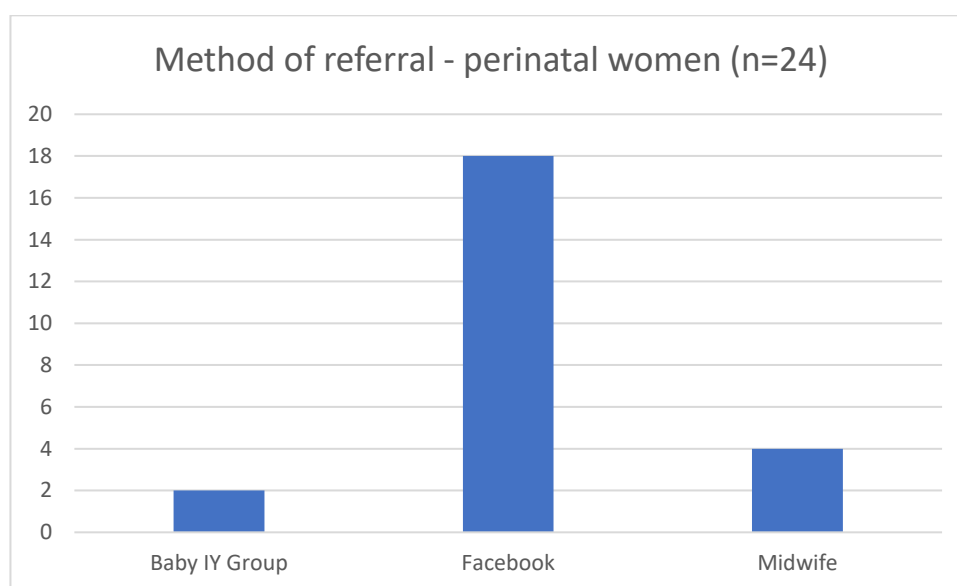


Figure 3. Method of referral - perinatal women

In total twenty-four perinatal women were recruited to the study, with twenty-three completing the study. One participant was withdrawn due to medical reasons. All participant identifiable information was handled securely and confidentially, and in line with the Data Management Plan (DMP) ([Appendix 2](#)). All delivery activities related to the study were recorded on EDGE.

5.5.6.2 Recruitment of midwives

Midwives were informed about the study at departmental and team meetings via Microsoft™ Teams, via posters in staff areas, recruitment emails, and conversations in the workplace ([Appendix 2](#)). Staff who were interested in participating in the study either contacted me directly or provided me with their contact details and invited me to contact them at a later date. In total fourteen midwives were recruited. One participant was withdrawn as we were unable to

schedule an interview that was mutually convenient. Thirteen midwives completed the study. Methods of referral are detailed in Figure 4.

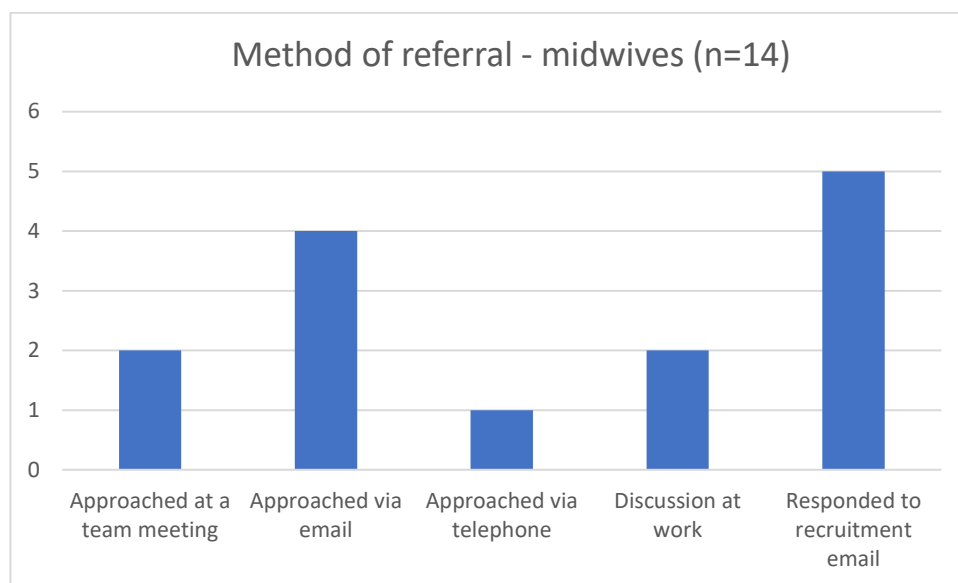


Figure 4. Method of referral - midwives

5.5.6.3 Informed consent

Consent was confirmed and documented electronically using Microsoft™ Forms. Participants from both groups completed an online consent form prior to data collection. Participants were sent a link to the consent form after eligibility had been confirmed. The consent form involved a set of simple, self-assessment questions which confirmed participants understanding. Each statement had to be answered in sequential order to progress to the next statement. Participants selected either 'yes or 'no,' to indicate their agreement. If they selected 'no' to mandatory statements they were redirected to the end of the form, which thanked them for their time and provided instructions about exiting the page, thereby declining their informed consent. The end of the form also provided hyperlinks to the PIS and the contact details of the research team. An electronic signature was collected at the end of the form, confirming whether the participant agreed to provide their informed consent or not. A tick-box option of 'yes, I do provide consent' or 'no, I do not wish to provide consent' confirmed whether they agree to participate or not. Both the HRA and the Medicines and Healthcare Products Regulatory Agency (2018) promote the use of e-consent procedures in studies with minimal risk of harm. The consent form supported the following accessibility functions: text-to-speech and adjustable font size. Consent was verbally re-confirmed with each participant prior to any data collection.

All study procedures were compliant with the Data Protection Act (2018 c.12), the European General Data Protection Regulations (GDPR) (2018), and those of the Sponsor.

5.5.7 Anonymity and confidentiality

Full anonymity was not possible for women who interacted with the study Facebook™ page in terms of liking and/or commenting on public posts, however anonymity was upheld as soon as women contacted me privately on Facebook™ Messenger, and for those women who became participants.

Each participant was assigned a sequential study identifier and a randomly generated pseudonym. Participants in the perinatal women group were allocated identifiers ranging from 'P001' to 'P023', followed by a randomly assigned name. Participants in the midwives group were allocated identifiers from 'PM001' to 'PM013', also followed by a randomly assigned name. To further protect anonymity and confidentiality, midwives requested that their job roles be excluded from all study materials. A full list of the identifiers and pseudonyms can be found in [Sections 6.3.1-6.3.2](#).

All study related documents, including the Investigator Site File (ISF), were stored electronically on EDGE and on encrypted servers at the Sponsor. Only I, the Chief Investigator, and the research team had access to the ISF and the study related documents for this research. Additionally, interview transcripts were coded in such a way that any information that could potentially disclose the participants identities were removed. No identifiable data was used in the data analysis. Data, inclusive of interview recordings, will be kept securely for five years from the date of final publication in accordance with [Bournemouth University](#) guidance. These measures were considered appropriate due to the sensitive nature of the research and my commitment to upholding a feminist care of ethics.

5.5.8 Data management plan

An online Data Management Plan (DMP) was developed, detailing the handling and workflow of research data during the active phase of the study and the practices supporting long-term preservation, access, and use of data after project completion. The DMP adhered to the Data Protection Act (2018 c.12), GDPR (2019), the Human Rights Act (1998 c.42), and with the common law duty of confidentiality. It also aligned with data management and governance policies from Bournemouth University and is presented in [Appendix 2](#).

5.6 Process of data collection

GT research is built upon the gathering of rich, in-depth data that uncovers the perspectives, emotions, intentions, and behaviours of participants, along with an exploration of participants

contexts (Charmaz 2006; Charmaz and Belgrave 2019). This process involved narratives with participants and the creation of comprehensive field notes and memos, which captured the conveyed experiences, emotions, and thoughts of participants. Such thorough exploration enables researchers to delve into a phenomenon or concept. Glaser and Strauss (1967) advocated for a diversity of data sources, noting that:

“various types of data provide the analyst with different perspectives or vantage points for interpreting the results...the methods for data collection, their application, or the kinds of data collected are limitless” (p. 65).

Data were amassed through remote interviews and demographic information.

5.6.1 The place of academic literature in Grounded Theory

Prior to exploring the intricacies of data types and collection techniques, it is beneficial to first consider the role of scholarly literature within GT as a valuable source of data. For researchers planning to embark upon a GT study, it is essential to consider the timing and influence of academic literature on the development of theory. Charmaz (2017b) emphasised that researchers are not merely observers but active participants in the construction of knowledge. She argued that objectivity involves the co-construction of consensus within a cultural context, meaning researchers must acknowledge their role in interpreting data and forming theory (Charmaz 2017a). Charmaz also recognised the value of engaging with literature as a reflective backdrop once a core category has emerged, allowing researchers to refine their findings and relate them to existing knowledge. This approach ensures that theory remains grounded in data, while being critically informed by scholarly work and fostering a balance between discovery and scholarly discourse (Charmaz 2017a, 2017b). Thus, while the initial stages of research may benefit from an unencumbered exploration of data, later stages embrace literature as a comparative tool to enhance and situate the emerging theory within a broader historical and socio-political landscape (Charmaz 2006, 2016a).

In the context of this study, a literature review was performed with the intention of determining a need for the current research through the identification of a gap within existing knowledge. Once I ascertained that there was indeed a need for a study of this nature, the literature on this topic was not reviewed again until advanced stages of data analysis.

5.6.2 The use of interviews in Constructivist Grounded Theory

This study examined the SDoH and psychosocial adversities that impacted perinatal health and wellbeing, from the perspectives of women themselves. In addition, this research examined how MCoC midwives addressed these issues as part of their public health role. Therefore,

selecting interviews as the main source of data collection seemed entirely justified given that interviews are dynamic and can generate rich data, support iterative analysis, and capture the complexity of human experiences - all of which are essential for developing contextually relevant theories (Charmaz 2002, 2016b).

Data collection took place during the COVID-19 pandemic over a period of nine-months, from November 2020 - August 2021. The majority of interviews were conducted during the second (5th-26th November 2020) and third (4th January-31st March 2021) national lockdowns in England. All interviews were carried out remotely due to social distancing measures. I employed a flexible interviewing style, utilising open-ended questions from interview guides that varied for each participant through the process of constant comparison (see [Appendix 2](#) for development of research questions).

The majority of interviews with perinatal women took place by telephone (n=16). The quality and content of telephone interviews were comparable to those conducted face-to-face. However, some authors caution that telephone interviews may make it harder to capture and interpret subtle non-verbal cues, thus placing greater emphasis on the verbal content (Irvine 2011; Block and Esrskine 2012).

At the request of once participation, their interview was carried out asynchronously on WhatsApp™. This was conducted on a study specific mobile phone over the course of six hours. Conducting research interviews over WhatsApp™ offers several advantages, including accessibility, convenience, cost-effectiveness, and flexibility in interview formats. Using WhatsApp™ as a data collection tool has also been shown to rebalance power dynamics, offering participants a sense of control over the information they choose to disclose, when, and how they chose to reveal it (Gibson 2020). However, there are notable disadvantages, such as data security and privacy concerns, potential technical issues, and the lack of non-verbal cues, which can be crucial for interpreting responses (Gibson 2020). I found conducting this interview challenging, but worthwhile, in terms of the freedom it provided us to express ourselves using text, speech, and digital media. For example, to establish rapport with 'Myra' (P006), I decided to start the interview with a voice note, where I introduced myself again, discussed the nature of the research interview, posed two initial questions and invited the participant to reply using any means of communication. 'Myra' replied about 10 minutes later via text and we proceeded to conduct the interview over the course of six hours, where I posed follow-up questions and prompts and Myra then replied in her own time. At one point

in the interview Myra used an emoji⁵ and the slang expression, ‘haha’ to empathise how she felt after giving birth. In a post birth daze, she had not realised she needed to take her babe up to her chest and her midwife had to call her name three times before she realised what she needed to do. In the following excerpt, the emoji Myra used suggested how she might have felt in that moment:

“When Tessy was delivered Benash was quick to call Francesco over to be involved with the two of us - I think we were both a bit dazed that we’d had a baby naturally and head first we didn’t really know what to do. She had to call my name three times before I realised, I was supposed to be taking the baby from her 🤔 haha”! – Myra, P006.

We both shared a joke following this - the emoji bringing to life how she might have felt in that moment.

A further six interviews with perinatal women were conducted over the video conferencing software, Zoom™ (n=6). All interviews with midwives (n=13) were carried out over Microsoft Teams™. Using Teams™ and Zoom™ for research interviews offers several benefits, including accessibility, cost-effectiveness, flexibility, and the ability to capture nonverbal cues through visual interaction (Archibald et al. 2019). These platforms also facilitate data management through recording capabilities and are generally user-friendly with robust privacy options. However, challenges include potential technical issues, the need for digital literacy, and privacy concerns (Archibald et al. 2019). While visual interaction helps, capturing all non-verbal cues can still be challenging compared to in-person interviews. I found this method of data collection to be the most rewarding, as it enabled me to progress with my research while seeing participants and attuning to their verbal and non-verbal cues.

Table 4 details the chronology of interviews with participants. I developed a nuanced understanding of the issues women were facing before I started interviewing midwives. Towards the end of the data collection period, I began to interview women and midwives concurrently and shared my emerging theoretical ideas with them. Participants were able to confirm or challenge my interpretations, which ultimately contributed to the grounded nature of the theory.

⁵ Emojis are small digital images or icons used to express ideas, emotions, and feelings in electronic communication. Originating in Japan in the late 1990s, they have become a universal language in digital interactions (Usmani 2024). Emojis help convey tone and emotion, making messages more engaging and easier to understand. They can soften criticism, express sarcasm, or show affirmation, adding a layer of emotional context that words alone might not fully capture (Aleksandra 2016). Studies have shown that emojis can trigger emotional responses and even induce empathy in readers (Harper 2022).

Table 4. Chronology of interviews with participants

No. of participants	Dates	Participant I.D – (P) perinatal woman, (PM) midwife	Pseudonym
1	06/11/2020	P001	Adrienne
2	13/11/2020	P002	Cathy
3	18/11/2020	P004	Vera
4	19/11/2020	P005	Michelle
5	19/11/2020	P003	Jeanette
6	20/11/2020	P006	Myra
7	27/11/2020	P007	Misha
8	02/12/2020	P010	Poppy
9	03/12/2020	P008	Millie
10	04/12/2020	P011	Imogen
11	10/12/2020	P016	Kellie
12	11/12/2020	P009	Sarah
13	16/12/2020	P023	Fatima
14	23/12/2020	P018	Ruth
15	23/12/2020	P012	Robyn
16	06/01/2021	P013	Beatrix
17	07/01/2021	PM002	Bella
18	08/01/2021	P015	Angela
19	08/01/2021	P020	Iris
20	14/01/2021	PM001	Dana
21	15/01/2021	P014	Lois
22	28/01/2021	P017	Claudia
23	03/02/2021	P022	Harriet
24	10/02/2021	P021	Amelia
25	17/03/2021	PM005	Karla
26	26/03/2021	PM004	Denise
27	02/04/2021	P024	Mavis
28	12/04/2021	PM009	Fife
29	14/04/2021	PM008	Amanda
30	22/04/2021	PM007	Jane
31	05/05/2021	PM012	Natalie
32	19/05/2021	PM006	Ruby
33	04/06/2021	PM011	Melanie
34	14/06/2021	PM010	Gemma
35	15/07/2021	PM013	Georgina
36	17/08/2021	PM014	Samantha

I conducted and recorded all of the interviews, which lasted between 20-90 minutes. In preparation for analysis, recordings were then transcribed verbatim by an external transcriber contracted by BU (see [Appendix 2](#)). To cover these additional research costs, I used part of my Researcher Development Fund, which was managed by BU.

Early on in the data collection phase, I reflected on what I learnt about myself as a researcher (Figure 6). I felt that I did not always actively listen, pause, or prompt participants when I should have. Looking back, I found attuning to underlying meaning difficult, likely due to the

context within which this research took place. It took some time to be comfortable with silence and hone my skills as an attuned interviewer. Charmaz highlighted the power of silence as a crucial tool for qualitative researchers. She believed that silence could encourage participants to reflect and elaborate on their thoughts, leading to richer and more detailed responses (Charmaz 2002, 2008). By allowing periods of silence, interviewers can create a space where participants feel comfortable to continue speaking, often revealing deeper insights and emotions. Furthermore, Charmaz emphasised that silence can be used strategically to enhance the depth and quality of the data collected (Low and Hyslop-Margison 2021). I reflected on this with my supervisory team and sought to improve my skills by engaging with relevant literature. Thereafter, following each interview, I reflected on the techniques and skills I had employed.

Reflective memo about my interviewing style

In early interviews I can tell I was not confident, and this is reflected in my inability to probe and prompt at intersections of conversations. I do not seem to be comfortable with pauses – why it this - to allow participants time to reflect, which gives space for them to explore their experiences more. If I had been confident in the silence, I would have received further insights into the conditions of women's lives.

I've noticed that this gets better as I settled into interviewing and became more confident and comfortable as a researcher. In some of the final interviews I engaged better in my theoretical sampling techniques, by responding to what the participants said and answer new questions and probes and prompts to gain a deeper, more nuanced understanding of participants experiences.

Good insights are often revealed when the interviewer is comfortable with silence and pauses. I look back at my initial thoughts and assumptions of participants, such as in Poppy's transcript P010, where I made an incorrect assumption about her mental health condition. My outlook on mental health and my analysis skills have changed since I have experienced my own mental health issues – that rendered me rather unwell.

I can really see the impact of poor mental health on my own life, and how a lack of personal experience with this impacted what I could see in the data, my ability to empathise, to connect with other's experiencing mental health issues, and ultimately how this impacted me as a research instrument in the space. This ultimately influenced the development and construction of theory and will impact my ability to clearly 'explain what's going on' for the participants.

Written on 03/02/2021

Figure 5. Reflective memo about me as a researcher

5.6.3 The use of theoretical sensitivity as data in Constructivist Grounded Theory

Theoretical sensitivity is a crucial component of GT research. It refers to the researcher's ability to recognise and extract concepts from the data to better understand their significance, demonstrating a deeper understanding of the studied phenomena (Charmaz 2014a).

Theoretical sensitivity involves being attuned to the nuances and complexities of participants' words and actions, allowing researchers to reconstruct meaning effectively from the data. Charmaz emphasised that the development of theoretical sensitivity is essential for generating robust and insightful theories (Charmaz and Thornberg 2020). Alternatively, Glaser and Strauss (1967) identified the term 'anecdotal comparison', which involves utilising existing anecdotal information or knowledge, whether from life experience, general knowledge, or engaging with relevant literature. Researchers are encouraged to incorporate these subjective experiences into their data set. Furthermore, Glaser and Strauss (1967) described anecdotal comparisons as being particularly useful for initiating research and developing core categories, allowing researchers to draw from their prior knowledge to make quick comparisons and develop relevant categories (ibid). Moreover, Charmaz supports this approach, emphasising that incorporating personal anecdotes can enhance theoretical sensitivity (Charmaz 2017b). By drawing on their own experiences, researchers can better understand and interpret participants' stories, leading to richer and more nuanced findings. I found this method particularly beneficial in my research, as my prior knowledge allowed for a deeper understanding of the participants' stories. Incorporating theoretical sensitivity and anecdotal comparisons was essential to producing a comprehensive and insightful study. Their absence would have limited the richness of both the research process and the resulting findings.

5.6.4 The place of data generation in Constructivist Grounded Theory - field notes and memos

In GT research, both data collection and data generation are integral processes. The term 'data generation' highlights the researcher's active engagement with data sources and their role in the data acquisition process (Birks et al. 2019). Recognising data generation in GT research validates the use of memos and field notes as valuable sources of data. Throughout the research process, I kept detailed field notes and memos after each interview and throughout constant comparative analysis. Figure 7 exhibits a memo I wrote after an interview with participant PM009.

Interview with Participant PM009.

Teams interview on [redacted]
day off. [redacted] was at home.
The internet signal wasn't ^{audio} great, but the recording ^{Date} 12/04/21.
was fine. I had my
usual set up - iPad
voice recording + Teams ^{Time} 10:00am.
recording (Experimenting with
captions so Teams generates
a transcript, as I have
run out of RAF money for
[redacted] to perform my transcriptions.

Prior to this interview I was
nervous about the questions
I have developed through my
constant comparison of prior
interviews with women + mediums.
I shouldn't have been nervous,
as true to the way [redacted] is
she answered a number of the Q
without being asked, + brought up

There are moments when troubles enter our lives
and we can do nothing to avoid them.

But they are there for a reason.

Only when we have overcome them
will we understand why.

THE FIFTH MOUNTAIN

Figure 6. Excerpt of a memo after interview with PM009

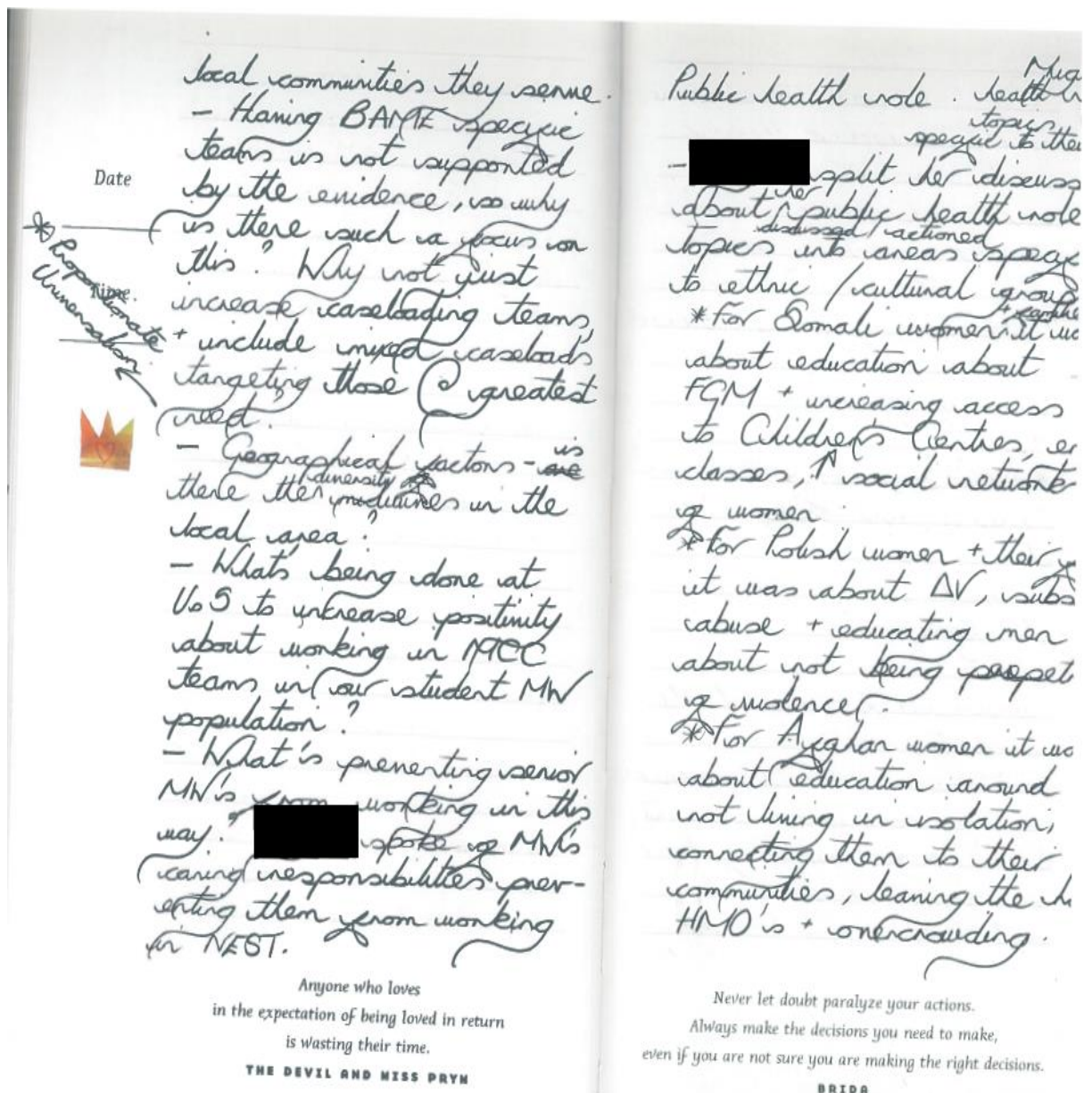


Figure 7. Excerpt of memo after my interview with PM009

Memo writing is a crucial component of GT analysis, serving as a method for generating codes and categories. The importance of keeping memos throughout the research process is advocated by Mihos et al. (2022), for their use to understand how each transcript addresses the research questions and assists with attuning to participants' lived experiences. Mihos et al. (2022) discuss the value of using key quotations and annotations, using prompts to frame quotations and support meaning making. Despite time constraints, Mihos et al. (2022) argue that memoing is essential for understanding data and facilitates making connections and comparisons within the data.

From a ConGT perspective, Keane (2022), akin to Charmaz (2012; 2014a), credited memoing as raising both the analytical and conceptual level of writing - encouraging researchers to stop

and memo whenever they have a thought and allowing ideas to flow freely. Charmaz (2012; 2014a) and Keane (2022) distinguish between early, simpler memos and later, more complex, analytical memos, emphasising the importance of constant comparison and conceptual memos to understand relationships between codes. Both stress the need for critical analytical memoing, which involves reflexivity and exploring the researcher's positionality. Together, these perspectives underscore the multifaceted value of memos in enhancing the depth and rigor of GT research.

Glaser (1992b) defined memoing as:

'the theorising write-up of ideas as they emerge...they are written up as they strike the analyst when constant comparison, coding and analysing' - pg. 108.

In this sense memo writing is an important part of expressing thoughts and assists the researcher to inch closer to the formation of a GT.

Memos become most useful in the advanced stages of analysis, as the researcher integrates the theory into framework (Glaser 2005a). As an essential component of GT, memos are seen as an important part of ensuring quality and rigour (Birks and Mills 2015). Memos are also useful for keeping an audit trail of the research process and provide an account of the decisions and observations made along the way. Memos thus assist with the process of abstraction from the data, ensuring that momentum is maintained throughout the process of analysis (Birks et al. 2019). Moreover, Birks and Mills (2023) suggest developing a habitual pattern throughout the research process.

I felt a natural inclination to memo after every interview and/or engagement with the research process. Memoing allowed me to record my thought processes and abstract ideas, so that instinctive reactions, interpretations and responses were not lost. As explained by Birks and Mills (2023), when working with data ideas are often sparked and when this occurs researchers should stop and start memoing. This is exactly the habit I developed throughout my research. Often ideas were sparked at the most unlikely of times – for example, listening to a podcast, walking, swimming in the sea, watching a movie, during conversation, and of course, whilst engaging directly in the research activities. I recorded memos in multiple formats, including creating visual mind maps and word clouds ([Appendix 3](#)). In total I wrote over 200 memos throughout the lifecycle of this research. All memos were uploaded into NVivo and stored for cross referencing. The gift of memos being within NVivo, meant that I was able to perform keyword searches across the database to review and compare my thoughts and ideas about theory development. In this way I upheld Charmaz's belief that

memos provide a space to become actively engaged in materials, to develop ideas, and to fine tune subsequent data gathering (Charmaz and Belgrave 2012; Hoare et al. 2012b).

5.7 Process of data analysis

Most qualitative research methodologies involve the completion of data collection before moving onto the analysis phase, however ConGT advocates a different approach. In ConGT data analysis begins when the first pieces of data are collected (Hoare et al. 2012a; Charmaz and Belgrave 2019). I found the process of data analysis to be complex, exciting, and at times tiresome, akin to what Hammersley and Atkinson (1995) described about the process of bringing ethnographic research together into a coherent whole:

"[...] this aspect - making it all come together - is one of the most difficult things of all, isn't it? Quite apart from actually achieving it, it is hard to inject the right mix of (a) faith that it can and will be achieved; (b) recognition that it has to be worked at, and isn't based on romantic inspiration; (c) that it isn't like a solution to a puzzle or math problem, but has to be created; (d) that you can't always pack everything into one version, and that any one project could yield several different ways of bringing it together" - p. 239.

Thirty-three interviews, along with secondary data, corresponding field notes, and memos formed the data set for this research. The process of how these data were analysed is explained in the following section.

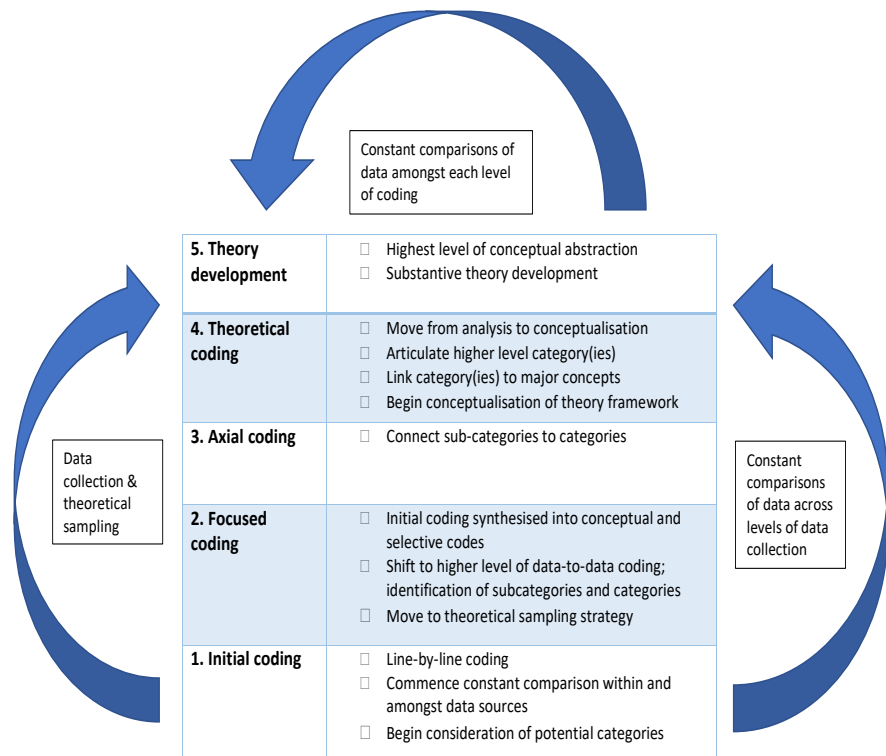
5.7.1 Concurrent data collection and analysis

ConGT is an iterative analytical method of constantly comparing and collecting or generating data, that results in high-level conceptual abstract categories rich with meaning, possessive properties, and providing an explanation of variance through categorical dimensionalisation (Birks and Mills 2023). A fundamental principle of GT is that data collection and analysis occur simultaneously and are in reciprocity throughout the research process (Birks and Mills 2015, 2023). In theory this means as data is collected, it should be analysed before endeavouring to collect more. It is through this concurrent process that researchers discern what major categories are emerging early on in the research process. The researcher then uses this information to dictate where and from whom they will collect further data through the process of theoretical sampling (Charmaz 2014a). However, the methodological literature is deficient in guiding researchers on the practicalities of upholding these principles. This is potentially misleading for novice researchers, who seek guidance to support the success of their chosen method (Nagel et al. 2017).

I found implementing constant comparative processes to be a significant challenge during the COVID-19 pandemic, not least because I continued to work as a clinical midwife alongside

delivering this research, but also because I had underestimated the effectiveness and success of my recruitment strategy. As discussed in [Section 5.5.6](#), within the first twenty-four hours, over one hundred members of the public responded to the social media campaign, expressing their interest to participate in the study. It was at this point that I faced a difficult methodological decision. If I were to interview all the women who had contacted me in timely manner, it would not be possible to analyse the data as it became available. Conversely, if I delayed the interviews, participants might have become discouraged and potentially lost to follow-up, impacting recruitment and the success of the study. It is well known that making the initial contact can be challenging for marginalised groups (Tully et al. 2021). If participants had experienced delays in being able to schedule interviews with me while I analysed previous data, this could have been disheartening for the women who took their time to make contact. I am not alone in expressing these concerns, as Draucker et al. (2007) have also reflected on the difficulties they faced during their GT study. The authors were also surprised by the success of their recruitment strategy and made the decision to perform initial coding of a number of interview transcripts, rather than just a few recommended by GT theorists. In practice this did pose multiple challenges. However, I found myself prioritising the needs of study participants, over the need to religiously follow the principles of constant comparative analysis. This ensured I maintained a trusting relationship with participants and ensured the success and completion of the research.

The process I intended to follow is detailed in full in the research protocol, which can be located in [Appendix 2](#). This would have involved following the comparative methods of GT (Glaser and Strauss 1967; Strauss and Corbin 1998) and the initial and focused coding procedures developed by Charmaz (2014a). A conceptual schematic of the intended analytical process is presented below, in Figure 8.



Constructivist Grounded Theory analysis process

This conceptualisation draws from Charmaz's (2014) description of the data analysis process in Constructivist Grounded Theory, which is iterative and emergent. Elements of Glaser and Strauss (1967), Strauss and Corbin (1998), and Corbin and Strauss (2014) have also been synthesised to more clearly explicate each of the steps in coding and theory development. Charmaz (2014) suggests that axial coding may be utilised at the researcher's discretion.

Figure 7. A conceptual schematic of the Constructivist Grounded Theory process – how it should happen

In reality the process was far more chaotic and turbulent, which is in keeping with how life was during the COVID-19 pandemic, and akin to how I imagine it might feel being sucked into a giant maelstrom! Figure 9 details a conceptual schematic I developed of how the process unfolded, which I coined as being the 'maelstrom of ConGT analysis'.

5.7.2 Initial data handling and coding strategies

Before and after the first interview I facilitated, I wrote field notes to contextualise the process and procedures of remote data collection and a reflective memo about my initial hunches and thoughts. I followed these steps before and after each subsequent interview. In the efforts of time management, I outsourced the transcription of interview recordings to a professional transcriber using BU Transfer, an encrypted file transfer portal. Despite the accurate transcription, the documents required extensive re-formatting before being imported into NVivo (v12.6.1 Plus). A task I later realised could have been completed by the transcriber had I instructed her to do this.

Upon receiving the transcripts, I saved them in corresponding participant files and listened to each interview again. This allowed me to correct inaccurate terminology and to create memos that contributed to early analysis. Additionally, I removed back utterances from the transcripts to enhance clarity. I also anonymised participants' names by assigning pseudonyms to each transcript, including assigning pseudonyms to participants' friends and families if they were discussed in interviews.

The formatted transcripts were then imported into NVivo and assigned to individual participant cases, with attributes classified based on initial memo analyses. To contextualize and compare participants' experiences during the national lockdowns, I organised the transcripts into sets based on the month each interview was conducted. Memos from interview files were similarly categorised to align with case data.

For comprehensive theoretical development, I created reflective memos for each interview and integrated my Endnote™ library into NVivo to support my theoretical sensitivity. This integration enabled efficient cross-referencing of evidence sources and transcripts, facilitating the development of concepts, categories, and the emergent theory. NVivo facilitates comprehensive management of research data, and it was imperative to maintain this with accuracy as the research progressed.

During what I termed the 'formal comparative analysis process', I was able to fully immerse myself in the analysis of each transcript in NVivo, whilst also actively engaging in theoretical sampling. I initially engaged in line-by-line coding, adhering to Charmaz's (2014a) coding strategies, and asked the following questions of the data, as outlined in Table 5.

Table 5. Line by line coding strategies, adapted from Charmaz 2014

Coding strategies	Questions to ask the data
• Break the data up into its component parts or properties • Define the actions that describe the data • Look for tacit assumptions in the data • Explicate implicit actions and meanings • Assign statements which define the significance of the data • Compare data with data • Identify gaps in the data • Code with gerunds	• What process or processes are present here? • How can it be defined? • How does this process develop? • How does the research participant act while involved in this process? • What does the research participant profess to think and feel while involved in this process? • What might their behaviour indicate? • When, why, and how does the process change? • What are the consequences of the process? • What larger analytical story do these codes suggest?

However, line-by-line coding proved completely unmanageable. After discussion with my supervisors and seeking peer support of other novice researchers using ConGT, I turned once again to the methods literature. Most notably, the coding techniques advocated by Saldaña (2016) were particularly helpful in furthering my coding techniques. As a result, in the initial stages of my research I refined my coding framework to focus on coding data that directly answered my research questions and/or provided significant insights and points of departure for the research. This led to a more structured coding framework, where emerging patterns allowed for the identification of preliminary categories. In Figure 10, I reflect on what I was experiencing at the time. Experiencing ‘coding paralysis’ and internalising my distrust of emergence, I grappled with this in the memos that follow.

Coding Paralysis

I've coded three transcripts now (P001,02,04) and line-by-line coding is not really working for me. Whilst I am following Charmaz ConGT I find it so difficult to fragment the data like this, code using gerunds and ensure I'm making sense of the data. I have been reading around the topic. Maybe it's because I'm using NVivo to manage my project, or maybe it's just not a technique that suits me? The Coding Manual by Johnny Saldaña (2016) has been transformational. Saldaña recommends being true to your chosen methodological approach but gives far more practical advice about how to actually code, using a variety of different coding strategies. For me right now, sometimes coding line-by-line works and sometimes it doesn't. So, I'm coding for instances, stanzas, subjects, topics etc. I am still trying to remain true to Charmaz's advice but understanding that other perspectives might well suit my style better.

Written on 31/01/2021

Is line-by-line coding helping or hindering my progress? I am reading Saldaña's book about initial coding strategies which include in-vivo and process (gerund) coding. Saldaña is critical of methodologists who recommend line-by-line coding. It can be overwhelming, and you end up with a million codes to manage, which hinders progression. I prefer Saldaña's choice of coding strategies. He recommends taking line-by-line coding recommendations from several qualitative methodologists, with a grain of salt. It has not been working for me and in fact has paralysed my progression. At this initial coding stage, I am going to use in-vivo and process coding (so still in keeping with ConGT), as these strategies both have the potential to stimulate more evocative memos about the phenomenon.

Written on 10/03/2021

Figure 9. Coding paralysis memo

The iterative nature of the initial coding process necessitated revisiting and refining my coding framework several times in NVivo. Examples of the coding of interview transcripts and my coding matrices can be found in [Appendix 4](#).

I continued to use in-vivo coding while organising related codes into folders, creating new nodes, as required, to address research questions and synthesise analysis across participant groups. This dynamic approach enabled the development of early categories, which also influenced the direction of questioning in subsequent interviews.

Throughout this painstakingly slow process, the support from fellow PhD researchers within an online community, provided invaluable insights and a platform for critical reflection - aiding in overcoming these methodological challenges.

5.7.3 Focused coding and theory development strategies

After synthesising the initial codes into broader conceptual categories, focused coding was carried out using a structured coding matrix ([Appendix 4](#)). This required a shift to a higher level of coding and required a greater level of theoretical sensitivity with the data (Corbin and Strauss 2008). This process was demanding and required multiple phases of analysis of initial codes and categories - making constant comparisons with codes and sorting of memos, which then assisted with writing the findings. Focused codes were refined and remained close to the language of the participants to explain the data, creating a frame for advanced stages of analysis of the constructed categories (Charmaz 2014a).

During phases of focused coding, data were subjected to questions, as outlined in Table 6, and analytical memos were also developed. This ensured codes related to the data and remained consistent with the ConGT approach.

Table 6. Questions posed during focused coding

Questions for developing focused codes	Questions to ask about the focused codes
• When did the experience, event, perception happen? • Where did it occur? • Why? • Who was involved? • How? • And what were the consequences?	• Do these codes reflect all that occurred? If not, what else is happening? • What are these codes getting at? • What was implied by the participants? • Are these codes indicators of something else? Perhaps, but what? (Adapted from Strauss and Corbin 1998, pg. 125).

Unfortunately, at this point I was once again paralysed. Was I subconsciously forcing my preconceptions onto the data, derailing its relevance? I was not sure, but I did not feel the categories I had developed accurately represented the data. I also felt a displeasure towards the process of emergence, was it even possible, was it an oversimplification of the active methods of comparative analysis I had already performed? As Glaser so vividly declared in his book, *'Basics of Grounded Theory Analysis: Emergence vs. Forcing'* (1992b), I felt like I had tortured the data, and the data had tortured me:

"if you torture the data long enough, it will give up! ... [In Strauss and Corbin's method] the data is not allowed to speak for itself as in grounded theory, and to be heard from, infrequently it has to scream. Forcing by preconception constantly derails it from relevance" – p. 123.

To combat this issue, I took a break from the data and sought advice from the literature. Qualitative researchers like Barrett (2023) have critiqued the concept of emergence altogether, as the concept can suggest a passiveness on the part of the researcher, rather than an active engagement in the co-construction of categories and theory. Furthermore, for something to emerge, emergence suggests that an empirical truth is somewhere in the data, waiting to be found, and if researchers look hard enough and are skilled enough, it will just emerge (Barrett 2023). However, in practice, every reality is different, and it is constructed collaboratively between researchers and participants. The practice of emergence in ConGT is far more nuanced and complicated and is a highly skilled part of the GT process. Charmaz (2014a) also emphasises that a GT is not just about the final product, but also about the process itself being emergent and abductive, requiring researchers to remain open to new insights and directions throughout their study.

Around the same time, I navigated some personal issues that impacted my mental health. When I returned to the data and compared what I could now see with earlier interviews, I saw the data through a completely different lens. It felt like my eyes were finally open to what the

participants, and the corpus of data, had been trying to tell me. It was at this point that I was able to finally move forward with my theoretical development.

I have reflected on the development of one of the core categories in [Section 10.5](#). I deliberately chose to place this discussion at the end of the thesis rather than include the process here, so as not to influence how the reader initially engages with the research findings in Chapters 7 and 8.

5.7.3.1 Visualisations in NVivo

During advanced stages of analysis, I engaged with some of the visualisation functionalities in NVivo, to further explore the data and to check the accuracy of my theory development. Using the visualisation functionalities in NVivo can significantly enhance qualitative research by providing tools that aid in data interpretation, presentation, and exploration (Niedbalski and Ślęzak 2018; Jackson and Bazeley 2019). Visualisations such as word clouds, charts, and graphs help researchers identify patterns, themes, and trends in their data, making it easier to interpret complex information and draw meaningful conclusions (Jackson and Bazeley 2019). Additionally, visual representations of data can make findings more accessible and engaging, effectively communicating results to stakeholders, colleagues, or in publications, thereby increasing the impact of the research (Hutchison et al. 2010).

Moreover, NVivo's visualisation tools facilitate exploratory analysis through mind maps, concept maps, and project maps, allowing researchers to explore relationships between different themes and concepts (Jackson and Bazeley 2019). This deeper understanding of the data can lead to new insights and perspectives. The efficiency of visual tools also streamlines the analysis process, enabling researchers to quickly see the distribution of codes, themes, and other elements within the data - saving time and effort (Jackson and Bazeley 2019). Furthermore, visualisations can reveal insights that might not be immediately apparent through text-based analysis alone, helping researchers uncover new insights in their research. Comparative analysis features, such as matrix coding queries and comparison diagrams, enable researchers to compare different datasets or themes, highlighting similarities and differences and providing a comprehensive view of the data (Niedbalski and Ślęzak 2018).

However, there were some disadvantages with using NVivo. For example, it took a considerable amount of time and commitment to master the programme and the tools that were most useful for my data and those which were congruent with the ConGT method. Nagel et al. (2015) noted similar issues in their GT study. There is also a risk of over-relying on visualisations, potentially leading to the oversimplification of complex data and the loss of important nuances and details

(ibid). This is something I found delayed my progress and obstructed the creativity of my analysis. Additionally, while NVivo offered a range of visualisation tools, they may not meet all the specific needs of every research project, and researchers might find certain functionalities lack customisation. Visualisations also have the potential to introduce bias (Hutchison et al. 2010; Jackson and Bazeley 2019). The way data is presented can influence interpretation and so requires caution. To mitigate this, I compared the visual representations I found useful with the raw data and made decisions based on my theoretical sensitivity with the topic.

Examples of the visualisation techniques I used to explore, compare, and validate the emergent findings are presented in [Appendix 5](#).

5.7.3.2 Data saturation

Theoretical saturation was the term used by Glaser and Strauss (1967) to describe the criteria that determined when to stop gathering data. They suggested that data saturation meant ‘no additional data were being found’ (Glaser and Strauss 1967, p. 61). Moreover, Strauss and Corbin (1990) later described theoretical saturation as occurring when there are no new codes identified in later rounds of data collection and analysis, and where a category, along with its subcategories, is well described and explained. Morse (2001) noted that saturation must be viewed in abstract terms and recommended the use of storyline to build a comprehensive and convincing theory. Glaser (1992a), encouraged researchers to always validate fit and relevance before reaching saturation.

Charmaz (2020), reinterprets the concepts of fit and relevance, replacing them with a more flexible and nuanced perspective compared to Glaser (1992a). Charmaz argued that fit should not be seen as a rigid criterion, but rather as the degree to which categories and concepts resonate with the participants’ experiences and the wider socio-political-cultural contexts of the study (Charmaz 2015). This means that fit should be assessed through the lens of the participants’ perspectives and the researcher’s interpretive framework, ensuring that the findings are contextually grounded and meaningful. Similarly, Charmaz (2017a, 2017b), extended the idea of relevance beyond immediate applicability, suggesting that relevance also involved the potential of ConGT research in addressing significant social justice issues. Charmaz (2017a), also highlighted the importance of considering the quality and depth of data, suggesting that saturation is achieved when the data is sufficiently detailed to support a robust and nuanced theory. Furthermore, Charmaz (2014a; 2014b), critiqued the traditional notion of saturation as merely an endpoint where no new data emerges. Instead, she proposed that saturation should be seen as a point where gathering data no longer contributes to new

theoretical insights, or the development of new categorical properties (Charmaz 2014a). This perspective emphasises the depth and richness of the data, rather than the mere absence of new information. By adopting this reflexive and iterative approach, Charmaz (2016b) encouraged researchers to continually assess and refine their GT research, ensuring that it remains dynamic, contextually relevant, and theoretically robust.

I identified that saturation had been reached as I completed initial coding of the last three interviews. At this point I found all data could be sorted into existing codes or categories. I memoed about this observation and discussed it with my supervisors.

5.8 Upholding quality and rigour in the research

To embed quality and rigour throughout this ConGT, key criteria espoused by Charmaz (Charmaz 2006, 2014a) were followed. To promote credibility, thorough data collection and analysis strategies were embedded, including member checking. Research findings should resonate with participants and others who share similar experiences. This means the research should capture the depth and complexity of the participants' lives and be meaningful to them. Two midwife participants (PM013 and PM014) reviewed and commented on the emerging findings to ensure the findings were relevant and accurately represented their worldviews. Unfortunately, due to a lack of time and resources it was not possible to arrange follow-up interviews with any of the participants from the perinatal women group, however at each subsequent interview I explored emergent findings with new participants. Their insights contributed to the development of more focused questions and comparative analysis procedures.

A ConGT should offer new insights and perspectives. Charmaz (2016) encourages researchers to ask themselves whether their findings provide a fresh understanding of the studied phenomena and contribute significantly to existing knowledge. ConGT research should also be useful for participants, practitioners, and other stakeholders, offering solutions or new ways of understanding issues (ibid). Moreover, researchers should continuously reflect on their own influence on the research process (Charmaz 2016b; Charmaz and Keller 2016). This includes being aware of one's own biases, assumptions, and interactions with participants, and how these factors shape the construction of knowledge. By adhering to these criteria, researchers can ensure that their ConGT is rigorous, credible, and valuable (Charmaz 2014a). These steps were achieved and are woven throughout discussions in Chapters 9 and 10.

5.9 Conclusion

This chapter has provided a detailed explication of the development, conduct, and analysis of data from this doctoral research. The next chapter will situate the research within its context, before presenting the findings from interviews with childbearing women and midwives in Chapters 7 and 8.

Chapter 6. Situating the findings

6.1 Introduction

The previous chapter provided a detailed exposition of the conduct of the study and reflection on the study methods. The purpose of this chapter is to contextualise the subsequent findings chapters. Firstly, I present an overview of England's socio-economic and political context in the ten years preceding the COVID-19 pandemic, before providing an overview of the health inequalities experienced by people living in the city in which this study was conducted. Finally, I present an overview of the participants and provide supportive information for Chapters 7 and 8.

6.2 England in context prior to and during the COVID-19 pandemic

In the decade leading up to the COVID-19 pandemic, England and the rest of the UK, experienced significant socio-economic and political difficulties. Economically, this period was marked by a slow recovery from the Global Financial Crisis in 2008, with austerity measures impacting public services and the welfare system (Office for National Statistics 2022a). England UK saw increased attention on issues such as immigration, healthcare, and housing (ibid). In 2016, the Brexit referendum, a pivotal moment in the UK's relationship with the rest of Europe, revealed deep divisions within British society and led to years of political uncertainty (Office for National Statistics 2022a).

The Conservative Party also dominated this period, with four electoral victories and three Prime Ministers. The socio-economic-political landscape was also influenced by global trends, including technological advancements and the growing importance of environmental sustainability (Emmerson et al. 2024).

The socio-economic landscape during the COVID-19 pandemic was marked by significant challenges. The pandemic prompted a historic shock to the economy, exacerbated by rising unemployment, especially in sectors like hospitality, retail, and travel (Office for National Statistics 2022b). The UK Government also implemented support measures such as the Furlough scheme and business grants, but these were not equally distributed within society, further widening inequities between the rich and poorest communities (Emmerson et al. 2024).

The NHS also faced unprecedented strain during the COVID-19 pandemic, causing significant delays in non-COVID related services and exposed deep-rooted health and racial disparities (Blundell et al. 2020). Mental health issues rose to exceptional levels, attributed to the effects

of lockdowns and the impact of social isolation (Emmerson et al. 2024). Education was also severely disrupted by school closures and the move to online learning, disproportionately affecting students with limited access to digital tools and poor digital literacy (Reece et al. 2023).

6.3 Overview of research setting

The IMD illustrates that the city where this study was conducted, is relatively deprived (Southern England City Data Observatory 2019). Based on the average deprivation rank of its neighbourhoods (Lower layered Super Output Areas), the city ranked 55th (where 1st is the most deprived) out of 317 local authorities (Southern England City Data Observatory 2019). The city is more deprived than comparator cities such as Bristol (82nd), Leeds (92nd) and Sheffield (93rd) (ibid). It has 19 LSOAs within the 10% most deprived in England and one in the 10% least deprived (ibid).

Deprivation and inequalities between residents and neighbourhoods are significant across the city, impacting levels of crime, antisocial behaviour, and poor psychosocial health (Southern England City Data Observatory 2023c). Economic growth was relatively steady prior to the COVID-19 pandemic (Southern England City Data Observatory 2024a). However, the city's characteristics relating to poverty and deprivation continue to present significant challenges and are in common with other urban cities across the country (Southern England City Data Observatory 2019)

A report on the health and wellbeing of women and children living in poorest areas of the city from 2019-2021 (Southern England City Data Observatory 2024a), revealed a concerning disparity in life expectancy - women living in the most deprived areas lived on average 4.3 years less than those from more affluent areas. Chronic conditions are also more prevalent among women living in these areas, compounded by structural issues affecting health literacy, trust, access, and use of healthcare services across the city (ibid). Approximately 20% of children live in low-income households across the city, facing challenges such as poor housing, debt, and food insecurity (ibid). Educational disruptions due to school closures and the impact of remote learning during the COVID-19 pandemic, adversely affected children's education and social development, especially in deprived areas (Southern England City Data Observatory 2023b). Grassroots community organisations provided additional essential support for families through the pandemic, with services like food banks and social support initiatives (King-Hicks and Michael 2021).

The proportion of pregnant women smoking at booking is 16.9 times higher for those living in the most deprived areas compared to those living in the least deprived areas of the city (Southern England City Data Observatory 2023a). In the city, 8.9% of women are smoking at time of delivery (Southern England City Data Observatory 2024b). This percentage gives the city the 6th highest prevalence amongst its comparators and is similar to England average (8.8%) (ibid). In 2018-2021, one of the most deprived areas had the highest prevalence of smoking at time of delivery, with 22.7%, while one of the least deprived areas had the lowest 4.4% (ibid). In 2019, the Integrated Care Board (ICB) for the city commissioned maternity services to develop a midwifery-led smoking cessation services, which saw a reduction in the prevalence of women smoking at time of delivery and continues to do so today (King-Hicks and Michael 2021).

Premature births are often analysed alongside smoking data to monitor the impact of smoking cessation interventions. While the city had a significantly lower rate of premature births than the rest of England - 70.6 per 1,000 live births compared to 77.9 in 2020/21 - it has been steadily increasing (Southern England City Data Observatory 2023a). Additionally, childhood obesity, which is more prevalent in deprived areas, poses a serious public health issue due to its association with persistent adult obesity and related health problems (ibid). Efforts to reduce smoking in pregnancy and address childhood obesity, particularly in underprivileged communities, are essential for improving health outcomes across the city.

6.3.1 Overview of the perinatal women who participated in the research

Most of the perinatal women who participated in this doctoral study experienced multiple, intersecting traumas and structural inequalities. These included ACE's, socioeconomic inequalities, and gender-based discrimination and violence. Nine out of twenty-three perinatal women lived in the poorest areas of the city (IMD 1-2) and eleven women lived in IMD 3-4 neighbourhoods. There was an interesting cohort of three participants who lived in areas of relative wealth (IMD 5) (Southern England City Data Observatory 2019). Through a relationship breakdown, one woman had been pushed into poverty through job loss. This participant was now in receipt of benefits and looking to move out of the area due to rising housing and living costs, however had found it difficult to find a private landlord who would accept housing benefits. The two other women formed an interesting sub-group. Unlike some participants, they were cared for by MCoC midwives, not due to living in areas of socioeconomic deprivation, but due to complex trauma and mental health histories. This highlights the pervasive nature of trauma in society and demonstrates that trauma can transcend social class

boundaries. These women were considered sufficiently 'at risk' enough to require MCoC care regardless of their relative social position and household income.

Another notable subgroup in this study comprised ten participants who were homeowners, with most residing in IMD 1-3 areas. At first glance, home ownership is typically associated with higher household wealth, social mobility, and better health outcomes (Clair and Hughes 2019; Crisp 2020). However, in 2018, the Joseph Rowntree Foundation reported that half of all households in poverty in the UK are homeowners (a third once housing costs are considered). Moreover, pathways into ownership and the conditions under which these women sustained mortgage commitments revealed that housing tenure alone is a crude and potentially misleading proxy for material wealth (Reis 2019). In this doctoral study, most of the women who were homeowners experienced low-paid work, discriminatory maternity policy environments during the COVID-19 pandemic, rising inflation, low statutory maternity leave pay, and elevated mortgage costs (Maternity Action 2025). These dynamics collectively undermined women's financial stability and exacerbated mental health issues, therefore challenging assumptions that ownership equates to socioeconomic wealth and prosperity across all domains of health and wellbeing (ibid). The ten participants in question were still eligible to participate in the study by the very fact they were receiving MCoC, and therefore it was considered paramount to include them and their perspectives in the study.

Participants reported two predominant strategies for achieving ownership. For example, four participants moved into lower-income areas within the city and bought ex-council houses, where affordability was possible due to historical right-to-buy pathways (Maternity Action 2025), or relocated in order to access local Help-to-Buy schemes in new housing developments outside of the city (Reis 2019). Both strategies involved compromise. For example, participants described a lack of local services such as shops, pharmacies, restaurants, social networks, and employment opportunities.

The majority of the perinatal women described themselves as White British (n=20). Two women described themselves as British Asian (n=2) and one woman as Black African (n=1). The majority of women were multiparous (n=18), and five women were primiparous (n=5).

Figure 11 depicts the Lower layer Super Output Areas (LSOAs) of the city, which are made up of groups of Output Areas (OAs) and the corresponding IMD scores. LSOAs comprise of between 400 and 1,200 households and have a resident population of between 1,000 and 3,000 persons (Office for National Statistics 2024).

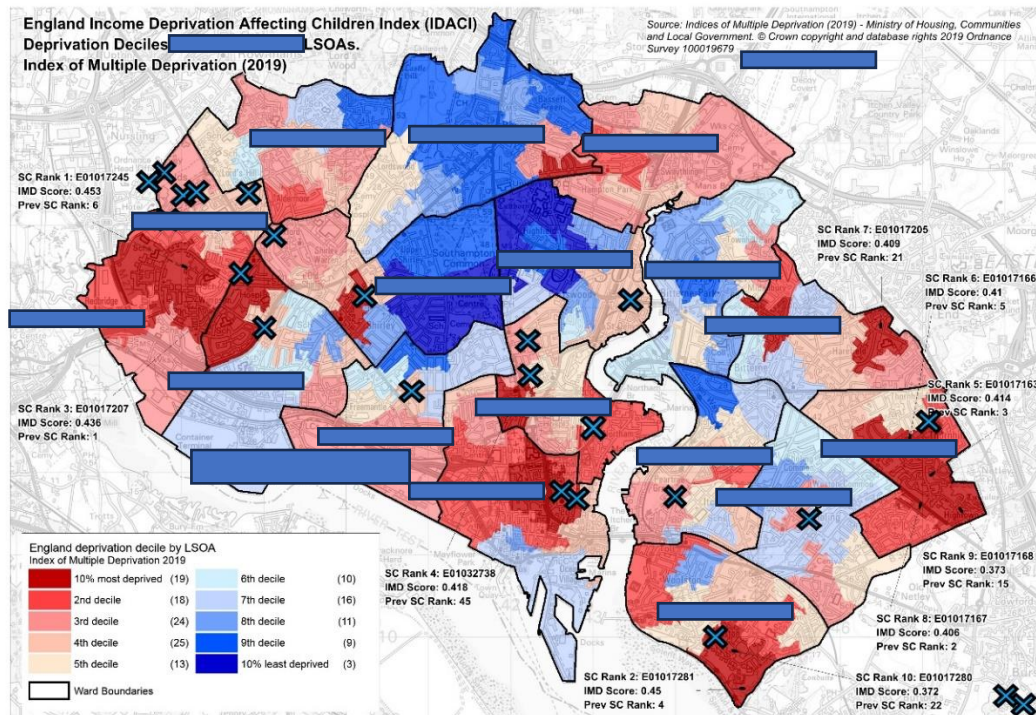


Figure 10. Spread of participants by Index of Multiple Deprivation

The demographic characteristics of the perinatal women who participated in the study are presented in Table 7.

Table 7. Demographic characteristics of the perinatal women who participated in the study

Demographic characteristics of the sample of perinatal women	n = 23
Age	
18-24	1
25-29	10
30-34	10
≥35	2
Level of education	
Secondary school only	11
Completed college	7
Completed university	5
Ethnicity	
White British	20
British Asian	2
Black African	1
Citizenship	
UK citizen	22
Seeking asylum	1
Parity	
Primiparous	5
Multiparous	18
Index of Multiple Deprivation Decile (IMD, 2019)	
1 st and 2 nd	9
3 rd and 4 th	11
5 th	3
Number of social risk factors disclosed	
1	3
2	5
3	2
4	1
≥5	12
Adverse Childhood Experiences disclosed	
Yes	11
No	12
Adult traumatic stress	
Yes	22
No	1
Pre-existing mental health problem	
Common	16
Severe	6
Marital status	
Single	6
Cohabiting	4
Married	11
Separated and/or divorced	2
Occupation classification (National Statistics Socio-economic Classification) (Office for National Statistics 2020)	
L14.2 (long term unemployed and in receipt of benefits)	9
L13 (routine occupations)	3
L12 (semi-routine occupations)	9
L3 (Professional occupations)	2
Housing tenure	
Renting – social housing	9
Renting – private sector	4
Homeowner	10

Table 8 details all participant I.Ds and associated pseudonyms for this group.

Table 8. Participant I.D and pseudonym for participants in the perinatal women group

Participant I.D	Pseudonym
P001	Adrienne
P002	Cathy
P003	Jeanette
P004	Vera
P005	Michelle
P006	Myra
P007	Misha
P008	Millie
P009	Sarah
P010	Poppy
P011	Imogen
P012	Robyn
P013	Beatrix
P014	Lois
P015	Angela
P016	Kellie
P017	Claudia
P018	Ruth
P019	Withdrawn from the study
P020	Iris
P021	Amelia
P022	Harriet
P023	Fatima
P024	Mavis

6.3.2 Overview of the midwives who participated in the research

Thirteen midwives participated in this study. All of the midwives were either currently working in one of the three MCoC teams or had previously worked in one of the teams. Other participants in this group were in leadership and managerial positions that supported the wider functions and governance of the MCoC teams. The decision not to provide any further details about the participants was made to preserve participant anonymity. All participants were allocated a participant ID and assigned a random pseudonym. Basic details are provided in table 8.

Table 9. Characteristics of midwife participants

Participant number	Pseudonym	Current employee
PM001	Dana	Yes
PM002	Bella	Yes
PM003	-	Withdrawn from the study
PM004	Denise	No
PM005	Karla	Yes
PM006	Ruby	Yes
PM007	Jane	Yes
PM008	Amanda	No
PM009	Fife	Yes
PM010	Gemma	Yes
PM011	Melanie	Yes
PM012	Natalie	Yes
PM013	Georgina	Yes
PM014	Samantha	Yes

Prior to 2016 the community-based MCoC teams operated exclusively within the most deprived neighbourhoods. However, eligibility criteria also incorporated an intersectional perspective, recognising that deprivation often intersects with other forms of inequality, such as ethnicity, migration status, and complex social factors. This comprehensive approach reflected a nuanced understanding of the community's needs and the complexities of social inequalities. Teams were mostly based with local Family Hubs, working closely with family support teams, health visiting teams, and other health and care professionals.

To manage demand and capacity and increased inequalities across the city, the MCoC model was redesigned by the local NHS Trust in 2017. The adapted model shifted focus to a needs-based assessment, rather than targeting resources in the most deprived neighbourhoods. This change aimed to address the needs of more women and their families, recognising the social gradient in health and the way inequalities affect people across all levels of society (Marmot et al. 2020a). In 2019, senior management at the NHS Trust asked the MCoC teams to expand their eligibility, to include caseloading for homebirths. This was presented as the only way to drive up homebirth rates in the region and to generate enough data for a business case for a dedicated homebirth team. This move which was met with differing levels of support and enthusiasm from staff.

The following year, the COVID-19 pandemic presented unprecedented challenges. The MCoC teams were soon managing in excess of 50-60 women per midwife, as midwives were asked to provide MCoC for all GEM women on top of their existing caseloads, without any additional

recourses. This ultimately compromised the core principles of MCoC. Additionally, once protected from being part of the escalation policy during times of high activity, MCoC midwives also started to get called into the hospital during escalation. This significantly impacted staff morale, led to burnout, and prevented the teams from being able to cover intrapartum care for women in their caseloads.

By 2023/24 there was a gradual return to geographically based teams in line with the evidence base and the principles of Proportionate Universalism (Marmot et al. 2020a; Marmot et al. 2020b; NHS England 2023e).

6.4 Reading the findings

Table 10 summarises the main transcription conventions applied to the interview data and used in the presentation of quotes in the subsequent chapters.

Table 10. Symbols used within direct quotations

Symbol	Meaning
(.)	One second pause
(..)	Two-second pause
(...)	Three-second pause
[...]	Used at the beginning of a quote, indicates that part of the original text has been omitted for brevity
Bold	Spoken loudly
<u>Underlined</u>	Spoken with emphasis
P001-P024	P = participants from the sample of perinatal women
PM001-PM014	PM = participants from the sample of midwives

6.5 Conclusion

This chapter has provided an overview of the wider socio-cultural-political context in which this research took place and introduced the participant groups, including the nature of the midwives working contexts before and during the COVID-19 pandemic. The next two chapters will present the findings from interviews with the perinatal women and midwives who participated in the study.

Chapter 7. Research findings from interviews with perinatal women

7.1 Introduction

The previous chapter provided an overview of key demographic and contextual data related to the participants in the study and the wider socio-cultural-political context in which this research took place. This is the first of two findings chapters that will present the main theoretical categories developed from critical analyses of interviews with twenty-three perinatal women and thirteen midwives. This chapter will predominantly focus on findings from interviews with perinatal women, while weaving in midwives' narratives where appropriate to expand on key ideas.

Interviews with perinatal women explored their daily lives during the COVID-19 pandemic, their experiences of having a baby during this time, and their experiences of receiving MCoC. Questions about the SDoH were framed as 'what issues have affected your daily life during the pandemic'? This language was considered to be more considerate and straightforward, as opposed to framing questions specifically around poverty and/or social complexities.

One of the most important findings in this study was that most women (22/23), regardless of which IMD they lived in, discussed having experienced traumatic events at some point in their lives. Some participants also experienced myriad social complexities during their pregnancies. Participants' conversations were peppered with stories of human survival, amongst stories of hope, joy, and triumph in the face of adversity. Women's lives were also shaped by a constellation of intergenerational and structural inequalities, which had a cumulative and weathering effect on their health and wellbeing. Moreover, the COVID-19 pandemic introduced additional, unprecedented complexities. For example, some women reported an increase in intimate partner violence and abuse (IPVA) during national lockdowns, pregnancy and maternity discrimination in the workplace, housing and income insecurity, and difficulties juggling home schooling alongside their other responsibilities. Some women also reported feeling traumatised by the introduction of regressive maternity policies that prevented them from having the support of family and friends during their maternity care (discussed further in [Section 7.4](#)). This included stories of receiving difficult news and experiencing pregnancy losses alone.

7.2 “Sucking it up and getting on with it” – the survival-based adaptation of perinatal women who have experienced trauma and social complexities

Overall, analysis suggested that in order to cope with what life had thrown at them, women in this study had developed self-preservation strategies to help them survive. This coping strategy has been coined ‘*sucking it up and getting on with it*’ and is presented as the first theoretical category. Moreover, it is grounded in women’s nuanced stories of how they survived historical interpersonal attachment traumas, as well as navigating further traumatic life events. Analysis of women’s interview data suggested that being in this survival mode not only impacted their relationships but also seemed to contribute to a high prevalence of mental and physical health issues amongst participants. These findings have important implications for the delivery of MCoC models and may help to identify interventions suitable for perinatal women with trauma histories.

This research did not set out to explore women’s childhoods, however, around half of participants (11/23) revealed they had been subjected to Adverse Childhood Experiences⁶ (ACEs). Women reported stories of interpersonal attachment traumas, including being subjected to parental physical and sexual abuse, abandonment, and acts of omission such as, parental neglect. These insights became an interesting point of departure for the development of the ConGT. With this in mind, in Section 7.3, the chapter will start with a presentation of the ACEs women disclosed, followed by an examination of the COVID-19 pandemic and the SDoH that shaped women’s lives, in Section 7.4. In Section 7.5, the explores how trauma and the SDoH appeared to impact women’s health and wellbeing, including stories about their intrapartum and postnatal experience. Section 7.6 summarises the chapter and introduces Chapter 8. The rationale for this format is to ascertain the contexts and conditions that shaped women’s lives prior to pregnancy, before exploring what women faced in their pregnancies.

A visual representation of the main categories that will be discussed in this chapter are presented in Figure 12.

⁶ Adverse Childhood Experiences - ACEs are potentially traumatic events or circumstances occurring before the age of 18 that have been shown to increase the risk of adult mental health problems and disease. Such traumatic events may include - psychological, emotional, physical, or sexual abuse; violence against mother; or living with household members who were substance abusers, mentally ill, suicidal, criminal or imprisoned. Maltreatment (child abuse, sexual abuse, neglect, bullying, etc.) causes chronic stress that can disrupt early brain development, and the development of the nervous and immune systems (Asmussen et al. 2020; American Society for the Positive Care of Children 2022).

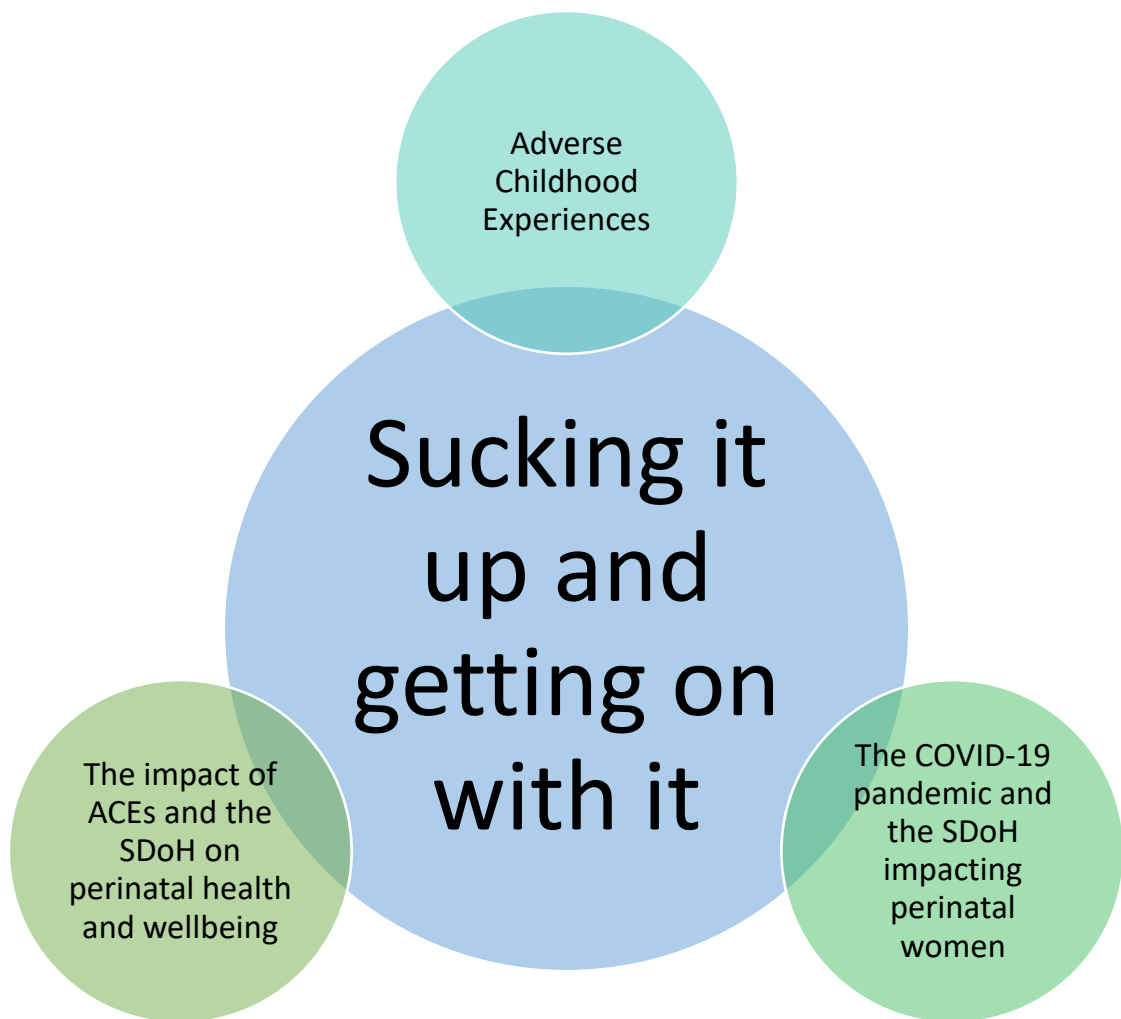


Figure 11. The main categories shaping the development of the survival-based adaptation, '*sucking it up and getting on with it*'.

7.3 Adverse Childhood Experiences

Eleven women told me fragmented stories of the ACEs they had experienced at the hands of their family; however, it is likely their stories were '*just scratching the surface of the complexities*' (PM008) women faced. Analysis suggested that women had learnt to '**suck it up and get on with it**' from an early age, whereby navigating the fragility of their family attachment systems was the norm. Two participants, one who experienced the death of her mother in childhood (P010) and the other, whose mother abandoned her as a child (P021), described their mental fragility in the postnatal period. Both women's narratives suggested

they dissociated with their realities - possibly as a way of coping with their traumatic births, but also possibly as a result of their own childhood traumas resurfacing when they became mothers themselves. Both women explained how they felt disconnected from their realities:

"I was so fragile, mentally, I couldn't deal with it, I used to detach myself" – Poppy P010

"I just felt kind of lost, I just, it just felt foggy" – Ameilia P021

My interview with Poppy (P010) revealed further insights into the ACEs she experienced and the relationship she experienced with her midwife. Not only did Poppy's mother die when she was three years old, her father was convicted of child sex offences and spent time in prison. Poppy described her whole childhood being 'rocked' by these experiences. Poppy went onto be separated from her siblings and placed into multiple foster care placements. When I affirmed '*I bet that meant a lot (to you)?*' in reference to the nature of her relationship she had with her MCoC midwife, without probing, Poppy went onto explain why this trusted relationship meant so much to her:

*"It meant so much to me, it did, because I was in and out of care, I don't have family, my Mum died when I was three [...] my Dad was in and out of prison for paedophile offences of some girls at my school and that just rocked, like my whole childhood. **And it was in the papers and then they put me in care**"* – Poppy P010.

I could hear the sadness in her voice as she relayed her story. The fact she no longer had a family, implied how betrayed she might have felt as a child and how this had manifested in her current reality. In order to cope with the reality of her past and be in a position to move forward with her life, Poppy seemed to draw upon her imagination and created a new narrative about her family - one where they no longer existed. This may well have become part of the way she coped with what she experienced as a child.

Like Poppy was, children who experience repeated interpersonal traumas are especially vulnerable, as they are unable to escape the people and circumstances that cause them harm (van der Kolk 2014). In order to survive their circumstances, children can learn to dissociate from their bodies and their lived realities (ibid). Early interpersonal traumas, like those experienced by some of the women in this study, can cloud perceptions and self-experience of the world, and are known to have a profound impact health and wellbeing across the lifecourse (Walker-Mao et al. 2024).

The eleven women who reflected on their childhoods appeared to show that the effects of their ACE experiences still shaped their present lives. Moreover, these participants had known mental health conditions, but services did not appear to be meeting women's needs in terms

of providing the level of trauma-focused care they deserved (discussed in detail in section 8.5.1). For example, in the year leading up to Poppy's (P010) most recent pregnancy, she recalled how uncontrolled her anxiety had become. She also talked about having multiple investigations due to experiencing shortness of breath and palpitations. Rather than making a holistic assessment and considering the evidence on the relationship between ACEs and health in adulthood (Johnson et al. 2023), Poppy's GP dismissed her and made her feel like the symptoms were all in her head:

"[...] I used to wake up with anxiety and go to bed with anxiety and it's not just anxiety, it's panic attacks, my pulse would constantly go at 160-200 beats per minutes. Then the GP was like, "oh, it's in your head," and they just kept telling me that it's in my head and I said, "no it's not!" So, they took me off the medication for a couple of weeks, it went away, then they put me back on it – it's like I'm a guinea pig" – Poppy, P010.

Poppy's life was once again 'rocked' when her long-term partner absconded from the family home, leaving her to look after their first-born daughter alone. Poppy discovered he was having an affair and confronted him and the other woman whilst out for a walk during the first COVID-lockdown. The altercation led the other woman to attempt to stab Poppy with a knife, whilst her ex-partner looked on. Escaping danger, Poppy's nuanced storytelling suggested she felt abandoned and overwhelmed; emotions which she also likely experienced as a child. Furthermore, Poppy seemed to shift between states of valorising her own independence and capacity to tolerate such levels of adversity, whilst also simultaneously longing for the safety and comfort of a trusted partner. As this was not possible, Poppy had no other option but to try to hold things together for her daughter and her unborn baby:

"[...] And with everything I've had going on...I'm trying to hold down the household and the whole time with being pregnant and everything, like I went through crying to anger about what happened, but then I also feel proud of myself..." - Poppy, P010.

Two other participants whose mothers also died when they were children, discussed their struggles. Lois (P014), a mother of five children, was a teenager when her mother died. The experience of losing her mother after the birth of her first child was a defining moment in her life:

"[...]I had post-natal depression with Nelly. It wasn't diagnosed through the doctor, but my Mum could see it, and – because I just didn't bond with Nelly straight away, it literally took for my Mum to pass away for my sister to then say to me, "right you need to buck up your ideas, Mum's now passed away, you need to bring your daughter up yourself" – Lois, P014.

Another participant witnessed the death of both of her parents and had to grow up fast in order to support herself:

"[...] I lost both my parents at the age of about eleven years. So, I finish urm junior high in my village and then I moved back to the city, yeah, where I worked as a house help or nanny, domestic servant...it was hard" – Mavis P024.

Other women also reminisced about the relationship they had with their mothers as children, whilst also reflecting on this relationship dynamic as adults. Women's stories brought into focus the level and complexity of trauma experienced by some of the participants and the impact these experiences continued to have in the present day. Couched within their narratives were memories of child abandonment, domestic violence, and grief. Robyn (P012) blamed her mother for not '*seeing*' the abuse she suffered at the hands of her ex-stepfather and for not intervening, '*I don't think she'd done enough (for me) as a parent kind of thing*'. Robyn's memories of the abuse made her even more determined to do things differently for her own children. Robyn reflected on her experiences and the difficult relationship she had with her mother:

"[...] so, it's been up and down, like my Mum, I'm not as close with my Mum as I am with my Dad's side because obviously...urr, there was a lot of problems growing up, I don't think she'd done enough as a parent kind of thing. Urm...we do, we have improved in that, but we've had our moments...I mean it all got brought up in other places as well, but it ended up with her getting mad at me and not talking to me for like six months. [...] she just doesn't see things, I think, like I do" – Robyn P012.

Moreover, Beatrix (P013) reflected on how she used to hide from her parents when she was a child to escape their arguments and explained she felt closer to her Dad now, suggesting she held her Mum accountable for some of her unmet needs as a child:

"I had quite a difficult childhood, my parents were going through a divorce and so there was just a lot of tension between the two of them, so I just kind of kept them at arm's length and hid rather than be around the tension. So, I'm a lot closer to my Dad than I am to my Mum, so he was there for me more than my Mum ever was" – Beatrix P013.

An interview with Ameila (P021) revealed the imprinted damage of maternal abandonment over the lifecourse. Amelia's mother walked out on her when she was a child and her account of this demonstrated the impact ACEs could have on new mothers. New mothers are particularly vulnerable and benefit from having the support of their attachment systems and social networks to help them recover and settle into motherhood (Refaeli et al. 2024). Additionally, Ameila had a traumatic first birth and this story signalled to me how important it is for women to have agency and control over their birth experiences. Unfortunately, Ameila developed what she referred to as a '*post-traumatic stress disorder type thing*' in response to her traumatic birth. Ameila's narrative and tacit meanings suggested her birth may have been retraumatising for her, as she referred to experiencing some of the same emotions she had

also felt in childhood. The consequence of this was that felt shutdown and her mental health declined as a result:

"[...] one of the reasons I was involved in social services is that I don't have a mum myself, she left when I was a child. And I guess there's a lot of...you know that ended traumatically...there wasn't...my partners mum came up a few times at the beginning to help after the birth, but you know there wasn't...I don't know, I just felt kind of lost in those early days. I just, it just felt foggy, I wasn't right...I had no idea what to expect, it had all kind of ended quite traumatically and I guess I didn't feel like there was anyone to talk to, a bit like I felt as a child and yeah, I went a little bit mad" – Ameila, P021.

After this interview I memoed about the emergence of birth trauma as a sensitising concept, as detailed in Figure 13. This provided another frame of reference in the analysis and the development of the ConGT.

Reflective memo about ACEs and its impact on women's self-experience as mothers in the early postnatal period

I need to revisit my codes about childhood trauma and more specifically about women who grew up without their mothers. In Amelia's (P021) interview she describes the impact of her Mum leaving her as a child and not having her support in her own transition to motherhood. This traumatic experience played out in her experiences and memory of birth and the postnatal period. Adjusting to life as a mother and the difficulties this exposed had a profound impact on Amelia's mental health, her sense of self, and her relationship with her baby. She seemed to long for her Mum to be there with her on this journey, but the reality was somewhat different, contributing to her feeling 'foggy and lost' for some time. It seems as though she shutdown, triggered by her traumatic birth and worsened by sleep deprivation. I wonder how other women with childhood trauma have talked about their birth experiences and what impact this had on them postnatally? Were their trauma's recognised by them, their MCoC midwives - are services trauma-informed and what does this look like in practice? What was the system's capacity to meet women's needs during the COVID-19 pandemic?

Memo written on – 13/02/2021

Figure 12. Reflective memo about ACEs and women's self-experience in the early postnatal period.

7.4 The COVID-19 pandemic

At the time of data collection for this research, England was in its second national lockdown. Inevitably the topic of the COVID-19 pandemic emerged as a core theme across all of the interviews, including what women thought about the pandemic, the potential risks of the virus, and how being in lockdown had affected every aspect of their daily lives. Analysis suggested that families were coping with relentless complexity, in a constantly shifting landscape. For some women, COVID-19 *'completely changed everything'* (P011), enduring the unprecedented nature of it all *'literally killed'* (P022) some women and their families. Other women suggested it was yet another thing for them to deal with, *'it's just another thing to be anxious about, isn't it?'* (P021). The long-term impact of having a baby and the experiences of being a mother during the COVID-19 pandemic are yet to be fully understood, however the following excerpts demonstrate the fear and hysteria women experienced as a result of the unknown consequences of the pandemic:

"[...] and the first time it came around it was like, all these...all these people are going to die, it's like the plague. They made it really scary the first time around I was so, so scared. Like people were dying all the time of this COVID, no one knew nothing about it..." – Poppy, P010.

"It's just, you know it has been horrendous for thousands, and thousands, and thousands of people, and...you know it's; I would give everybody a medal if I could because it's been so crap. And there is no right or wrong answers you know, it is what it is, and you know, on good days you sit there, and you go, "do you know what there's nothing I can do about it, I've just got to suck it up," but it doesn't stop you from feeling crap on the bad days" – Claudia, P017

"[...] well, the pandemic was, because having anxiety before, it's just another thing to be anxious about, isn't it? Whether that is...the virus itself or the impact that that then has on all of your decisions...so, for someone who's prone to spiralling anyway...it massively impacted me" – Ameila, P021.

Often women's responses suggested how isolated they felt having had to spend their maternity leave in lockdown. The following excerpts demonstrate how different their realities were:

"[...] I was getting upset with because I wanted to spend some time with friends and obviously being, you know a baby, obviously yes you want to spend time at home – but you also want to spend time with friends as well" – Adrienne, P001

"I was really looking forward to maternity leave and being off again and being able to see them (friends) for a Monday and I've not been able to once; we've not had one at all. I'm going to end up going back to work having not seen any of those people...I've missed that social side of it..." – Amelia, P021.

Multiple concerns were expressed about the impact lockdowns were having on their babies developmental milestones. Women felt as though their children were missing critical social

interactions, which are crucial for an infant's cognitive, emotional, and physical development in the first 1001 days (Best Beginnings et al. 2020). For example, some women felt their 'lockdown babies' (P007) had become scared of seeing other people:

"and that's kind of the horrible thing in the way, now they don't want to go near other people, it's sad. But...hopefully you know, they will, you know, learn at some point not to be scared..." – Beatrix, P013

"I am gutted that she's missing out on so much...I'm really conscious that I don't want, you know a scared baby...she needs to be like her Mama, she needs to be strong..." – Harriet, P022

Amongst other things, women also seemed particularly concerned about their children's development:

"[...] It's been tough...it's been actually okay, it's been okay, it's just more of the... with the baby I haven't actually...he hasn't really seen many people which is concerning for his development..." – Fatima, P023.

Sometimes women were confused about the logic of some of the social distancing restrictions and the impact these had on their children:

"So, I just can't grasp how it can be okay for him to go to nursery with thirty children, but he can't go to a swimming lesson with three other children in a massive pool. I think that's the hardest thing. But I feel that he's missing out..." – Vera, P004.

Women were also fearful of being outside even if the risk of transmission was low:

"But going to parks and so on, even though everyone is going, it still feels like a risk. It's such a big risk, should we or should we not?" – Fatima, P023.

Other pregnant participants discussed how confusing it was to receive conflicting advice and opinions from their family:

"[...] I had my in-laws going, "you have to be stuck in doors, there's a virus," to my parents going, "no you need to have exercise, let's get you out!" So, I had two really different (views)..." – Imogen, P011.

Interestingly, a few women who gave birth before our interviews took place, were surprised at how well they had adjusted to the 'new-normal' (P002; P013) of lockdown life. The second lockdown gave some families an opportunity to spend time together they would not normally have had after birth:

"[...] It hasn't impacted me too much, I had Tessy just before (2nd) lockdown so it's been lovely to be able to spend the time at home with both my girls and my partner being able to be more present...it's been hard not being able to see family and spend time socialising with Tessy whilst on maternity leave - but we try to think of the positives and those being that we've not been ill and been able to spend time together" – Myra, P006.

"[...] it's just been actually really nice just being home, not faffing about to make appointments, not faffing about to meet so-and-so" – Fatima, P023.

Parenting responsibilities and domestic chores seemed to be shared more equally in some households and women also sensed that together as a family was having a positive impact on their other children:

"[...] Reggie as an individual is a lot more relaxed than Jack was, so I think the kind of postnatal experience has been less, less traumatic as well this time around...you know it's felt like a much nicer easing into our changing family dynamic than the first time around" – Cathy, P007.

Another participant, Claudia (P017), felt her mental health would have suffered if it had not been for the support she received from her partner being at home:

"[...] it has made a huge impact on being a Mum in the first year. We've missed out on a lot, my kids have missed out on a lot, and it's been so hard. And if it wasn't for the fact that my partner is incredibly supportive, I don't think I'd have, I'd have made it through with my mental health intact if I'm entirely honest" – Claudia, P017.

Conversely, two women who separated from their partners during the pandemic, detailed the sadness they felt about being left to parent alone:

"[...] he's supposed to be there; he's supposed to be there for me and our children" – Poppy, P010

"[...] 'I expected him to be a little bit nicer to me and our daughter and look after us, but he never did...'" – Mavis, P024.

Another participant, who was a mum of five children, lived separately to her partner and faced considerable difficulties when she was taken ill in pregnancy. A family support worker who supported Lois (P022), advocated for the children to remain in school but things were difficult:

"It was hard because you know he'd call us, yeah, you know on a daily basis, but it was just more so, I couldn't get that physical support from him...it was so difficult, because at one point I couldn't even Hoover, because I was just so bad, I couldn't even stand up for that long. So, but yeah it did play a big bad role" – Lois, P022.

Lockdown provided other women with the opportunity to end their relationships. Beatrix (P013) did not live with her husband when the first lockdown was imposed, which gave her a window of opportunity:

"[...] it was actually lockdown that prompted me to end the marriage...he is very controlling...it gave me that kind of backup to say "I don't want – I can't see you"...so, lockdown for me, it's been tough, but at the same time it's been a blessing, a complete blessing because it gave me that kind of boost, you know" – Beatrix, P013.

7.4.1 'Juggling everything was really hard'

Women with school-aged children were more likely to discuss how they felt about the excessive demands placed on them to 'juggle everything' (P008). Women were generally shouldering the majority of the responsibilities to homeschool their children, whilst also looking after their younger children and/or their new babies. Women's narratives suggested the extent of the complexity they faced trying to juggle everything:

"[...] it's hard as a parent to try and you know, deal with your own anxiety about certain things, and then also try and make everything seem completely normal for a child" – Beatrix, P013

"[...] so, my daughter is going to school still, but my son has lots of home-ed activities that I need to take him too, and I just couldn't, I couldn't do it at all, that was a really, really tough one..." – Ruth, P018

"Even though I put on the happy smile, and I think everyone just sees the happy smile, everything's kind of organised at home, but really it's just so tiring..." – Fatima, P023.

One participant, who became unwell during her pregnancy, expressed the guilt she felt over her daughter having to help her around the house. She remembered how it felt when she had to care for her sick mother as young child:

"[...] so, she was like a little carer, but I didn't want to put all of that on her, because she's only, she was only like, well she was twelve at the time...I didn't want Nelly to be in the same sort of position of what me and my siblings were in when we was younger, but we didn't have any other help" – Lois, P014.

7.4.2 Support bubbles and friendships

As lockdown measures eased towards the end of the first lockdown, the introduction of 'support bubbles' including 'childcare bubbles', provided some eligible families with the opportunity to share childcare with another household (Department of Health and Social Care 2020a, 2020b). This was welcome news for everyone, but especially for women who lived on their own with their children:

"[...] I have my friend...who's also my boss as well, so he's my support bubble, it just makes sense because then I can see him for work and social so..." – Beatrix, P013

"It's been really tough because...I'm a single parent and with the lockdown and everything, I just felt that it really had, had a knock-on effect on the experience that I've experienced as a new parent...when I came out of hospital the right decision was to go back to my parent's house for a few weeks to recover and to get the extra support" – Harriet, P022.

Being in lockdown encouraged a renewed sense of community spirit for some women:

"[...] my friend Magda she's sixty-three, she lives over the road, she's like a surrogate mother to me, she's always there, she would come to the hospital with me and be tested for

COVID and stuff and be there. And my neighbour upstairs is looking after my dog” – Poppy, P010

“I was lucky because urr...my neighbour who I recently started talking to out the window because of COVID and actually started to get to know, she urm offered to drive me to the hospital and wear a mask in the car and stuff otherwise I would have had to get two busses there and two buses back, which I wouldn’t have managed – Robyn, P012.

As the second lockdown was imposed during the winter months some families were in crowded houses, often with minimal options for their own space. This seemed especially difficult for women trying to plan childcare for when they went into hospital to give birth, or when they returned home and had their other children to consider:

“[...] it’s been really tough because you can’t go outside, you can’t, you know, you can’t really do anything and I’m trying to get, you know a time pinned down to have a conversation [with friends]...and even when you do, you’ve got kids screaming in the background and you can’t do anything and you feel like you’re going mad – Claudia, P017

“The benefit of induction I guess was that at least I knew roughly when I was going in, and I could set up a plan. But, yeah, I just didn’t know where to put him...which friends do you maybe go to? Who is willing to put themselves at risk for me?” - Ameila, P021.

Friendships with other women could mitigate the necessity of women having to **‘suck it up and get on with’** life’s stressors on their own. Moreover, other women going through similar situations were especially important for women to feel they could cope. Friendships seemed to be especially important to women who experienced intimate partner violence and abuse (IPVA). Women in these situations had often been gaslighted by their ex-partners, which impacted their self-esteem. Good friendships provided the safety women needed:

“Oh God yeah, they’re always, they’re always telling me, like my friend, like she messaged me, and she goes, “what do you expect from him? He’s been rubbish the last couple of years and you’re trying to hold onto someone who’s not there anymore...he’s not going to change. Which is true, sometimes you just need someone to be brutal with you” - Poppy, P010.

The COVID -19 pandemic forced our main avenues of communication online or on our mobile phones. Women seemed to find some comfort in being able to stay connected with their support networks like this. Some women made new friendships on digital health mobile applications like Peanut™ and MUSH™, which were designed to connect women with other mothers in their local areas. This was a lifeline for some women, as Claudia revealed:

“ [...] I’d signed up to Peanut and MUSH and stuff, and I’d started talking to a lady...and because of lockdown we became really close, really, really quickly, because we were talking all the time. And...we’re very kind of similar in terms of our thinking and being, you know, okay with kind of messaging each other going, “these fucking kids!” - Claudia P017.

7.4.3 Intimate Partner Violence and Abuse – “I’ve been through hell”

Intimate Partner Violence and Abuse (IPVA) encompasses various forms of control exerted by a perpetrator over their partner in an intimate relationship. According to the Centre for Disease Control and Prevention (2024) in the USA, IPVA includes multiple forms of abuse, such as physical and sexual violence, stalking, and psychological aggression (including coercive control) by a current or former intimate partner.

Nine women in this study, six of who also revealed ACE histories, revealed they had experienced male-perpetrated IPVA. All nine women had already separated from their ex-partners and were no longer living with them; however, this did not stop some men continuing to be controlling from a distance. Women reflected on how difficult and isolating it had been for them to live with this kind of abuse whilst being pregnant. One woman, Mavis (P024) described living with her abusive partner as ‘*like living in hell*’, especially during the first national COVID-19 lockdown and that ‘*it was a whole lot to deal with*’. Arriving from Ghana just before the COVID-19 pandemic, Mavis travelled with her daughter to live with her husband and his family. She had minimal contact with anyone outside of the family home, so the abuse went on unnoticed until the news of another pregnancy increased the abuse. Mavis explained that one day, her husband drove her and their daughter to the nearest train station and abandoned them. The desperation she must have experienced in that moment was clear:

“[...] yeah, it was a whole lot. So, from there, I didn’t know where to go to. And then, when he drop us at the city centre...somewhere I don’t even know, we comes to this country when it was a pandemic you see, so I don’t really know anywhere...so, I stood there for ten or about fifteen minutes, I don’t know what to do, I didn’t know where to go to” – Mavis, P024.

Being abandoned in an unfamiliar place, Mavis was in shock. However, her survival instincts propelled her into action to seek a place of safety for her and her daughter. After approaching a stranger in the street for some help, she was directed to the local police station. She disclosed what had been happening to the police, only for the police to call her husband - the perpetrator of the abuse - rather than to call social services:

“[...] it started raining, so I struggle with my luggage...we went straight to police station. They ask me everything that happened and then I told them everything that has been happening since I was in that house. And then the police started, tried to contact him, and ask him to come and take us home because [daughter] is too small, and we can’t survive on the streets. Yeah, and then he refused to come, he said because I went to police station, he and his family don’t want me around their house” – Mavis P024 .

Analysis of other women’s experiences suggested that not only did women feel unsafe in their homes, but they also felt isolated from the outside world. One woman felt powerless as a result of her situation, ‘*when they’re in your tummy and you’re being abused, you feel*

powerless don't you'? (P013), whilst another woman commented on the secrecy of the abuse she had experienced, 'a whole lot was going on in that house behind closed doors, it was awful' (P020).

Other women revealed how their ex-partners continued their abuse after their relationships had ended. Women who shared these stories also reported being accused of harming their children, chased by debtors, being referred to Children's Social Services, the police, and the family court system. One participant, Sarah (P009) described how her ex-partner, *'picks and chooses'* when he saw their son, despite having a court order in place that specified his terms of access. Sarah decided she would apply to take him back to court, at which point her ex-partner made a malicious referral to Children's Social Services:

"[...] James reported me for apparently abusing Oliver, so they [social services] came out and they did everything that they needed to, they checked everything, police checked everything and there was nothing...but, yeah, he, obviously we've got a court order in place, but it tends to be that he picks and chooses when he actually sees our son...it's not fair on Oliver, it's not consistent, he needs routine...any child needs stability" – Sarah, P009.

Sarah also explained that her own childhood had been tumultuous. Analysis suggested that Sarah's actions may well have been a mechanism to prevent a cycle of generational trauma. Using the family courts was a strategic move in which to safeguard her son from his father.

Other women in similar situations described feeling a sense of guilt about who their children's fathers were. One participant described feeling having to delay leaving her abusive partner as her desire to be a mother was stronger:

"[...] but... it sounds, I guess it sounds really selfish, and I do live with a lot of guilt to be honest, with the father I've given my daughter. But after. After losing Peter, I just, nothing else really mattered to me, and I just... needed to be a mum" – Beatrix P013.

Poppy's (P010) also felt a sense of guilt, which stemmed from how much her ex-partner let their daughter down due to substance misuse and poor mental health:

"[...] he'll just disappear, and then I'll just, and then I'll feel guilty because he's not around for our daughter for a few weeks. It's just, he doesn't see what he's doing. Like she rang him today and he's like, "are you coming around?" And he was drunk, she could hear it, she's got her earphones, she's twelve" – Poppy, P010.

Another woman reflected on her positive relationship with her own father and how concerned she was that her daughter was missing out on this core attachment relationship:

"I have a fantastic relationship with my Dad, I couldn't imagine life without my dad, so to know that my little girl isn't going to experience what I experienced with that, it's really sad. But she's got lots of other key role models around in her life, so..." – Harriet P022.

Abuse could also extended to wider family members. One participant named Robyn (P012), provided insights into what was like living with her stepfather during her pregnancy. Confided to her bedroom to avoid confrontation, she recalled how he hid the keys to her bedroom windows during the peak of the summer, which triggered traumatic memories from her childhood with him:

"I was in like a bad situation living with someone who was mentally, emotionally abusive. Yeah, so like I'd spend most of my time in my bedroom with the door locked or shut, like. And like, I didn't like, have like the greatest upbringing with him anyway, he was so controlling, but we didn't have anywhere else to go so..." – Robyn P012.

Women also shared insights into what their experiences had taught them about themselves. Their responses suggested they were aware of the strength and determination it took them to survive such turmoil, whilst also navigating the complexities of having a baby during the pandemic. Two participants described feeling grateful to have had their experiences. Ending the cycles of abuse and coming out stronger at the other end likely improved their self-worth:

"[...] yeah, that's like, it's like, it's like fate, everything happens for a reason. I never thought of that before but now when you look back in time at situations like... it's a blessing in a way everything that's happened because I don't want to be around someone who's drinking and all the madness or do I want my kids around that? No. I don't, so why do I need to be with someone who wants that?" – Poppy, P010

"[...] although like I've been through a lot, I'm genuinely in a better place now that I could say I've ever been. So, yeah, I'm really grateful to have been through it in a way. Yeah, it's made me stronger, it's made me more confident, it's made me more sure of...what I want really and who I am. So yeah, I can't, I can't regret any of it really" - Beatrix, P013.

Through not living with their abusive partners, women also noticed the positive impact this had on their children's wellbeing:

"[...] she had a lot of speech delay, and then as soon as he had no more contact and she started nursery, she's just come on leaps and bounds, now she won't stop talking. So yeah, she's, she's doing so well, yeah" – Beatrix P013

"So, she always cry, when we are in that house. Always cry, and then she was never happy, I think she was never happy. So, when we left there, I don't think she have any memory of him. [...] but she's very okay now and she look happier" – Mavis, P024.

7.4.4 Housing insecurity – 'It's pretty hard, and the system is flawed'

Housing should be a place of safety and refuge and provide a good foundation for life (Crisis 2021; Desjarlais-deKlerk 2021), however a number of women in this study revealed they faced housing difficulties before and during the pandemic. Sarah (P009) recalled memories of her first pregnancy. She lived at home with her mother at the time as she was sixteen years old when she had her first baby. Unfortunately, this impacted her mother's welfare benefits to the

point that Sarah had to move out and live with at her boyfriend's parents. Sarah spent the first two years of her son's life living with her in-laws. Sarah's lack of agency and control over her life as a young mother, had a detrimental impact on her maternal instincts and her mental health. Sarah explained the severity of living in a controlling household and the impact it had on her experience of motherhood:

"[...] that was horrible. The worst, the worst two years of my life. I couldn't be a parent in that respect, James's, James's parents are very full on and quite controlling, and they take over everything. So... I couldn't be the parent I wanted to be...It's just, yeah, it didn't feel that I could be who I wanted to be at that point, I was trying to be somebody I wasn't – Sarah, P009.

Sarah eventually moved into a flat with her boyfriend, only for this relationship to end. He moved out and left her to shoulder the rent arrears they had run up with their council. This debt was difficult for Sarah to manage whilst living on a low-income. A few years later she had another baby with a new partner and was still trying to clear the debt:

"[...] when he left, it left me with a lot of debt, and I've still got that hanging over me that I'm still trying to clear it. I'm not working, so trying to clear debt and provide for two children and myself isn't the easiest situation to be in" – Sarah, P009.

Despite the difficulty of this situation, Sarah was steadfast in the face of this adversity and was determined to 'suck it up and get on with it' for the sake of her family's future:

"[...] It is just, I think once you've been through such tough times, you've just got to, get up and suck it up you know, get on with things. As much as you didn't want to. You're never going to get anywhere if you don't" – Sarah, P009.

Two women revealed what it was like for them to be made homeless at the height of the pandemic. Robyn (P012) lived with her mother and stepfather, but tensions grew between them, until one day Robyn left with her newborn son:

*"Yeah, eventually it all came to a head when I **refused**, *sigh*, he never used to like pay for his half of like the electric and stuff and I, after I had Dylan I couldn't afford it and I was just like, you know, so then he was like, "well you can get out of my flat then," and I was like, "fine" – Robyn P012.*

Another woman was forcibly removed from the family home by her abusive husband:

"[...] when I told him about the pregnancy, he really get angry and then yeah, and then he joined hands with his brother and sister and they threw me on the streets with [our daughter]" – Mavis, P024.

Navigating the housing system as a single mother was extremely difficult and precarious. For example, Harriet (P022) was trying her best to navigate the private rental sector during the pandemic. In the year before Harriet fell pregnant, she lost her job and ended up living in a hostel. Her mental health declined so much that she attempted suicide and spent time as an inpatient on a psychiatric ward. Receiving support from multiple agencies, Harriet started her

healing journey when she found out she was pregnant. This was a defining moment for Harriet. She was determined to not be temporarily housed by the council with a new baby:

“[...] I don’t want to end up in emergency accommodation, which is then just full of crack heads and goodness knows what” – Harriet, P022.

Of her own accord, Harriet managed to find a landlord that would accept housing benefit - in essence she presented her case to the landlord and secured herself a place of safety. She proudly told me how she orchestrated this and her hopes of finding somewhere better in the future:

“[...] I’m looking at the moment but...because it’s very difficult to find a landlord that will accept somebody on benefits. And as soon as you say, ‘single Mum on benefits’...but they’re just not biting at it. So yeah, it’s pretty hard...And even though my place is small, it’s privately rented, I’m safe, my neighbours are lovely, they’re really supportive so, we’ve just got to ‘suck it up, buck up’ as they say.” – Harriet, P022.

Harriet’s story shines a stark light on the discrimination single mothers in receipt of income benefits can face as they try to secure suitable and safe housing for their families. Her comment, ‘suck it up, buck up’ powerfully illustrates the courage and determination women in this study possessed to survive the adversities they faced.

7.4.5 Workplace discrimination during the COVID-19 pandemic

In March 2020, the then Conservative Prime Minister, Boris Johnson, and the Chief Medical Officer of England, Professor Chris Witty, declared that all pregnant women should self-isolate at home (Bragg et al. 2021). This was swiftly followed by revised advice, that pregnant women should instead be stringent in following social distancing measures. Misleading and changing advice and gaps in official guidance characterised the Government’s handling of the risks COVID-19 posed to pregnant women, resulting in widespread confusion and misinterpretation of health and safety law in the workplace (Bragg et al. 2021).

Some of the pregnant women in this study felt their health and safety were compromised at work, as their employers prioritised their business interests over the safety of pregnant employees. Angela (P015) felt she had little control over her safety at the height of the first lockdown:

“[...] higher management, they were already all at home, even the ones that didn’t have health problems because they’re far more important than us, clearly! And...I was still having to go to work after being told I was going to be working from home...so I was kind of messed around with that...but it eventually happened” – Angela, P015.

Misinformation circulated about the risks that COVID-19 posed to pregnant women and their unborn babies, which resulted in many pregnant women being misinformed about their rights

to income protection through the Government's Furlough Scheme (Bragg et al. 2021). Some women were forced to go on sick leave, take early maternity leave, or even resign from their jobs. This impacted their rights to maternity leave pay and curtailed the length of time many women could afford to take off to look after their babies. Imogen (P011) was initially forced to go on sick leave even though she was well, as her employer received inaccurate information from His Majesty's Revenue and Customs:

"Yeah, it was when, when the treasury said, "no, she's only going to get six weeks sick leave." I said, "I'm not sick, I can't have sick leave. You can't give me sick leave; you shut the church down. I'm not sick. I'm not taking statutory sick pay, because it's...to go on nothing until my maternity starts, that's ridiculous". So, there was a bit of a fight with that..." – Imogen P011.

Another participant felt she had no other option than to leave her job, as her employer refused to let her take Furlough. This significantly impacted her mental health, and she had to claim benefits:

"I was like, do you know what, I'm going to take myself out of that, I'm going to hand in my notice...because if I'm just continuing to be put on sick...so, I just took myself out of that situation. And then I signed, I got put under [mental health services] because I got really bad with my nerves...then they set me up with a Personal Independence Payment (PIP), so now I get PIP as well because of my mental health, as well" – Poppy, P010.

Other women had no other choice than to start their maternity leave earlier than planned. The main reason women gave for this decision; was that statutory sick pay was so low there was no other way to survive. Vera (P004) had to start her maternity leave at 28 weeks gestation as she was too unwell to continue working. Six months into her maternity leave she stopped receiving statutory maternity pay and had to return to work, as she could not afford to have any more time off unpaid. Despite working in teaching, her employer refused her request for flexible working. Vera ended up leaving her career and took on an unskilled, low-paid job in the retail sector just so she could work around her childcare responsibilities:

"[...] in terms of kind of getting back to work they were, they were not flexible about it...so I work nights now at [a supermarket]. Just because it fits around my husband when he's working...so, it at the moment it doesn't make sense to pay childcare, it doesn't make sense for it really to be any other way" – Vera, P004.

Figure 14 is an excerpt from a memo I wrote about the theme of pregnancy and maternity discrimination. In this memo I reflected on what I perceived as Vera's lack of awareness about the discrimination she faced and what this might suggest in the wider context of gender discrimination.

Pregnancy and maternity discrimination in the workplace

Description: Forces at play impacting women's careers/employment opportunities etc during the COVID-19 pandemic.

Prior to having her baby, Vera (P004) worked as a teacher in early years education, educated to master's level, but had to go on maternity early due to her poor health in pregnancy. When she had to return to work, her employer would not support her requests for flexible working and she felt she had no other choice, but to leave her career and take up work in the retail sector, so she could work more flexibly and so her family could avoid extortionate childcare fees. She took a low-paid job 'as she had no other choice'. In terms of her household income – Vera took a pay cut.

In her interview, Vera did not mention anything to do with experiencing gender and maternity discrimination. She did not seem to be aware of it, or maybe did not have the language to communicate that with me, or didn't want to communicate it with me? In some respects, it was unseen.

Other participants have discussed how they moved in and out of different income brackets due to ineffective and discriminatory flexible working practices. Childcare costs in the UK are some of the most expensive in the world and put working families, especially women who shoulder the majority of caring responsibilities, at a significant disadvantage in the labour market (Whitehouse and Farquharson 2020; Warren et al. 2021). This is also known to have a direct impact on women and children's life chances (Psarros et al. 2023a).

It is interesting that Vera does not recognise this as discrimination, is reluctant to share her thoughts with me, or does not feel it is important to her and her own family context? Having to take on unsociable, low-paid work, in a completely different sector seems extremely unfair to me, but it does not seem to be reflected in Vera's discussion.

Through constant comparative analysis, I noticed that other women also implied or discussed similar issues, which I think may well be useful for theory development, in terms of where this knowledge and activism should/could sit within midwives' public health role. The tacit assumptions within Vera's interview and my thoughts about the wider meanings and implications for women in similar situations, provided a foundation on which to build on in subsequent interviews.

Memo written on 22/09/2021

Figure 13. Pregnancy and maternity discrimination in the workplace

Another participant went through an employment tribunal after facing maternity discrimination. After having a termination for fetal abnormality and needing to take some time off work to grieve and process the loss of her baby, Beatrix (P013) received threats from her employer. Beatrix eventually took her employer to a tribunal, which was still ongoing at the time of our interview. She refused to give up, making a stand against this maternity discrimination:

"[...] they sent an e-mail to me saying, "why should we have to pay for you to be off when you had an abortion?" Yeah, and just all sorts of things like that, they were just not very nice at all. So, I took them to an employment tribunal, whilst I was pregnant [second pregnancy], and they stopped my sick pay – not anybody else's – they don't give me pay rises,

just basically everything you can imagine they shouldn't do, they did, so, yeah so, I took them to court" – Beatrix P013.

Other women had to put their desires for furthering their careers on hold whilst they looked after their young children. This was especially difficult for mothers with complex needs and women with disabled children, who faced multiple and systemic barriers to get the right care and support in place. One participant, Robyn (P012), did distance learning courses in preparation for when she was able to return to work:

"[...] I'm on carers allowance at the moment, which is why I'm not back at work...So yeah, so I just do distance learning...urm...but yeah so whilst I'm off I'm just expanding my knowledge because I do want to work in end of life care...I just like being able to help people and know better, so I can do better" – Robyn, P012.

Moreover, higher education institutions made it difficult for pregnant women with complex needs to access further education:

"[...] I just I just don't understand why they would put such a block on people like myself that want to study, you know? But yeah, it was a struggle" – Harriet P022.

In contrast, some women reported how supportive their employers had been to them during the pandemic by supporting them to work at home (for women working in sectors where this was possible):

"So, I was really fortunate with the team that I was in that they were able just to literally cut me out of patient contact, and I went straight to just doing everything on a telephone and stuff" – Millie, P008

"Yeah, [I work] for my friend's business, so I'm, it's nice because he's really understanding of the fact that I've got Belinda so if I need to go – my hours are really, really flexible. And I'm working from home so..." – Beatrix, P013.

Receiving peer support from colleagues, especially colleagues with children, helped women feel validated in the workplace, *'she could understand where I'd be coming from and what would potentially help me'* (P003). When Misha (P007) found out her baby had a congenital disorder incompatible with life, she was comforted by her line manager who had been through a similar experience:

"[...] what really helped was because my line manager, who is sort of my friend anyway, and as a colleague, she, she went through a similar sort of experience when she lost her little boy at twenty weeks gestation. And so... you know hearing her experience and being able to share my experiences with somebody who has gone through a similar journey, was just really kind of nice for me" – Misha, P007.

7.4.6 Living off benefits – “am I even going to be able to afford this baby”?

For most women in this study, regardless of whether they had a partner, having a baby negatively impacted their household incomes and disproportionately impacted families living on the lowest incomes. At the time of data collection, women living on the lowest incomes were more likely to be single mothers and in receipt of benefits. With the rise in cost of living, benefit entitlements were felt to not be enough to survive on:

“I now get universal credit and that but sometimes it’s just not enough, ‘it’s nothing to live off really when you think of it’. Not with welcoming a new baby into the world...so before you’ve got to try and buy everything with next to no money...” – Sarah, P009

“[...] and then I asked him the other day, I was like, because I was running low on cash, and obviously I’m paying for everything here, I’m on universal credit because I’m not working now and you go from having two people working to not even one, I’m not working and then get benefit’s and it’s hard...it’s really hard to make ends meet” – Poppy, P010.

Things were especially difficult for women who got caught in the child benefit cap. A welfare policy that restricts child tax credit and universal credit to the first two children in most households (Bragg et al. 2021; Psarros et al. 2023b, 2023a). Lois (P014) explained the impact of this policy on her and her four children:

“Yeah, I get caught in the benefit cap because I had the four kids, so I only get universal credits for three of them...so I’m like why am I getting put in that, when it’s come into place after I’d had Leanne...How are we supposed to survive?” – Lois, P014.

Levels of entrenched poverty deepened even further for the most deprived families during the COVID-19 pandemic. As increased demands were placed on households, those in the lowest income households were disproportionately affected in terms of having to homeschool their children and shoulder the burden of these associated costs. The demands placed on single mothers was especially difficult:

“It’s been really tough because... I’m a single parent and with the lockdown and everything, I just felt that it really had, had a knock-on effect on my experience...” – Harriet, P022

“[...] I was crying down the phone [to the headteacher], I was like, “oh my god, oh my god,” because the kids were just stressing me out so much, I’m on my own. And with Leanne being so head strong and like so argumentative and stuff, it’s like, “I’m so glad you’re back at school.” So now the kids are on a list permanently, if we get put into another lockdown after this one, they’ll be back at school with that one as well” – Lois, P014.

On top of this, women did not always have a support bubble to help them with childcare and domestic labour. Some of the single mothers in this research, also revealed how difficult it was when their ex-partners stopped paying child maintenance. This left women with no other

choice than to bear these additional costs alone. Poppy (P010) described how difficult it was for her:

"[...] so I asked him for twenty pounds, because obviously I've got to get some food in for the weekend, and then yesterday he said, "have you got my twenty pound?" and I'm like, "are you serious, you've paid no child maintenance for nearly two and a half months and you're asking me to give back your twenty pounds" - Poppy, P010.

Analysis suggested single mothers may have felt trapped in their situations, as financial pressures prevented them from engaging in all aspects of life, including activities with other mums and children. Four women in the study who had babies before they were 18 years old, were particularly burdened by their lack of financial security. Sarah (P009) reflected on how restricted she felt living on benefits:

[...] I think once I paid all my bills off, I think I end up having like £30 left...I was stressing so bad...I just felt like I couldn't even afford to get my driving or anything, public transport, I couldn't afford things like that. I did feel very trapped and very alone...I felt very restricted in what I could do and what I couldn't do and what I could afford and what I couldn't afford for the baby" – Sarah, P009.

Migrant women with no recourse to public funds, especially women who were seeking asylum in the UK, are particularly vulnerable to exploitation and increased health inequalities, as they have little to no way of paying for goods and services to meet their material needs (Feldman et al. 2019). In 2018, research by the UK maternity rights charity, Maternity Action, found that migrant women are particularly vulnerable and rely on being connected to organisations in their local communities, however the COVID-19 pandemic significantly restricted how grassroots organisations could support women and their families.

Mavis (P024) was in a particularly precarious situation after entering the UK. After accessing maternity care, she found out she had a sexually transmitted infection and was advised not to breastfeed. In an interview with her MCoC midwife later on in my data collection, the midwife (PM010), explained how the NHS and social care were incorrectly 'arguing' over who would fund the formula milk as Mavis had no recourse to public funds. It was her MCoC midwife, who stepped up and contacted multiple charities on Mavis' behalf. One of the charities agreed to fund the formula along with other baby equipment:

"[...] the funding... urm yeah, at the moment urm, on maternity leave as I have no public fund because of the type of visa I have, so [my midwife] make sure, I get everything I need for the baby, before the baby will arrive. Yeah, they have really been a good help for me, and I have milk for the baby now. Contact every place that they think I might get help from" – Mavis, P024.

7.5 Impact of trauma and the Social Determinants of Health on perinatal health and wellbeing

An interesting finding in this study was the manner in which some women framed discussions about their health and wellbeing. I reflected on this in the following memo (Figure 15).

How do people in the UK think about their health?

Research by Think Tank, Reform (Rees et al. 2022) identified a range of ‘cultural models’ or stereotypes, that people in the UK use to think about health. Cultural models are the assumptions, snap judgements, and patterns of thinking that we draw on – and default to – in order to make sense of our world. This research revealed that dominant thinking about health is highly individualistic. Health in the UK is thought to be the result of choices we make over what we eat, how often we exercise, and whether we have the willpower and discipline to stick to a healthy lifestyle.

Health in my study was also thought of simply as the absence of illness and the medical care received from the NHS. This dominant thinking obscures the impact of the wider determinants and the role they play in shaping health.

I wonder how I framed questions about health to participants? I do not think I was direct enough in my questioning for fear of causing offence. However, research by Buzelli et al. (2022) for the charity, The Health Foundation, recommends being direct and framing questions about the SDoH as a matter of life and death – for instance, some childbearing women and their babies are dying younger/earlier than they should and have less life chances than people who are wealthier. This is political choice of successive Governments that have failed to eradicate poverty in the UK.

Making the issue ‘about’ life expectancy rather than health also helps people broaden their thinking beyond individual behaviours and cultural norms. The term ‘health’ remains a powerful cue for lifestyle and individual choice for most people. When people hear the word ‘health’, they think of diet, exercise, smoking and drinking, health education, and even budget control for families on benefits. By making the wider determinants a question of life and death, we nudge people to go beyond these dominant beliefs about what health is and the things that influence it.

Written on 07/09/2024

Figure 14. How do people in the UK think about their health?

Analysis demonstrated that women in this study who experienced ACEs were more likely to also report they had poor health. Their nuanced responses suggested their bodily symptoms may well have been based on their previous experiences of abuse and the cumulative impact of stress on their bodies (Brunton 2024). Furthermore, women may well have been so distracted by the external complexities they faced, including coping with the unprecedented nature of the COVID-19 pandemic, that they might not have been attuned to understanding and/or meeting their own needs during the perinatal period.

There is a substantial body of evidence from disciplines such as neuroscience and psychology, that explores how the body expresses deeply painful experiences (Bloom et al. 2013). This

evidence base supports the assumption that a mind/body disconnect, seen more commonly in people with trauma histories and/or living in highly stressful circumstances, physiologically manifests in the brain, which has wide-reaching effects on areas of the brain responsible for executive functioning and recall (van der Kolk 2005b). This is especially concerning for women and babies from the poorest households who experience multiple, intersecting social adversities and has grave implications on perinatal morbidity and mortality (Dagher and Linares 2022; Jones et al. 2022).

The significance of these findings emerged during advanced stages of analysis and memoing. Figure 16 is an example of a memo, where I reflected on the explicit and tacit assumptions in the first interview I completed with Adrienne (P001), where she spoke about her childhood and her health. I wondered if these experiences had shaped her mind/body disconnect, as well as the explicit and tacit assumptions within her narrative, which might reveal how - and whether - these issues were addressed in the maternity care she received.

A mind/body disconnect in the face of women's experiences of trauma?

I have reflected on Adrienne's interview multiple times during the analysis, but I wanted to go back and analyse the way in which she described her health and wellbeing and the tacit assumptions underpinning her narrative. Data analysis of the interview transcripts, including my own theoretical sensitivity to the topic of trauma, suggests that Adrienne's early childhood experiences and the chronic stress she has experienced in her adult life, may have impacted her relationship with her reality and with her relationship with herself. Trauma was not something I set out to ask women, but its significance in women's lives emerged from the first few interviews I completed and remained a constant theme throughout women's interviews.

I wonder whether Adrienne cannot or does not want to think about how the traumatic events she experienced in childhood, may have also affected her perinatal health and wellbeing and that of her children? There is a growing wealth of interdisciplinary evidence that seeks to expand our understanding of how our mind and bodies hold onto and are affected by trauma at key developmental stages in our lives (van der Kolk 2014). According to this body of evidence, one of the most commonly reported observations of traumatised people, is that they often knowingly or unknowingly report a disconnect with their bodies. Furthermore, people have been found to lack a degree of their emotional intelligence (due to the physiological effects of trauma on the brain), in which to recognise the trauma they have faced and how it might have impacted their bodies. According to Van der Kolk (2014), traumatised people are said to technically own their bodies but do not properly live in them.

This corpus of evidence is significant and goes some way to help me make sense of the tacit assumptions within Adrienne's narrative, about how she perceives herself, others, and the world. For instance, when I initially asked Adrienne about her health in pregnancy, she said that her health had been 'perfect', despite having just told me about the trauma she experienced, including the multiple pregnancy losses she had over the years. Scattered throughout her interview, were references to her contempt towards social services, including blaming them for causing her recent miscarriage. Adrienne recalls the moment she

found out she had miscarried and how she fixated on the words of staff from the Early Pregnancy Unit:

"I've always been negative towards social services and I always will, so. But if it wasn't, if it wasn't for them being - if they weren't involved, I would never have miscarried, because even the Early Pregnancy Unit said it would have been the extreme amount of stress you went through every single day. Because baby was growing absolutely perfectly; they were measuring three or four days ahead of what they should have been. Exactly the same as when I was pregnant [with my daughter]. She was growing three or four days ahead – there was nothing wrong with the baby at all".

Blaming social services for causing this traumatic event seemed like a legitimate way for Adrienne to cope with the grief of losing another baby - that and making it her mission to try to fall pregnant again as soon as she could, as a way to maybe distract herself from the pain of her grief. She therefore made it her mission to contact another sperm donor to help her:

"I couldn't cope with the miscarriage so – because obviously due to grieving. So, my partner and I went to see Pink last year in Wembley – And I – yeah, and then we decided, urr to try again. So, we found a new sperm donor, which I spoke to previously already in the past. So, I knew about his background mainly anyway. And then we decided to try in August, and I fell pregnant on my first try".

Research suggests that childhood trauma survivors are more likely to act impulsively and engage in risky and/or self-destructive behaviours in adult life in response to current stressors (van der Kolk 2005a, 2005b). MRI imaging of the brains of traumatised women compared to imaging of non-traumatised women, demonstrated that childhood trauma exposure has a detrimental impact on regions of the brain responsible for impulse control (Andersen et al. 2008). This evidence goes some way to explain why traumatised people might make unwise or risky decisions. Trying to conceive using unregulated sperm donation and artificial insemination was something Adrienne could control in an otherwise unpredictable world. Despite it being during a national lockdown, she still met up with her sperm donor to do the exchange and then went home to complete the artificial insemination herself. The fact that she was breaking the law by meeting up with people outside of her household did not seem to matter to her - she was doing what needed to be done to retain some control.

Interestingly, when we then went onto talk about what health meant to Adrienne, she said, *"obviously good health means no, normally no admissions really [laughs], but... no illnesses...no mental health issues, nothing like that".* Adrienne then revealed she had been diagnosed with Borderline Personality Disorder (BPD) a number of years previous. Research into BPD, demonstrates a significant relationship between experiences of ACEs before the age of 7 and diagnosis of BPD in later life (Herman et al. 1989). This correlates with what Adrienne had revealed about her childhood. When I probed her to tell me more, she was not able to. Did she not have the words to describe this, the memory, or did she just not want to tell me? Adrienne went on to explain that she did not think her mental health impacted her pregnancy yet made multiple references to the stressors she faced and the impact of these stressors on her pregnancy and subsequent loss.

Memo written on 23/05/2023

Figure 15. A mind/body disconnect in the face of women's experiences of trauma?

Another participant, whose four children had been removed from her care, seemed to have little memory of her experience during pregnancy and hardly responded to questions about

her experiences. The embedded meanings within her narrative, along with other observations I made during her interview, suggested she may well have avoided discussing these or alluded to her traumatic memory being too fragmented to recall:

“What were your pregnancies like? I don’t really remember.

Really? No.

What was it like when your, when your body was changing, what was that like? It was alright, it’s not very urm... it’s not very easy, I didn’t know, it all felt weird to me when I was pregnant knowing my babies were going to be taken away...” – Kellie, P016.

A number of other women spoke about having to make difficult decisions during their pregnancies, alongside making fast-paced decisions in their daily lives. A few participants discussed experiencing fertility issues and pregnancy loss during the pandemic, including women who had to terminate their pregnancies. Most of these women had to experience such procedures on their own, as a result of punitive restrictions placed on birth partners during COVID-19 restrictions. These experiences shaped the way women felt about themselves and impacted their mental health:

“I had to go alone to have the pessaries inserted, urm to help the miscarriage along. Urm... and then just being in lockdown, isolated, just really didn’t help and I could feel my mental health like getting bad again...” – Robyn, P012

*“‘[...]...so, in my mind there was no choice really, I knew what was best for me but also what was best for him. So, oh god sorry, *cries* sorry, so I made that decision to end the pregnancy - it sounds really bad, I hope you don’t judge me, but I was just so keen to have another baby as soon as possible so I tried again as soon as I could...”* – Beatrix, P013.

7.5.1 Perinatal mental health

As previously discussed, most women in this study reported a history of mental ill-health (22/23). Of these women, 14/23 disclosed living with common mental health conditions including anxiety and depression, and 8/23 women reported having severe mental health conditions such as bipolar disorder, personality disorders, and psychosis. In addition, mental health was the most commonly reported reason for having been referred to the MCoC teams. Managing mental health conditions during the pandemic seemed like yet ‘another thing’ (P010) women had to juggle on top of the unknowns of having a baby during a pandemic. One participant explained:

“[...] I think before because I was always anxious, like I think a lot of people now are starting to get anxiety and worrying, whereas I’ve always had it [anxiety]. So, it’s like, oh, it’s another thing. It’s another thing that’s come along and it’s another thing that you’ve just got to be aware of and deal with...” – Poppy, P010.

Two women with severe mental health conditions and complex adult trauma, disclosed how they attempted suicide in the year leading up their pregnancies. The explicit and tacit assumptions within their narratives, suggested they had little control or agency over what was happening to them. Attempting suicide seemed like the only way out for Claudia (P017):

“I was still having problems with her Dad being a bit of a twat and it was, everything just got on top of me...I just couldn’t cope with it anymore. And it got to the point where I tried to end my own life because I just thought you know, everybody’s better off without me. You know, you get so brow-beaten and burnt out that you just think, “I just can’t do anything, I’m no good for anybody” – Claudia, P017

Harriet (P022) felt that attempting suicide was the only way to be taken seriously by NHS services:

“[...] it got to a point where... I was attempting suicide for the attention side of it. For the fact that I needed to go to hospital because I wanted to then be referred, I wanted to go down that route. And, and that, you know, that wasn’t working either. So, you know, you have to get to that extreme to get the support. But then when you get to that extreme, you’re an absolute nutcase and you’ve lost the plot, and you know; you’ve let yourself down” – Harriet, P022.

Harriet (P022) went on to discuss her experiences of claiming benefits after trying to take her own life. Rather than helping her reintegrate into the labour market, staff at her local Job Centre informed her they would not contact her for another three years before she would need to find employment. This caused Harriet to feel ‘written off’ by the system and left her struggling to make ends meet:

“So basically, I’d been put into this group on benefits where they like, you’re written off for three years...most people jump at the chance of that, however I was very much like, “what?”...So yeah, it was a real, a real struggle...so in the end, I did cleaning work...so I was getting a few extra quid in that way, cash in hand you know...” – Harriet, P022.

A number of other women also described facing system-wide barriers in accessing the right support for their mental health, especially when trying to navigate community mental health services (CMHT), including the difficulties they faced transitioning between CMHT and Perinatal Mental Health services. It seemed quite easy for women to go under the radar. Women’s experiences suggested that services appeared to take a reactive, as opposed to proactive approach to care. This left the following two participants feeling abandoned by services:

“[...] so, I was under the [removed] Team – or whatever it was at the time. And they wouldn’t see me because I was pregnant. I’d been referred to the Perinatal Team – they wouldn’t see me because I had ongoing mental health conditions that they said weren’t pregnancy related. Even though the pregnancy had made it worst. So, neither would actually see me as a patient – Vera, P004

"[...] when you've got someone who's actually under your care struggling...me personally...I would be reaching out to that person going, "is everything okay," even just to have a chat. Ringing somebody up on the phone just saying, "are you okay - is there anything we can help you with," as their job as a mental health person and as a, as a so-called social worker, where are they? They haven't been there" – Poppy, P010.

Other women suggested they had to 'keep pushing' (P015) to have their concerns validated.

This could mean multiple appointments with their GPs before their concerns were taken seriously:

"[...] my doctors weren't helpful at all before I was referred to the perinatal service. They were like, "oh, well, we'll change you back to your old antidepressants"...so, I changed, and it made my mood quite unstable throughout my pregnancy...they weren't really...supportive about my mental health" – Angela, P015

"[...] Urm..., I have spent years going back and forth to the doctors who kept trying to chuck me on pills and more pills and changing pills and I was like, "I need therapy, this is what's going to help me," and it was just pushing for it. And eventually I managed to get therapy, we went to couple's therapy as well and that helped loads, I came off my medication urm... I mean we've; it's also about implementing changes in our lifestyle" – Robyn, P012.

Postnatally, women also felt their concerns were not taken seriously, causing delays in accessing the right psychological support. This had serious implications for the maternal/infant attachment relationship. Angela (P015), felt despite 'screaming out for help', her cries went unrecognised for some time. This experience contributed to her feeling like she was not being taken seriously:

"So, I spoke to someone else on the phone and they were like, "oh yeah, she decided she was going to wait until she next saw you." And I was thinking, "I'm screaming out for help here, I'm really struggling, I had no bond with my baby whatsoever." I didn't want to look after her...And...sort of one of the midwives that then came over was like, "yeah, I can see how much you are struggling, and I am going to refer you." So, kind of, it took a bit of effort to make them realise how difficult I was finding it. I felt like I wasn't being listened to. But yeah, then I was referred to the perinatal team – Angela, P015.

Sarah (P009), the youngest participant in the study, felt especially vulnerable. She reflected on her lack of support from services during her first pregnancy:

"[...] I ended up having a lot of postnatal depression because I didn't feel that I had the support around me from, from like the medical side of things, I mean I had like my family around me and that, I couldn't fault my family. But, you know, I should have been able to turn around to my midwife and say, "look, I'm struggling with this, is there anything you can do or is there anything I could do to help with this?" But I just didn't feel like that was available" – Sarah, P009.

The collective experiences of women in this study demonstrate the disproportionate inequities women can face when trying to access services and relates more broadly to theories such as, the inverse care law (Tudor Hart 1971). The inverse care law refers to the unequal distribution and provision of healthcare spread across populations, with those who need it most often

going without and suffering further inequalities as a consequence. Those who need care and support the least are more likely to be able to access and receive the care they need because of their relative socioeconomic position within society (Tudor Hart 1971).

7.5.2 Perinatal physical health

The physical health of most women in this study appeared to be impacted by the level of stress and trauma they had experienced. This was particularly evident in the language some participants used to describe what it was like living with multiple co-morbidities. This included participants describing the somatisations they experienced, like fibromyalgia, which are known to be more common in women with experience of trauma and mental health conditions (van der Kolk 2014). The following excerpts detail the level of complexity some women were facing and the potential consequences on their mind/body disconnect:

"[...] I had post-natal depression with Nelly. It wasn't diagnosed through the doctor, but my Mum could see it, and – because I just didn't know, I didn't notice what was happening..." – Lois, P014

"Yeah, so... again, hindsight makes it easier. With my first I didn't know that I wasn't well. But I think I can see now that I wasn't well. And I just, I don't know...I just...I think it was almost post-traumatic stress disorder type thing, rather than like a post-natal depression type thing" – Ameila, P021.

Harriet (P022) powerfully explicated that her mind and body do not communicate, which seemed to exacerbate her health conditions:

"[...] I have suffered with my mental health now for quite a few years, I'm diagnosed with bi-polar, and I also have endometriosis, stage three endometriosis so, hormonally my body and my brain, we're not in the best of places. They don't seem to talk to each other..." – Harriet, P022.

Poppy (P010) was told she manifested symptoms in her head, which caused her to experience somatisations throughout her body:

"[...] I used to convince myself that I had all this stuff wrong with me. And then I'd get symptoms and my doctor, what is it... 'synchronised symptoms'? Basically, you think about it so much, that basically you can get a headache, you can get these aches and pains because you're causing your body to have this stress" – Poppy, P010.

After my interview with Angela (P015), I wrote a memo (Figure 17). This memo detailed my observation that Angela, like other women in this study, reported a high level of pain disorders. These seemed to be largely ignored and poorly managed during their maternity care. Angela disclosed she had also been sexually assaulted by an ex-partner and had multiple co-morbidities including Autism, depression, PTSD, and fibromyalgia. Angela also felt unable to disclose she had Autism to her MCoC midwife. Her neurodiversity seemingly went unnoticed

by the services she interacted with, leading to a stark lack of personalised care and support.

Angela describes the complexity of her health and the chronic pain she lived with:

"[...] so, I am autistic, which I never disclosed to them, so...yeah, that causes me quite a lot of problems. But I have like...hypermobile joints and fibromyalgia and sort of a bone condition in my elbows as well that makes kind of mobility quite difficult...it made it, it made...the, the first trimester I was very kind of fatigued and in a lot of pain, and then the second trimester I felt okay. But when I hit the third trimester, I was in so much pain across, kind of my lower abdomen and...and my legs and my pelvis and my back in particular because my lower back doesn't move properly anyway. So that was like excruciating" – Angela, P015.

Other women also shared experiences of their poor health in pregnancy. Claudia (P017) went from being independent and working as a nurse, to being wheelchair bound in her pregnancy. She described how pelvic girdle dysfunction was not taken seriously, despite her being confined to a wheelchair:

"I'd ended up going from being a very independent woman to being in a wheelchair, bawling my eyes out twenty-four/seven, you can kind of, do you kind of get a bit of a sense of how bad it is? But I think, people just think, "it's just normal kind of pregnancy twinges, or everybody gets uncomfortable towards the end," sort of thing. And it's like, "no, actually this is absolutely crippling and debilitating" – Claudia, P017.

Another participant reflected on the culminative impact that stress had on her health in pregnancy, including sleep deprivation and pain:

"[...] I just couldn't sleep, like my body is just... I don't know, just my boobs are starting to hurt more...my back...and obviously with my anxiety-I get myself in a bit of pickle..." – Poppy, P010.

Even after experiencing two 'mini-strokes' (P009) in her first pregnancy, Sarah recalled feeling like no one took her seriously:

"[...] my [first] pregnancy with my first was horrific. I had two mini-strokes, so two TIAs and I was in so much pain. Obviously, I was only sixteen as well, so it was quite scary and no one took me seriously even though I could barely function" – P009, Sarah.

7.5.3 Intrapartum and postnatal experiences during the COVID-19 pandemic

At the time of data collection, the MCoC teams were frequently unable to provide 24/7 intrapartum care due to their high caseload numbers, staff shortages within the teams, and being called into the unit during periods of escalation. This meant that some women received care from multiple, unknown rotational midwives. This increased anxiety amongst some participants:

"[...] I think a lot of people probably have had more traumatic births around now, because obviously they're scared which isn't going to help. We're even more scared not having our people around us" – Robyn, P012

"[...] all the services are so disjointed at the moment, this person's not working, this service isn't running, you kind of you just get stuck in a rut of "I don't know where to turn now..." – Claudia, P017.

Beatrix (P013) experience demonstrated how disruptive it can be for women having to repeat themselves at every shift change and the potential impact this could have on the flow of labour:

"[...]it's not necessarily their fault but you just felt like kind of groundhog day every twelve hours or so or having to explain yourself and your life and your partner and your, you know what I mean? Yeah, but if [my midwife] was there like, she knows me, I don't have to explain anything, we can just concentrate on why we're here" – Beatrix, P013.

MCoC teams were functioning under immense pressure during this time. At the time of data collection, some midwives were carrying caseloads at a ratio of 1:50+, as opposed to the recommended average ratio of 1:27 (NHS England and Improvement 2021a). This compromised the provision of continuity, which impacted quality, safety, and staff morale, as the following participants discussed:

"[...] full timers are supposed to have no more than twenty-four, but recently some midwives had forty-five plus on their caseloads because they were so short staffed...unless you can provide that flexibility and that more intensive support...I don't see the need for these continuity of carer roles unless you can do that extra stuff" – Dana, PM001

"[...] we're lucky if we get to deliver a fifth of our women at the moment. Because of the sheer numbers, we've had to be removed from a lot of night cover because otherwise it impacts on your community time" – Fife, PM009.

Women's birth plans were more likely to be missed if MCoC midwives were not present for intrapartum care, which had the potential to cause re-traumatisation. Re-traumatisation occurs when someone re-experiences the stress and emotional pain of a past traumatic event due to new, similar stressors or reminders (van der Kolk 1997; van der Kolk et al. 1997). This can happen consciously or unconsciously and may be triggered by a range of factors such as certain environments, smells, sounds, or even interactions that resemble the original trauma

(Ayers et al. 2024). Common symptoms can include flashbacks, anxiety, hypervigilance, and intense emotional reactions. It is important for practitioners to be mindful of these triggers to help prevent re-traumatisation, especially in supportive or therapeutic settings, such as the intimate nature of intrapartum care (Bradshaw 2023). Angela's (P015) birth plan not only detailed her previous experience of rape, but also how she wished to be communicated with during labour due to her neurodiversity. From Angela's perspective, this was ostensibly ignored, which triggered painful somatisations during her labour:

"[...] So, I was left for ten hours not knowing I could top up the epidural and by that point they told me to not top it up if I could help it. And I was like, "look, I'm in a lot of pain...and not because I'm trying to give birth, it's my pelvis." And then my trauma related spasms were coming on, while I was pushing, and I just, I had to stop pushing at that point because the pain was so great. And them telling me not to take the epidural and so...I didn't feel really supported very well during that moment" – Angela, P015.

After Angela's interview, I memoed about the lack of personalised care Angela received (see Figure 18). Angela's experience demonstrated the effect of poor communication and data sharing between professionals, which could increase the likelihood of perinatal trauma. Perinatal trauma has wider implications for infant development and the mother-infant attachment relationship (Van Sielegheem et al. 2022).

Birth Trauma

Angela (P015) discussed her experiences during labour with me (the caseloading team midwives was not on-call for her birth, which was becoming increasingly normalised at the height of the pandemic due to chronic staff shortages and MCoC midwives being called in for escalation). It got me thinking about how women can be gaslighted by the medical community.

Medical Gaslighting as a concept will be really interesting to unpack here.

Angela was a survivor of sexual abuse at the hands of a previous partner and suffered from PTSD and trauma, which manifested in her body. She felt the staff looking after her had not reviewed her notes and her history or her birth plan curated by her and her midwife. This led to her feeling disembodied and disempowered in her birth experience - not feeling seen or heard and her feelings and experience of pain ignored.

Angela tried to explain her levels of pain to the team, but due to her outward expression of pain being less than what staff expected, she may have been gaslighted by staff.

Staff neglected to consider how her neurodiversity might have impacted her experience and expression of pain and disregarded her reality.

The impact of not having her caseloading midwife present in the birthing space led to her feeling the care she received was not personalised.

Written on 02/11/2022

Figure 17. Birth Trauma

Features of disempowerment in the birth environment, such as choices being ignored, infringe upon women's human rights in several ways (Birthrights and Birth Companions 2019). When women's choices are ignored during childbirth, it violates their right to make informed decisions about their own bodies and the care they receive (ibid). This kind of treatment may also contribute to women's loss of liberty and agency. Human rights laws emphasises the importance of treating individuals with dignity and respect (Birthrights and Birth Companions 2019). Disregarding a woman's preferences during childbirth can undermine their dignity and contribute to a dehumanising experience, which may increase the risk of re-traumatisation - especially for women with previous traumatic experiences and contribute to worse perinatal outcomes (ibid). Other women also confirmed these observations in the data:

"[...] first time around I did experience, some postnatal depression, and PTSD, a recurrent PTSD from my birth – it was just an awful experience" – Cathy, P002

"[...] and this time around obviously I plan to have a c-section and before I had a really traumatic birth and stuff and c-section after, and I so was really scared about having another baby in case I went back to that place..." – Poppy, P010

"With my first I didn't know that I wasn't well. But I think I can see now that I wasn't well. And I just, I don't know... I just... I think it was almost post-traumatic stress disorder type thing, rather than like a post-natal depression type thing..." – Amelia, P021.

Women were also more likely to report a traumatic birth if they required an induction of labour, an instrumental birth, or emergency CS – interventions in childbirth known to increase the likeliness of birth trauma (Ayers et al. 2024). Two participants experienced sleep deprivation after their traumatic births and found bonding with their babies difficult:

"[...] it ended being a very, not even just the birth was traumatic, but the labour and then afterwards was traumatic because of the pelvic pain I was experiencing...I didn't resent my baby, I just had no connection to her whatsoever...I wasn't sleeping very well; I was worried about the sounds of her breathing" – Angela, P015

"[...] And so, when it came to it and the depression aspect, I did have the exhaustion aspect of things and it effected everything, its different..." – Iris, P020.

Another interesting finding emerged in this study. Women with experiences of ACEs also described how difficult it was to adjust after being discharged from their MCoC midwife to the care of their health visitor and back into primary care. Participant's responses suggested this transition was a form of loss. Some participants felt there was lack of cohesion between services to support them to adjust to life again after receiving such intensive support from the MCoC teams:

"[...] if I was going to change anything it would maybe be that I'd see them a bit a bit longer after the pregnancy. Just until you feel comfortable that everything has settled

down...we still had issues going on...I don't know that kind of cohesion between services could maybe be improved a little bit" – Claudia, P017

Other participants felt like they had lost their support system:

"Like when you've had that support then, I'm going to lose them soon...and just the thought of not having that...team, that's, that's the hard bit it's like, like obviously I'm going to have baby and it's going to be great, but then like I'm losing my support network..." – Poppy, P010

"[...] it was a bit of a transition, it was a bit of a shock transition to be so heavily supported and then all of a sudden, well baby's out, so we're not going to see you anymore" – Beatrix, P013

Amelia's (P021) experience highlighted that the discharge process can sometimes feel premature. This suggests that a more personalised approach could improve the experience; otherwise, it risks feeling like an abrupt ending to the midwife–woman relationship, rather than providing a sense of closure for the women receiving care:

"[...] it really feels like a really unsatisfactory end to a relationship that you've developed over all of those months and then they're gone, and they haven't even seen the end of it – Amelia, P021.

Midwives in the study also echoed similar sentiments. Some responses suggested there was an overall lack of evidence in which to inform best practice about the discharge process (especially during the COVID-19 pandemic). This has the potential to exacerbate inequalities further:

"There's not the structure around support anymore. And you know, for most women, that's fine...and most women, most families who feel that they need it will seek it out. But sometimes, it's the ones that need the support most that don't get it..." – Jane, PM007

"[...] And before you know it, and it's like every service is then withdrawn, ours, and we're only there initially, and then they're just left with nothing..." – Fife, PM009.

Concerns were also raised about the welfare of women whose babies were removed closely after birth. Women were not only grieving the loss of a child but also lost the financial and emotional support they received in pregnancy. The following midwives elaborated about their concerns over the withdrawal of support:

"[...] she needs, so she has so much support around her right now and she needs that to continue. But to lose everything, [removed] said yesterday, she said 'they don't just lose all those support networks, they lose financially... that money goes as well...' – Dana, PM001

"[...] I found that the women that had complex social, they didn't engage with midwifery once the baby was born. And I don't know if that's because some of the babies were going into the care system...I found that there were a few women that I never actually formally discharged because they didn't engage. And I think that's quite a common theme..." – Denise, PM004

"[...] I think some of the ladies that...who have had previous social care...for ladies that have had previous babies removed, it's trying to support them following the removal of the baby but it's...Who's following it up once they're discharged from the midwife...?" – Natalie, PM012.

As MCoC midwives are uniquely placed to assess whether a woman is ready for discharge, participants felt that they should be able to exercise their professional judgement about its timing. The following participant recommended that this decision should rest with midwives' as autonomous practitioners, rather than being driven by management pressures experienced during the pandemic:

"[...] she [the midwife] is a person that they're seeing regularly, she is, she is a person that they're having face-to-face contact with, and she's going through a journey with them, and you know, we're ending that journey when we discharge them, why can't we discharge them on the basis that they're sorted? Until they are ready and we are sure... – Ruby, PM006.

When MCoC midwives were present at the births of women in their caseloads and were also able to complete postnatal care, it could have a powerful impact on women's psychological safety and provided opportunities for personal growth, as this participant explained:

"[...] it was like having a friend there more than a stranger because I'd been seeing her then for the past nine months, so it was nice to have that rather than just a midwife who happened to be on shift if that makes sense, who's like stranger.... And it was just, yeah, it was really nice to, to have her there because as far as I know it's quite rare for your midwife to be the one who delivers, actually delivers your baby. So, yeah it was just a really nice experience to sort of round off the whole care that she gave me, and I felt better about the experience" – Adrienne, P001.

Claudia (P017) had experienced multiple disadvantage and described the impact of having her MCoC midwife involved throughout her entire perinatal journey. Her response powerfully demonstrated the nurturing aspects of the midwife-woman relationship. Claudia also felt the level of continuity she experienced helped her to process her experiences and prepared her to move onto the next chapter:

"[...] you know seeing her again over the coming weeks and being able to go through you know, what had happened, because you know a lot of it's blocked out, adrenaline's pumping, you forget bits...being able to kind of go over that sort of birth story almost...it's quite nice to be able to paste over the cracks in your memory...Being able to thank her and know who they are and know that that person brought your baby into the world...that helped kind of, it's not closure but, you know it helps to kind of put a lid on the box and you feel like that's, that's, that's done then, time to move on" – Claudia, P017.

7.6 Conclusion

In this chapter, the category '*sucking it up and getting on with it*', has been discussed to demonstrate the pervasiveness of trauma experiences in the sample of women who took part in this study, and their subsequent survival-based adaptative behaviours. The study also highlighted the impact of these coping mechanisms on women's health and well-being during pregnancy. Additionally, most participants experienced ACEs and/or traumatic interpersonal experiences as adults, whilst also facing a complex web of intersectional, structural inequalities. The interplay of these determinants played a significant role in shaping women's survival strategies and their experiences of care during the perinatal period. By exploring these behaviours and skills, we gain insights into the contexts and conditions of women's lives before accessing maternity care, emphasising the prevalence and importance of addressing trauma and the wider determinants impacting women's health and wellbeing.

Chapter 8 will examine how women's trauma histories and the SDoH were integrated into the MCoC model as a core part of midwives' public health role, drawing on the experiences of women and midwives.

Chapter 8. Research findings from interviews with midwives and perinatal women

8.1 Introduction

The previous chapter explored findings from interviews with perinatal women and focused on explicating the contexts and conditions of their lives. Most women in the study revealed they had a mental health condition as a consequence of experiencing interpersonal trauma and the culminative effect of multiple inequalities. Women also reflected on what it was like having a baby and interacting with services during the pandemic. Analysis also demonstrated that women developed a survival mechanism coined, *'sucking it up and get on with it'*, as a result of these myriad events to protect themselves and their babies. We also saw the effects of chronic stress on women's health and wellbeing and participants birth and postnatal stories.

This chapter will integrate the experiences of women and midwives and explore how MCoC midwives addressed trauma and the social complexities women faced, and how these were enacted in the MCoC model.

A visual representation of the categories that will be explored in this chapter is presented in Figure 19.



Figure 18. 'We're only really scratching the surface of the complexities women face' – category and subcategories

8.2 “We’re only really scratching the surface of the complexities women face” - MCoC midwives stories of addressing widening inequalities

The NHS entered the COVID-19 pandemic after a decade of austerity and underinvestment under the Conservative Government, which left the health system with fewer resources and lower resilience compared to other high-income health systems (Darzi 2024). The pandemic strained health systems globally, but the NHS was particularly impacted, with higher excess mortality rates and significant reductions in routine care (ibid). This deep-seated malaise widened the gap between the richest and poorest families (Dorling 2024), leading to worsening health inequities and a reversal in life expectancy for women living in the 10% most deprived areas across England (Goldblatt 2024).

The category *‘we’re only really scratching the surface of the complexities women face’*, emerged from the analysis to explain how challenging it was for MCoC midwives’ (on a micro level), to address increasing inequalities within a health and care ecosystem (meso level) consumed by the COVID-19 pandemic (macro level). Midwives observed rising inequalities in the communities they served, but in essence their stories suggested that they were largely *‘only really scratching the surface of the complexities women faced’* [PM008]. This was evident in the nature of midwives’ stories about the difficulties they encountered trying to *‘unpick women’s stories’* [PM005] and *‘understand and navigate the complexities’* [PM001] families faced, to better understand the most effective strategies for support, both within their disposal and in the wider system:

“[...] yeah, I mean, obviously, it's [COVID-19] has had a massive impact, it's increased risks across the board from a safeguarding perspective...you know, domestic abuse has escalated. Reports of child abuse has escalated...and it's, it's made everything so much more difficult to manage” – Jane, PM007.

For the midwives in this study, understanding and navigating increasing complexity was a fine balance of establishing and maintaining relational attunement, empathy, and personalised care on an individual/micro level, along with balancing professional responsibilities to their employers, professional regulators, and the wider system. Some midwives described being left to *‘pick up the pieces in terms of [addressing] public health’* [PM006] in place of community organisations that had withdrawn support due to social distancing restrictions. Despite increasing levels of need, often women did not meet thresholds for support from statutory and non-statutory organisations within the local ecosystem. This in turn left some participants in a challenging moral dilemma. In essence this increased the chance of MCoC midwives working beyond their scope of practice or *‘stepping up’* [PM002] to meet women’s needs themselves.

As the need was so great, midwives did not want women and their babies to lose out on vital support:

"[...] there's still the anomalies where they don't quite meet the criteria...but if not, then I guess we step up to what we feel that organisation would have provided them with, whatever it is, as we can't not do anything, you know..." – Bella, PM002

"Some women just aren't vulnerable enough to receive the support they need, so we do it, even though they are clearly vulnerable and we're not the experts, but we still do it..." – Melanie, PM011.

Despite increasing levels of inequality, trauma, and therefore need amongst their caseloads, most participants reported having received little if any post-registration training in public health or trauma-informed care. Such training would have provided them with the underpinning theoretical knowledge of these principles, explored the evidence of the most effective strategies to address perinatal inequalities, and the role of midwifery in health promotion and population health .

Despite the need being so great in the local area, participants' professional development in these areas did not appear to be prioritised in comparison to other core competency training (NHS England 2023a). Midwives nuanced responses implied this increased variation in their knowledge and practice, which in turn could lead to inequitable care and exacerbate health inequalities further, as the following quotes illustrate:

"The most challenging thing for me was the work environment, it can be very difficult to try and be your best under those conditions without the right education, but the expectation we can solve everything..." – Denise, PM004

"[...] I don't feel I had the training to deal with this stuff properly...and the training that we're given on the job is often like the difficult conversations training, that was difficult to even come by, for even the case-loading midwives, it wasn't prioritised for us..." – Karla, PM005

"Urm I've had a few significant, massive mental health query ladies. And mental health...for a lot of people it isn't our comfort zone, we're not mental health trained particularly. And some of it's like living and learning...but you hope that you do make a difference..." – Ruby, PM006

"I think... it would be lovely if there was a specific training package for this role...it's really hard...yeah and I think especially when they're asking us to do so much, you've got to give something back in return" – Natalie, PM012.

Unlike many other professional groups at the time - whose services were restricted during the pandemic, MCoC midwives continued to see all women and their babies face-to-face. Some midwives also saw the level of need being too great not to visit women in their homes. Despite putting themselves at risk, continuing to see women at home was a mechanism in which to gain a better understanding of women's living conditions and the support networks they had. This was central to midwives capacity to risk assess and uphold their safeguarding

responsibilities to women and children. One participants' response, detailed below, captured the overall feeling amongst participants about the disparity between different professional groups and the expectation placed on them to continue seeing women in their homes. In essence the following quotation highlights the moral injury midwives may have experienced, had they not continued to see women at home:

*"[...] we tried as much as we could to continue the care, I mean we had to in light of some of the ladies being on like, they're children being on child protection plans and what have you, we couldn't, there was no way we could just be a phone call to see how they were doing postnatally and at like the height of COVID, we had to go in the homes, which is **very interesting** because the social workers didn't have to, they could do like, you know, do [remote assessments]. But we physically had to be in the home to see them" – Natalie, PM012.*

During the height of the second and third national lockdowns, NHS England instructed maternity care providers to place all women from certain GEM backgrounds onto a MCoC pathway, due to the increased risk of COVID-19 related morbidity and mortality seen in women from certain population groups (NHS England and Improvement 2021a). Whilst this call to action was supported by national funding at the LMNS and provider level (macro and meso level), midwives in this study felt overwhelmed by the additional amount of women they were suddenly expected to look after, without additional resources being ringfenced at the individual level. Some participants reported their caseloads rose overnight with little warning from approximately 1:27 women per annum to in excess of 1:45 or more. Understandably this caused participants' considerable concern and compounded multiple aspects of personalised care, including relational continuity. Effective policy implementation requires coordination across macro, meso, and micro levels (Middlemiss et al. 2024; Sandall et al. 2024), however coordination of this policy seemed poorly executed and resourced, which in turn can lead to ineffective outcomes. Two participants described the effect of this policy in their local area and on their working practices:

"[...] well again, it's another knee jerk reaction isn't it, as we're picking up ladies that are quite affluent but are from BAME backgrounds, so again, it's just how do we make this work? ...with how few midwives at the moment want to do it (work in MCoC models), there obviously has to be some way of ring-fencing it and making sure it's going to have the best outcomes for women – Karla, PM005

"[...] my idea of the NEST teams is they had smaller caseloads of more needy women, but they had more flexibility, which isn't happening at the moment...so, if you've got too many women, you're not actually going to be able to do it right, are you...it immediately defeats the whole point of being a caseloading midwife" – Samantha, PM014.

One participant revealed she experienced burnout when she was a MCoC midwife (prior to the pandemic), which contributed to why she did not return to caseloading after her maternity

leave. She recalled the excessive ‘noise’ [PM005] she carried as a result of the level of need of the women in her caseload:

“[...] I definitely have noticed a difference now when I just go in [to the unit], do my job – I mean there’s down sides...but I do like the fact that I don’t have all of this noise all the time, in the back of my head, from caseloading” – Karla, PM005.

8.2.1 Managing complexity in the moment

During the COVID-19 pandemic the cumulative impact of regressive funding cuts associated with austerity measures, shone a stark light on the ingrained and insidious health inequalities experienced by the poorest families in England (Goldblatt 2024). Therefore, attempting to address the trauma and SDoH impacting women’s health with scarce resources, midwives recalled relying heavily on their experiential knowledge of local assets and partnerships, as opposed to being well supported by an agile system that ringfenced their professional development. Participants expressed myriad concerns about ‘working in a system’ [PM009] that did not prioritise their professional development yet placed overwhelming expectations on their productivity and the impact of MCoC on local health inequalities. Training in preparation to become a caseloading midwife was seen as inadequate by some participants:

“It’s difficult trying to find a space within the hours of mandatory training that you can fit in for midwives to have the training, so they’ve just had to find me a little slot somewhere that we can do some training in...” Georgina, PM013

“[...] we got a two-hour training session on honour-based violence. Now I’m not being funny but predominantly [removed] and [removed] are fucking white background...I’m not saying we should overlook it...but we’re being taught to look out for things that are one-offs...let’s talk about how much money these women get, let’s talk about how much that has to be spent on rent arrears, let’s talk about what rent arrears looks like. Let’s talk about what they then can spend the money on, let’s talk about those things, because that’s happening to probably ten out of thirty of your caseload...” – Amanda, PM008.

Some participants also noted how ill-prepared they felt to manage rising inequalities. One participants’ response suggested they were firefighting on a daily basis to manage the level of need in their caseloads’:

“[...] so, I started back in October, and I started, never done any safeguarding other than what I’d done in the hospital, so it was a completely, you know, a completely different role for me...when I started and there was three of us and we had caseloads of about forty women which was just crazy! We couldn’t keep on top of it and because of you, know our caseloads are so big and so complex, it scared me...” – Gemma, PM010.

Senior midwives in the study felt MCoC teams were also at breaking point. Focus on preventative interventions had been paused due to the pandemic:

"I've temporarily needed to cap the bookings because urr...they were getting too many in to be able to book. Staffing's low as well...so again, to be able to provide that continuity and package to cover that twenty-four seven, seven days a week, you'd need a team of between 7.4 and 8 whole time equivalents and we just haven't got that right now" – Melanie, PM011

"So, yeah because the way things are at the moment, they're [MCoC midwives] just so busy...so, it's been really hard to kind of, move anything forward public health wise. And I feel, personally I feel awful asking them to do anything else. I just don't think that they can take much more...I think they're almost at breaking point really" – Samantha, PM014.

Midwives described how they approached meeting women's immediate psychosocial needs in the moment by making sure every contact counted. Midwives recognised that every interaction had the potential to be an intervention to improve perinatal health (McNeill et al. 2012). This often relied on making intuitive risk assessments, in pressurised environments. Routine clinical care could sometimes become secondary or '*sandwiched in*' [PM002] during appointments, where midwives would draw upon their repertoire of personal and professional skills to prioritise women's greatest needs first. The adversities some families faced during the pandemic may well have gone unnoticed if women had not been accessing maternity care. Participants responses described the complexity of mobilising different agencies during this time and the need for midwifery oversight to propel care forward:

"[...] I don't know what you'd class as outside of midwifery care, I suppose. Because a lot of it, I suppose is to provide some level of midwifery care, isn't it?...I suppose the safeguarding aspect, we attend additional meetings...going out of the way trying to organise public transport or a taxi to get to hospital appointments. Referrals to different agencies...foodbanks, going to collect foodbank stuff for them. Sorting out furniture...double beds and washing machines and stuff like that. And electric heating and gas..." – Dana, PM001

"[...] I had a late booker who had concealed her pregnancy, and I went to go do her booking at home and it came out that you know, it was so complex...so, I spent, before we even did the booking - we were applying for furniture...registering her with the GP and applying for a foodbank...and then you kind of fit the booking in the middle of all this that's going on. You sandwich it in, but that can take four hours – Bella, PM002.

Discussions about NHS maternity care turned to the difficulties some women faced trying to navigate the complex health system. The antenatal care pathway was also seen as being too rigid for some women, which could lead to disengagement:

"[...] I think... we put our own barriers in place in the NHS which are not helpful for women" – Karla, PM005

"[...] they have no idea, and the ladies that did have an idea, even what to search for and how to follow the system, especially if they don't speak English, or read any English...so urm yeah, definitely loads of women are not getting through the system early, in a timely manner because of this system, which is a shame" – Ruby, PM006.

Maternity care in the UK functions within a wider social system that perceives childbearing as inherently risky, which may hinder professionals' confidence in addressing the wider

determinants of health for fear of deviating from routine schedules of care (Skinner and Maude 2016). To address these limitations, midwives need greater flexibility and autonomy to meet women's needs holistically, which could be achieved through a more person-centred approach, building trust and mutual respect with women at its core (Naughton et al. 2024). While midwives were not always in a position to fulfil all clinical care requirements, it was crucial to establish trust first, as this seemed to be the catalyst for engaging women in the rest of their antenatal care. The flexibility to adapt working practises to suit women, were seen as imperative mechanisms which could influence perinatal health equity, as these midwives explained:

"[...] why can't I say to her, "come on, let's go to the cafe, I'll meet you at the cafe." I know that I can't do a palpation and all that sort of stuff, if she's that sort of person that I'm not seeing at all...that's better than nothing. A quick check of the blood pressure you know or...what I'm trying to say is that we should be allowed more autonomy...it's too ridged, the programme that we're asking them to follow..." – Amanda, PM008.

"[...] a good example is the lady that you know...she had major financial difficulties, you know she couldn't, she couldn't afford to come and see me...that would be between coming to see me...and getting a bus and you know potentially feeding herself and her child in the evening. So, we see a lot of that...so I did weekly home visits, just because I think she had so much going on..." – Gemma, PM010.

8.2.2 'The training we get doesn't prepare us for the reality'

Whilst participants had comprehensive knowledge of the evidence base for MCoC, in practice the MCoC midwives worked in a variety of unique ways based on their experiential and anecdotal knowledge of the wider resources available to their local communities. In essence, midwives were *'doing the best you can with whatever ingredients you've got'* [PM005], which introduced natural variation in practice. Midwives in the study did not receive any additional training before becoming a MCoC midwife. Responses suggested that participants largely felt ill-prepared for the magnitude and responsibility of their public health role in these contexts. In essence, MCoC midwives were *'pushed into the deep end'* [PM006], which suggested this may have had implications for the quality-of-care midwives were able to provide in the MCoC model. Midwives reflected on their gaps in knowledge about health promotion and prevention:

"[...] in my head I can know what a healthy diet is but actually, am I qualified, how much information can I give you? Because I'm not a qualified dietician and we have zero training really!" – Bella, PM002

"Urm I've had a few significant massive mental health query ladies. And mental health, you know I think for quite probably, a lot of people it isn't our comfort zone, we're not mental health trained particularly. And some of it's like living and learning on the job..." – Ruby, PM006

“You know you kind of mention it [contraception], don’t go into detail, we don’t have any training on it, it’s only from my own – you know, it’s only from personal experience with contraception, about what’s available” – Gemma, PM010.

Natalie (PM012) highlighted how midwives were expected to ‘hit the ground running’:

“[...] you learn on the job...but yeah, no, little to no training...and...there’s an expectation that we’re supposed to be really well trained in certain areas such as mental health, and actually we’re not...” – Natalie, PM012

Other participants verified these experiences. One of the participants, who went to work in a different role with the City Council, reflected on the stark difference in her training for the role. The PAUSE programme is a trauma-informed intervention for women who have had, or are at risk of having, multiple children removed from their care (Pause 2021b, 2021a, 2021c). Based on a trauma-informed approach, which acknowledges the impact of trauma and structural inequalities on certain groups of women, the PAUSE programme aims to break the cycle of repeat pregnancies and care proceedings by providing women with the opportunity to develop new skills and responses that can help them create a more positive future (Pause 2021c). As part of the induction programme to PAUSE, Amanda (PM008) reported the training she received to be ‘second to none’ in comparison to her experience as an MCoC midwife, where she was expected to know how to identify and manage the same level of complex needs. She reflected on how the PAUSE programme had developed her knowledge as a critically reflective and attuned practitioner:

“[...] and that’s what the training and the job will do, that’s what I mean when I say it’s going to enhance my practice within the area of social complexity. Because my professional curiosity and the way I think now, I probably doubt everything now, and I doubted stuff when I was a midwife, you know, and questioned it. But I question everything...I’ve gained so much, I’m so pleased I was brave enough to take the job” – Amanda, PM008.

Amanda’s experience demonstrates the disparity in training that different professional groups receive, despite MCoC midwives managing the same level of complexity and safeguarding responsibility. Amanda felt that women’s needs, including the contexts women live in, were not appropriately risk assessed in maternity as midwives had not received the level of training she had as a PAUSE practitioner. In essence, this reflects a system that did not value the professional development of midwives working in these specialist models of care. Amanda’s experiences outside of MCoC, demonstrated that ultimately a lack of education could impact professional curiosity. In turn this could compromise patient safety and undermines the potential for midwives to identify issues that impacted women’s lives. Amanda elaborated further about how inadequate training is for midwives:

“They [midwives] get the training...it’s so ‘from a book’ training, where in actual fact...if you actually looked at the reality and what is, you know what is cuckooing⁷? Actually, what does that look like when you walk into a house? ...let’s give an example, let’s talk about actually what support you can give and...the sort of thing that they’re going to say to you? Because they [maternity] don’t...and [removed] does her best with the old domestic violence training, but now I look at it and I’m just like, no! That’s not what it looks like at all...it’s laughable really...” – Amand,a PM008.

Prior to the COVID-19 pandemic, only one midwife spoke of having an induction period when she joined a MCoC team as a junior midwife, however she did not receive any targeted education about the responsibilities of the role. Having an induction period gave her protected time in which to scope out local services in the community and build her network of support. However, this did not seem to be standard practice for everyone, which perpetuates the belief that midwives are simply expected to ‘*learn on the job*’ [PM006]:

“[...] so, I think like my first six weeks...I didn’t have labour shifts and stuff like that...and I used that time to – I went and met someone at [removed], to have a chat with them about what they offer. I think I met up with someone from the Family Nursing Partnership, I went along with colleagues to different social services meetings. Yeah, I used that time to sort of build up a bit of a network list...”- Dana, PM001.

According to the Strategic Technical Advisory Group of Experts for Maternal, Newborn, Child and Adolescent Health and Nutrition (STAGE), transitioning to midwifery models of care globally and widening the scope of opportunities for professional development in areas such as public health, can improve midwives’ skills and confidence, and provides a platform in which to influence the strategic direction of population health (World Health Organization 2024c). Amanda (PM008) reflected on how the valued position of midwifery in society represents a missed opportunity to harness the potential impact that MCoC midwives could have on population health. Amanda (PM008) noted that pregnancy and childbirth are critical periods for addressing inequities, but in the current NHS system, midwives are ‘*just scratching the surface of the complexities*’ women face:

“The thing that I’ve learnt is that there’s, I was just scratching the surface of the complexities as a midwife...we’re very blessed as midwives, nine times out of ten, within these deprived areas, we’re one of the good ones, “oh it’s the midwife, oh yeah she’s alright.” They hate the health visitors, they hate the police, they hate the social workers, anybody from the council...you know out of all the professionals that will be involved in a young family’s life, especially if they are vulnerable...the only ones that they really like is us, the midwives. So,

⁷ Cuckooing - is a form of modern slavery and is a practice where criminals take over the home of a vulnerable person to use it as a base for exploitation and illegal activities, such as drug dealing, financial abuse, and sex work(The Centre for Social Justice 20251). It takes the name from cuckoos who take over the nests of other birds. Midwifery education typically focuses on maternal and newborn health promotion and may not specifically include training on spotting cuckooing.

we're in a really valued position and one that we could do so much more with from a social perspective" – Amanda, PM008.

8.2.3 The lack of ethnic diversity in midwifery affects health promotion

Four midwives reflected on the lack of ethnic diversity in the MCoC workforce. They discussed the barriers they felt this created in terms of cultural competence and their awareness of key public health issues within and across diverse cultural and religious groups. Analysis suggested that some participants may have felt uncomfortable in their Whiteness, as *'a bunch of white midwives'* [PM005] having conversations with women from GEM communities about the link between structural racism, socioeconomic position, and COVID-19 related mortality and morbidity. Midwives nuanced responses suggested an overall concern about the imbalance of power these conversations may have created. A lack of racial concordance in the local midwifery workforce, seemed to impact how confident and competent midwives felt they were in having conversations about structural inequalities. Several responses alluded to the fact that as a predominantly White workforce, midwives' were uncomfortable that conversations such as these may have perpetuated *'White Saviour'* [PM010] colonialism that was rooted in existing models of healthcare (Wake 2022; Mackay et al. 2023). As a consequence of a lack of cultural competency training for instance, there seemed to be wide variation in how or indeed whether such conversations took place. This was crystallised in the following responses:

[...] we had a really good Sure Start team lead, and she was also from a BAME background herself so she could help us with some of the cultural conversations we were dealing with, and I felt that that helped us break the barriers down a little bit, so it wasn't just white midwives trying to tell people what to do" – Karla, PM005

"[...] Urm I don't generally tell them [GEM women] that's why they've come to us, I don't know if I should. It's a really...I wouldn't say it's an awkward conversation to have, but it's a bit of a funny one, because I have brought it up with some women and... I've noticed they kind of look at you like "...okay, why so ...?"I feel that they may feel they're being singled out...but there was this kind of thing about, you know, being 'White Saviours', you know you're having these white midwives tell you, you need our help" – Gemma, PM010

"[...] I don't think it's [discussions about race] provided in that way; it's talked, they're talking about ... the, you know the higher rates of ... let's say stillbirth or maternal deaths... but they don't say that race would be one of the reasons why. And equally it's probably harder as a complete group of white women to turn around and say to these ladies, "we are going to give you this gold standard of care as a group of white women..." – Natalie, PM012.

Another midwife felt the UK's professional trade union for midwives, the Royal College of Midwives, and the Nursing and Midwifery Council, should have better supported staff to frame conversations about the intersections of COVID-19, race, and perinatal inequalities.

Consequently, conversations were less likely to discuss racial inequalities, which contributed to

the confusion some women had about being offered MCoC as opposed to receiving standard midwifery care:

“[...] there isn’t really any advice or – I mean the government has got something on their website ...but actually there isn’t anything from the RCOG or the RCM or NMC, there isn’t anything that says, “this is the language you should use and the conversations you should,” ... I mean...it’s really hard as a white person to know what language to use” – Georgina, PM013.

Interestingly, having conversations about complex safeguarding issues was thought to be easier than having conversations about intersectional inequalities, as the following excerpt demonstrates:

“[...] it’s hard...I actually feel more comfortable – which is just really sad – having the conversation about really intense safeguarding than race...” – Natalie, PM012.

8.2.4 Being relationally attuned – an interpersonal mechanism that supports the midwife-woman relationship and assists with tackling inequalities

As previously discussed in [Chapter 2 - Sections 2.9-2.11](#), the evidence on relational continuity within therapeutic relationships is compelling (Guthrie et al. 2000; Freeman et al. 2001; Sandall et al. 2024), and it has long been considered the cornerstone of quality and safety in healthcare disciplines, including primary care, nursing, mental health services, and maternity care (Siow et al. 2013; Perriman et al. 2018; Khatri et al. 2023). Therefore, it was not surprising that participants in this study also discussed the importance of the relationships they shared with one another. Relational practice was essential for midwives to effectively identify and address the unique needs of each woman, particularly regarding women’s mental health. However, novel findings for midwifery knowledge emerged in this study, which further our theoretical understanding of mechanisms that underpin the benefits of MCoC models and will be discussed below.

Establishing a trusted relationship with women based on the core values of social justice and empowerment, influenced how safe women felt to disclose the issues they faced. This in turn impacted how women could feel towards receiving external support from other professionals and agencies:

“[...] she made me feel at ease. It felt like she had no judges and grudges against us. Urm... she just made me smile...” – Adrienne, P001

“I mean from a – on a kind of, personal level with her level of care and her as a midwife herself, she was she was so kind and empathetic and understanding and in no way dismissive of any of my wishes or any of my...” – Cathy, P002

“[...] she’s a very confident person and like, she... she knew...when I was sometimes going potentially into that red mist and go into a manic episode. I see those vulnerable people

as potentially a target...Because I need strong people around me, because I can be quite a dominant person. And I think she [the midwife] took on that role fantastically...” – Harriet, P022.

The utility of attachment theories, theorized by Western developmental psychoanalysts such as John Bowlby and Mary Ainsworth (Ainsworth 1969; Ainsworth and Bell 1970; Bowlby 1979, 1982), were important frames of reference in which to explain how the midwife-woman relationship may have operated in the context of this study. Childhood attachment theories describe the impact of the interpersonal bond between a child and its primary caregivers (most notably the mother-infant relationship), that serves to protect infants from harm (Ainsworth 1969; Ainsworth and Bell 1970; Bowlby 1979, 1982). Attachment styles are developed based upon the cumulative effect of successful or failed interactions with primary caregivers to meet an infant’s needs (Bowlby 1982, 1988). An infant’s experiences of their caregivers responsiveness and sensitivity to their distress, forms an individual’s internal representations of themselves and others, known as the ‘Internal Working Model’ (IWM) (Piaget 1964; Young 1964; Bowlby 1982). The IWM consists of conscious and unconscious rules and expectations that influence how a person perceives and interacts with others in future relationships (Bowlby 1982). Moreover, a key function of the IWM is the development of a person’s identity of themselves as worthy of love and protection and is inextricably linked with attachment experiences in infancy. The formation of a secure attachment base in childhood and a secure IWM, where a child feels safe and knows how it feels to trust their caregivers, is a critical aspect of human development, including self-efficacy and self-esteem (Pressley 2023). Evidence suggests this is also associated with positive outcomes across the lifecourse such as, increased educational success, adaptive socio-emotional functioning in adulthood, lower risk of morbidity, and increased life satisfaction (Bowlby 1988; van der Kolk 1998; Grafft et al. 2023). Conversely, an insecure attachment, where a child does not feel safe and does not have their needs met, impacts a child’s sense of self as worthy of love and protection and is associated with multiple comorbidities in adulthood, such as poor mental and physical health (Felitti et al. 1998), difficulties with emotional regulation, complicated adult relationships, increased levels of substance abuse, antisocial behaviour, and criminality (Marmot et al. 2010; van der Kolk 2014; Grafft et al. 2023; Mamun et al. 2023).

Ongoing interpersonal interactions throughout the lifecourse are said to be the ‘relational living out’ of the IWM, whereby the intentions and motives of others are identified and interpreted implicitly and impact the way people form attachments in adulthood (Bruschweiler-Stern et al. 2007). The same principles can also be applied to how adults interact

and respond to others in a therapeutic relationship (Pressley 2023), such as how women in this study were in relationship with their MCoC midwives.

Attachment theorists define the concept of attunement as being the process where a mother (or other close caregiver) is biologically, physiologically, and psychologically aware of, and responsive to the needs of their child (Bowlby 1979). Attunement helps to foster a sense of safety and security in an infant and lays the foundation for future interactions in adulthood relationships. The concept of attunement has also been applied in adult therapeutic relationships, such as those between a therapist and client - in other words, how attuned a therapist is to the psycho-emotional needs of their client and how they respond (Finlay 2015; Rocco et al. 2017; Talia et al. 2020). This can often determine how successful a person responds to interventions and the feeling of being seen and heard (Bowlby 1988; Talia et al. 2020). Furthermore, the principle of attunement, alongside midwives' assumptions and values about health inequalities, appeared central to the quality of women's maternity experiences and their openness to interventions:

"[...] it's the human touch of our jobs, isn't it? It's that knowing your woman, and her feeling comfortable with you. You're sitting there and you hold her hand or you just, you know you smile at her and your body language and your empathy and all the things that you learn, your trade as a midwife..." – Samantha, PM014.

"So, we were trying to unpick the story as well to make sure it was nothing safeguarding wise. But I think we finally managed to unpick that it was that she was in a relationship with a guy, but it was better off for them to be in separate households because they got more money that way. So, it wasn't necessarily anything that we needed to be worried about, but I spent a lot of time trying to unpick things. Yeah..." – Bella, PM002.

Theories about attachment also helped to explain the significance of the historical interpersonal traumas women had experienced and the emotional wounds women carried. How much women experienced a secure attachment to their MCoC midwives and how much they could trust them to meet their needs, were essential to establish. Existing evidence about women's maternity care experiences during the COVID-19 pandemic has demonstrated that personal, protective equipment (PPE) and social distancing restrictions impacted the midwife-woman relationship (Schmitt et al. 2021; Keedle et al. 2023), however some participants in this study described still being able to establish a secure relationship despite these barriers:

"[...] we'd had phone calls because obviously we were in lockdown. But then it didn't actually matter because they then said to me, which I thought was lovely...we still want you to come in, we still want to meet you, we'll just be at a safe distance, masked up...so, for them to actually, not by-pass the rules, but be strong enough to be able to say, you know, we are still continuing our services and we still want to see you face-to-face – Harriet, P022

"[...] in pretty much all e-mails and at all of our meetings she just said, "use your own risk assessments for your women, we're not going to dictate how you want to do it, because we're a bit separate to the universal hubs anyway." So that has been quite good that we haven't had to – I think we justify to ourselves, but we don't have to justify to everybody repeatedly why we're doing what we're doing for our women..." – Bella, PM002.

The blanket restriction of birth partners in maternity services had unexpected outcomes in terms of improving opportunities for women to disclose sensitive information. Midwives recalled noticing the positive impact that attending clinic alone had on some women, leading to a more open and trusted relationship:

"[...] I think it has made an improvement, because it gets them out of their home environment...it gets them away from partners if they need to disclose anything. It also forces them to get away from their children for half an hour...And they can, yeah, I think they're quite open actually at clinic...because its more on-on-one, it's about them, it's the focus on them..." – Dana, PM001

"Yeah, that's come out in a number of conversations, I can't say that people have said, "oh we can't wait for partners to come back," namely they've said it's provided very good opportunities for women to...say that they're not safe or you know, that they've got issues that they maybe wouldn't talk about in front of their male partners" – Fife, PM009.

Moreover, an attuned and reciprocal relationship could be a powerful mechanism for women to self-reflect:

"[...] I feel like I'm talking to someone who's treating me like an equal, who has things that she has to ask me and go through, but is more – it sounds silly it sounds – when you have that conversation, it is like having a friendship conversation of genuinely just checking in on how you are but also medically..." – Iris, P020

"I've always thought with my mental health with my doctor I'm a number, but with the midwife team, like, I want to be pregnant forever. Just so I can keep them in my life" – Poppy, P010

Lois (P014) had a powerful and positive experience with her midwife, describing her as being like a therapist:

"[...] with this pregnancy I was a lot more, like with my anxiety, I was a lot more scared about giving birth...And now after speaking to her a few times about it, I was fine. So, she was sort of like a...talking therapist to get me out of that sort of like mind-frame...she was literally everything, she was like my therapist, midwife, doctor. She's all in one" – Lois, P014.

Midwives also reflected on the impact of being relationally attuned to women. Attunement was implicit; a relational knowing of the potential needs of an individual that developed over time, based on repeated interactions with each other (Finlay 2015; Rocco et al. 2017; Talia et al. 2020). Despite the overwhelming pressures placed on midwives during the pandemic, working in the MCoC model still facilitated more opportunities for midwives to be relational as opposed to task-orientated care. This in turn impacted how attuned midwives were to subtle changes in women's behaviour and mental health:

"[...] it's all that subtle stuff, and yeah it is...although it's subtle, it ends up not being that subtle and that's the power of working in this way even in a pandemic...we can pick on the subtly of things in their lives and women trust us enough to have these conversations with them" – Ruby, PM006

"we're another piece of that puzzle, so we can understand the kind of nuance of the situations" – Jane, PM007

"[...] a lot of problems that go on within these families are within the home, so you don't tend to find out about them until you really get into the home...and you kind of link these things together and it's all kind of quiet, hush, hush, and then once you go into the home...you kind of start to put the pieces of the puzzle together..." – Natalie, PM012

Cross-disciplinary findings affirm that a continuous flow of un-worded communication occurs between humans (Tschacher and Meier 2020; Atzil-Slonim et al. 2023; Peebles 2023).

Women's responses suggested they felt like they were both 'on the same page' [P017], which created a safe space for curiosity and led to midwives recognising unspoken behaviour, as these participants described:

"[...] if I'm feeling shit, I tell her that I'm feeling shit, and establishing that quite early on, she was quite like kind of frank and up front and again not beating around the bush...And that kind of helped because we were both on the same page. We both you know kind of understood each other in the same way" – Claudia, P017

"The good thing about seeing the same midwife across the period is recognising where you've changed...there's a case for listening to what I'm saying, but there's also a case for noticing the things that I'm not saying...So yeah, that was an important role that she played in recognising that for me when I couldn't recognise it myself" – Ameila, P021.

Midwives accounts also suggested they felt similar:

"I definitely think we were very well trusted in that area" – Karla PM005

"[...] you know often there's a whole load of other complexities that you're working with and trying to work out and get them set up on, as best as you can with what ingredients you've got to work with, sort of thing! – Ruby, PM006.

8.2.4.1 Establishing and maintaining a secure attachment base

In order for the MCoC midwives to establish a secure attachment base with women at the start of their relationship, some of the midwives discussed how they worked hard to *‘equalise and stabilise the relationship’* [PM008] from the outset, in an attempt to level power dynamics within the therapeutic relationship. Analysis suggested that midwives were implicitly attuned to women through their observed expressions and actions of reciprocity, in their attempts to establish trust and safety early in their relationship. Cross-disciplinary evidence from fields such as psychotherapy and psychiatry, suggest the skill of attunement may well be shaped by a therapists’ own attachment styles (Rocco et al. 2017; Atzil-Slonim et al. 2023). The same ideas also emerged in the way midwives described how they executed their practice, which relied on them creating a secure attachment during the early contracting of their relationship with women. Amanda (PM008) reflected metaphorically on how she approached developing mutual respect from the offset, before setting out to address the wider determinants of health:

“I think that I’ve always feel like I’ve been a midwife that has ‘got’ the women and the women have warmed to that. I’ve always, positioned myself, if you look at a ladder of personality or a ladder of...I find their place, their rung on the ladder, and I will match it...” – Amanda, PM008.

Midwives who displayed interpersonal competences such as expressiveness, sensitivity, and responsiveness, seemed to be the most effective at attuning to women’s needs and restoring trust and safety in relationships, which is especially important for women who may distrust meeting new people (Rayment-Jones et al. 2023). If we continue with our example of a therapist/client relationship, the therapist is there for their client, the client is not there for their therapist (Talia et al. 2020). In the same way as the MCoC midwives are there for women, the role of the MCoC midwife working with complexity, is to be deeply attuned to women, so that women feel safe in the knowledge that they are not being judged. Two participants described how their midwife made them feel comfortable enough to discuss their mental health, which increased opportunities for external support:

“[...] we both you know, kind of understood each other in the same way...there was that kind of trust then that I could be honest and feel it, and she would know that I’m telling her exactly how I’m feeling as well” – Claudia, P017

“I think my midwife, she...her personally was very good at like the mental health side of things...so, she was very good...it was almost like I could tell she had dealt with that situation before so she felt very confident in what...like how she could help me”– Jeanette, P003.

8.3 Addressing widening inequalities and the issues MCoC midwives faced

8.3.1 Midwives acting as metaphorical linchpins

Analysis suggested that midwives in this study served as a linchpin, metaphorically speaking, in that they held together myriad threads of care and were the driving force behind efforts to propel care further, into the wider system. Midwives did this at pace and intensity specific to women's needs, which in turn created a sense of cohesiveness and confidence in the quality-of-care women received, as these participants described:

"[...] she was very good at urm...orchestrating kind of support further from herself and throughout as well..." – Cathy, P002

"[...] they followed their job through and, you know, they didn't give up until they found what I needed you know" – Michelle, P005

"There was always that kind of cohesive continuity and I knew that you know, if something needed doing, Vanessa would do it for me, she would do the referrals, she would speak to her colleagues, she would you know, chase this up or whatever. And knowing that you've got someone that's managing that is a huge weight off your shoulders" – Claudia, P017.

In essence, midwives' maintained the stability, effectiveness, and integrity of the wider system.

"Yeah we would feed them in, so often it was I would fill in an early help assessment form with them, and get that sorted out, so they'd have family nurse partnership and then I would often, or family nurse or... the family support workers, so we could then talk to them about, they would then sort out the other bits that weren't my remit but I would make sure they were fed into that" – Karla, PM005.

This operated successfully under the following conditions:

- when a secure attachment relationship had been formed midwives' were more attuned to subtle nuances and changes in women's behaviour;
- in turn this meant midwives were more adept and comfortable to have difficult conversations about psychosocial issues and behaviour change interventions, such as IPVA, mental health, and substance misuse;
- an attuned midwife-woman relationship led to more open and transparent conversations and the opportunity for more targeted strategies such as advocacy, liaison, practical help, referral, counselling, and management of care needs with the wider interdisciplinary team and external agencies.

However, in the context of this study a few midwives alluded to the difficulties they faced when statutory and voluntary services were increasingly unable to support women. In essence the following narratives suggested the moral dilemmas this left midwives in:

"[...] safeguarding sometimes have a suggestion...but if not, I guess we step up to what we feel that organisation would have provided them with, whatever it is. Whether it's housing

or baby equipment or...support with the family or support with applying for things. I guess we would just help them instead if we couldn't find an organisation that would also help" – Bella, PM002.

Other midwives had learnt to step back from doing too much. Signposting to specialist services was seen as a way to protect themselves from occupational burnout and to encourage women's agency:

"[...] within the defined parameters of the public health role of the midwife, you then need to say, "this is where we will sign post you, and I will tell you where you need to go, but that's as far as it goes," you know women still, even if they're vulnerable they still need to have their own sense of agency in terms of going on to the next step, because midwives can't do that for them" – Georgina, PM013

"[...] it takes you a while to distance yourself from those and learn to...to sort of step back and think, "no I, I am just a midwife," you know, "I'm not your social worker, I'm not your health visitor, I'm not your, you know, I'm not your friend, unfortunately." So, I just think you do need to step back. So, it took me a long time to get that..." – Natalie, PM012.

One midwife participant, Bella (PM002) explained how being attuned with women helped facilitate having conversations about health promotion, such as smoking cessation and routine carbon monoxide testing in pregnancy. Bella used what she termed as '*shock tactics*' to increase engagement in such conversation, which included involving women's families and children in the process of carbon monoxide testing:

"[...] And I'm like, "oh okay, fine...let me do my reading, let me do your toddler's reading, let me do your partner's reading, oh look, we're all above the recommended now. So that tells me there's smoke in this house...so you know, let's work it out who is it?" So that's quite interesting as well and I think often that's a bit of a shock tactic when their toddler blows a six or something, but you think, well I've got through to them..." – Bella, PM002.

As discussed in Chapter 7, most women in the study disclosed having a mental health condition and half revealed they had experienced ACE's prior to pregnancy. Being in relationship with a midwife who was consistent, competent, and reliable, meant that women were more likely to have confidence in the quality and safety of the care they were receiving:

"[...] The level of care she gave was just incredible and just having her there from the start...every subsequent appointment and also she was there at my birth, was just, yeah, it was like the gold standard" – Cathy, P002

"She was reassuring, and the consistency was fantastic...she was amazing at advocating my wishes and things...and she just sort of kept grounding me..." – Millie, P008

"There was always that kind of cohesive continuity and I knew that you know, if something needed doing, she would do it for me, she would do the referrals, she would speak to her colleague...chase this up or whatever. And knowing that you've got someone that's managing that is a huge weight off your shoulders" – Claudia, P017.

When I asked women to explore their thoughts about midwives' public health role, responses generally focused on midwives' safeguarding responsibilities, checking the wellbeing of baby, and the importance of feeling safe, seen, and heard:

"[...] a midwife is a woman – is just advocating for women and their choices and things and supporting them. And I think if everyone had such a positive experience like...you know, like I did. I think, you know, the general feeling would be overall much more positive" – Millie, P008

"[...] like supporting the person through the pregnancy. Obviously like making sure that the baby's okay, obviously giving you that reassurance of everything, that the pregnancy is going to be fine..." – Lois P014.

"[...] obviously there's a lot of health promotion stuff and I expect for a lot of women there are other issues going on. And one thing I will say is, she was very hot on the fact that I'd had domestic violence issues with my ex-partner...you know safeguarding was very much at the forefront, healthy eating and lifestyle advice was very much at the forefront" - Claudia, P017

"[...] I feel like I'm talking to someone who's treating me like an equal, who has things that she has to ask me and go through, but is more – it is like having a friendship conversation of genuinely just checking in on how you are but also medically...she does it in such a way that it feels natural and it feels normal" – Iris, P020.

Knowing women could trust their midwives appeared to have a positive effect on women's relationship with themselves and engagement with wider services. The following excerpts reflect the experiences of women whose mental health deteriorated in pregnancy and their perception of their midwives' coordinated efforts to connect them with the wider interdisciplinary team. Being attuned seemed to propel women's care forward in a timely manner:

"[...] it's knowing that if you've got problems with anything that you, you can talk to one person and that person will then escalate things as needed...it's knowing that you've got, you've got this kind of one stop solution to all your problems almost" – Claudia, P017

"[...] I remember in my first pregnancy, the point in which my midwife noticed where things had changed, that I wasn't okay anymore...there is...a case for listening to what I'm saying, but there's also a case for noticing the things that I'm not saying" – Amelia, P021

"A positive impact with regards to just... feeling like someone had my back...actually someone in authority for a change. I just felt like the world's been against me for so many years, so to then come under the team was just a really sort of enlightening experience for me..." - Harriet, P022.

8.3.2 Tackling housing inequality

As discussed in [Chapter 7 – Section 7.4.4](#), two women in this study had experienced homelessness and/or were currently living in insecure housing. Rates of housing instability have continued to rise in the UK and were exacerbated during the COVID-19 pandemic (Agbai 2023; The Healthier Housing Partnership 2023). Housing status is a critical determinant of health. Among the general adult population, housing instability is associated with poor

healthcare utilisation and adverse health outcomes, such as depression and mortality (Brown et al. 2022; Reno et al. 2022). Pregnancy is a time of psycho-social-emotional evolution, and the association between housing and health may be even stronger during this time in a woman's life, because of the need for certain behaviour changes and enhanced engagement with maternity care (Theobald et al. 2022). In 2023, evidence from the perinatal mortality report 'MBRRACE', revealed that women who reported housing instability were more likely to be younger, from a GEM community, have lower educational attainment, and have a lower household income than those with stable housing (Knight et al. 2023). All of these sociodemographic factors have been associated with adverse pregnancy outcomes and increased costs to the NHS, and society (Cosstick et al. 2022; Knight et al. 2023). Inevitably, housing was a complex topic for the MCoC midwives in this study to negotiate in their practice. They expressed concerns about having limited knowledge or training on the role of the NHS and housing (The Healthier Housing Partnership 2023). Midwives' ability to influence housing was limited by fragmented integration between NHS maternity services, local authorities, and the wider ICS. A lack of standard operating procedures for managing unsafe housing incidents and inadequate data reporting and interoperability between EHRs and providers contributed to these issues. The following participant highlighted her concerns with the systems in place:

"[...] so, the council were having to provide information to the government on safe accommodation for women and children, but if the government start asking for statistics on that, then we'll have to stick something in BadgerNet, you know, "does this woman have accommodation, is she in a safe place? You know, does she need refuge etc?" you know all of those sorts of things. But can you imagine how big the bookings going to be, it's already like four miles long, isn't it? Why can't the systems just talk to each other?" – Samantha, PM014.

Midwives voiced their concerns about the impact of deprivation and expressed their frustration about their limited ability to improve families living conditions:

"[...] some women can't have their partners live with them because then they lose their money. So, they try and think practically, but then they lose that support. And then of course that affects their mental health and that affects their pregnancy and that affects their support with a new-born baby. But you can't really encourage someone else to live there because then they'd lose the money that they rely on – Bella PM002

"[...] overcrowding in housing, not being able to move house because of the council...violence, a lot of burglaries, a lot of crime, more so in the partners. Mental health, I would say was in absolutely every client I looked after, a hundred percent...you had it all...and domestic violence, the toxic-trio...was rife in pretty much 80% of all my women. So, I was dealing with not one thing but three, sometimes four..." – Denise, PM004

"[...] we've got massive, massive pockets of deprivation within the city centre. A lot of the tower blocks etc...and when you do approach housing or you do approach social care...you are met with a lot of resistance [from the housing department] – Natalie, PM012

Gemma (PM010) observed how difficult and isolating it was for migrant families, whose extended families were unable to visit due to regressive visa restrictions:

“Yeah, we get a lot of it, a lot of it [overcrowding], you know there’s not a big amount of movement at the moment... you know, we’re not getting the women that bring their mums and dads over to you know, an already crowded house to look, you know help look after the baby because you know, the visas aren’t allowing it...” – Gemma, PM010.

Visiting women in their homes and witnessing the conditions women lived in was shocking at times:

“[...]the whole place stank of dogs and urine and faeces and you just, you know, that woman had presented herself the whole time in clinic perfectly fine...but on that first postnatal visit at the house I didn’t even want to sit down, I wouldn’t have washed my hands there and you just think, you’ve got a new baby...the place wasn’t clean, it was filthy” – Samantha, P014

“[...] I did a booking at her home, the house was awful, you know they didn’t have a bed to sleep on, there was dirty food, everything lying around on the floor, there wasn’t a clean space anywhere. The only bit that was, was the coffee table, and - which just had like white stuff on it, and so I put the notes on there, and it was white cocaine powder that blew everywhere. Yeah, so actually you know, yeah, you can gain a lot from seeing people, from seeing them at home – Dana, PM001.

A lack of financial freedom and poor childcare options were seen as contributory factors forcing some women and children to remain in abusive relationships. Women living in the poorest households were seen to have little influence over their housing situation, which perpetuated cycles of abuse and deprivation, as Dana (PM001) and Denise (PM004) discussed:

“[...] I think, actually if some of our women had money, better childcare options and things to do, they wouldn’t end up in abusive relationships, I think it would be a different circumstance. But the - deprived areas the sort of the, the council flats...I think make it quite a challenge. Actually, if you live in them...it’s difficult to say without being mean or rude to the women, because that’s their life and what more options have they got...?” – Dana, PM001

“[...] it’s really difficult because you find that they either have...abusive partners that then they leave, which is excellent, but then, unfortunately a theme I saw was if you’ve had one, you tend to kind of go to another one. So, then they’re back into square one, which was really difficult – Denise, PM004.

Common misconceptions of poverty and structural inequalities influenced some of the midwives’ unconscious biases. Participants responses suggested that some believed women played the housing system as a survival mechanism, which may have impacted equitable care:

“[...] most of them now, their parent’s kind of tell them from the age of sixteen to try and get on the housing register as soon as they can, or whatever. Just to at least register their interest because it is often a two, three-year wait” – Bella, PM002

“[...] so, I think that they kind of, they know how to work the system to get the accommodation, or they’ve learnt what they need to do to get the accommodation from their parents. This is possibly, this sounds really cynical, I don’t mean to be cynical, but it’s kind of a survival thing, for them...” – Ruby, PM006.

The introduction of the Homelessness Prevention Bill (Anon. 2018), developed to tackle the housing crisis in the UK, included information on the statutory role of public services, including the NHS and social care, in reducing people's risk of homelessness. In 2019, the RCM published guidance and developed an e-learning module available to RCM members, about the role of midwifery in preventing homelessness. When this was explored in some interviews, midwives had not heard of the legislation or received any training about their role within the wider context, as this midwife concurred:

"[...] I've had families go into emergency housing...there's just so many different situations. But yeah, I think you come up against, and it's very, very hard because housing can only do so much, and I've not heard of the training you mentioned, didn't have a clue. As a midwife you can only do so much as we haven't had the training and I've no idea how we'd find the time – Natalie, PM012.

Considering the MCoC teams were based in areas of deprivation where housing was a considerable issue, this suggested an overall lack of policy to tackle the housing crisis or appreciation of the daily battles midwives faced trying to engage with local authorities. One participant wanted to gain more insight into her role in tackling the housing crisis, but highlighted her reluctance to assume additional responsibilities in an overstretched system:

"[...] I think we could have the scope to expand our knowledge on housing or, like I said, at least expand our contacts! At least to expand our knowledge in terms of contacts of who to signpost and refer to, rather than know the in-depth processes of housing and things like that...I do think we have got the ability to do that, but not without the staff" – Dana, PM001.

In practice this meant the majority of participants' knowledge was based on their experiential knowledge and awareness of the link between housing and health, rather than evidence-based information on prevention and intervention:

"[...] I feel like I know enough from building those networks and those contacts to signpost, but to actually provide advice, yeah absolutely, I think, I don't know half as much as they want us to know sometimes" – Dana, PM001

"[...] it leaves us vulnerable to giving the wrong information" – Fife, PM009

*"They think because you're a midwife that you...fair play, you know, they just think you should know how to do that and they just say, "well I want to move house, I need a house, I'm in overcrowded housing," you just kind of look at them like..."I don't know," *laughs*" – Gemma, PM010.*

8.3.2.1 Addressing the housing crisis is not a system priority

Throughout Amanda's (PM008) interview, she recalled the stark difference in the needs assessments she performed as a PAUSE practitioner compared to when she worked as a MCoC midwife. Her practice was informed and supported by the routine use of validated screening

tools, clear pathways of referral, and a broad knowledge of local assets. Working with PAUSE had increased her curiosity about the conditions women lived in, which she considered imperative as a critically reflective practitioner:

"[...] Then you've got, what's your current housing situation, have you got a legal tenancy, are you living with a partner? You know, are you currently homeless, but this is a bit more specific than are you living with family...but it will be something that you're going to have in your head 'if you're a fucking good midwife' – excuse my – and you're going to come back to it...Do you need help to access support?" "well yeah, I do but I don't know, what, what support, what are you talking about?" "So, then you can go...let me ring my mate down at housing, let me just quickly ring her whilst you're here and see if she can get you booked in for next week yeah?" – Amanda, PM008.

Despite the link between housing and health, participants narratives suggested that working to address this SDoH was not a policy concern for wider system partners. As a consequence, participants found themselves managing women's expectations about what they could influence, as some women thought midwives had more power to influence housing than they did:

"[...] they just didn't realise that the government had really just cut everything back, and they just really assumed that they'd be able to come in and I'd wave a magic wand and be like, "here you go, here's your council house, here's your things," and that's really not how it works anymore – if it ever did work like that." – Karla, PM005

"They think because you're a midwife that you...fair play, you know, they just think you should know how to do that...they think miracles will happen and you'll be able to click your fingers and sort something out, but I just, I'm very straight with them I just say, I don't have anything to do with housing, at all – Gemma, PM010.

8.3.2.2 'Our input seems to make little to no difference whatsoever'

The housing system and the wider socioeconomic and political milieu within which the midwives worked, did not seem to value the contribution of midwifery to the broader public health agenda. This assumption is based on the following quote, which suggested that prior experiences and a lack of integrated partnership working, meant that when midwives helped women on an 'ad hoc' basis their efforts were often ignored by organisations:

"[...] so, throughout the whole of pregnancy, I was emailing and contacting the housing officers to be like, "right, this is my concern, there was damp, there was mould, she didn't have flooring"...eventually she was moved but it was through a lot of determination and communication, I wish they made it easier for everyone involved" – Denise, PM004.

This left some midwives feeling like there was little point in recording and reporting the conditions women lived in. Other than to determine housing tenure at booking, the new EHR, Badgernet, implemented at the NHS Trust, did not facilitate the routine collection, analysis, and reporting of SDoH data like housing. There were also no validated screening tools or clear

referral guidelines to support midwives to collect and report on this data upstream. Midwives reflected on their experiences and the difficulties they faced when trying to act on housing issues:

“As midwives we used to be able to submit letters to say, you know, of supporting evidence, but they’re not listening to those anymore, it’s literally just a matter of time now...” – Bella, PM002

“I mean, almost none [influence] to be perfectly honest in my experience, both in this role and previously working with women more directly. It makes little to no difference whatsoever. It used to...a letter from midwives saying actually you know, the flat they’re living in is mouldy or they’ve got no access for a buggy or those sorts of things. We would write a letter and actually it would bump them up at least a few places, not significantly. But you know, it might make an impact” – Jane, PM007.

Some midwives did however recognise there was a national appetite for this to be integrated into new maternity EHRs:

“I don’t think we’ve ever been very good at collecting any kind of extra data, to be honest and that again will be something that is much more homed in I think over the next couple of years, I’m getting lots of questions, particularly from the domestic abuse and housing side of things...and hopefully with the more digital systems, we’ll be able to collect that and it will be a much more efficient system” – Samantha, PM014.

Describing the conversations she had with women about social housing, Bella (PM002), encouraged women to think about the location of the houses they were bidding on in relation to their families and important local assets:

“So, then we have to have conversations about, “okay so where are you bidding? Okay, why are you bidding there? Your family’s house is all the way over here and you don’t drive so that’s four busses to get there, so how about you bid for one nearer to your parents which, is also near a school and urr, oh its walking distance to your GP,” or whatever...” – Bella, PM002.

Another participant described how the local housing department had deterred her from making referrals. Natalie (PM012) recalls being told to look beyond her assumptions of what suitable living conditions were. Her response suggested an internal, moral conflict:

“[...] a lot the time I’ve heard things said to me along the lines of, “well you need to look past what you think is suitable housing and look at it as, could you live here?” Look past what I would consider like an ideal place to live and look at it is as, some people are quite messy, some people do, like don’t particularly look after their homes very well, like look past that” – Natalie, PM012.

Some participants made referrals to the Early Help teams within the local Family Hubs. A lack of clear referral pathways regarding housing, likely led to variation in practice and a lack of equitable access for women:

“[...] but also, the other issue you’ve got is you have to remember that you’re not the social worker. So, I can do the referral into housing, or I can do, depending on...what their

situation is, so it might just be like an Early Help referral...and then that incident it's kind of handed over to them in terms of their housing!" – Natalie, PM012.

As a result of a midwife making a referral to Early Help, one of the participants was able to secure more suitable housing. It was clear from the participants narrative below, that living in an overcrowded house had impacted her health and wellbeing. Michelle (P005) reflected on the difference she experienced after she was appropriately housed:

"[...] We were living in a one-bedroom property, with four of us. And within...probably within six weeks of being with Early Help Hub, we then got a two-bedroom property. So that made a big difference, because we weren't sat on top of each other, we all had our own space and they also helped me, because I had quite a lot of anxiety and I suppose postnatal depression because my first labour was so traumatic...And, I think it's all thanks to my midwife that we finally got the support we needed to finally give us a better lifestyle than we had, you know..." – Michelle, P005.

For women at substantial risk of homelessness or those who were currently homeless, where the immediate need was greater, midwives could also make urgent referrals to the Homeless Healthcare Team or to social services. However, this relied on self-disclosure. During the COVID-19 pandemic, midwives saw less women at home and so homelessness was more likely to go unnoticed. This observation in the data aligned with other evidence on the invisibility of homelessness during the COVID-19 pandemic (Crisis 2021; Theobald et al. 2022; Eliason et al. 2024). Women were more likely to withhold this information for fear of shame and stigma:

"so, there's like a homeless health visitor. Urm... yeah, the health visitor is really good, there's like a homeless health visitor, if they're actually homeless, or the housing office, and you basically just direct them in the way of the council, and they'll get allocated a homeless, sorry a housing officer, and they'll have meetings with them" – Gemma, PM010.

Ruby (PM006) recalled struggling for hours to get an organisation to take responsibility for the welfare of one a pregnant woman who had been made homeless. Despite social distancing measures, Ruby sat the lady in her car whilst trying to navigate a complex social care system. Until Ruby (PM006) involved the Director of Midwifery, a lack of routine pathways between health and housing caused considerable delays to the woman and her child being safely housed:

"I spent three hours, in my car with her on the street - I had the Director of Midwifery involved, I had safeguarding, I'd rang children's social services, I'd rang the homeless health care, blah, blah, blah, blah, blah. And kind of we were at the point where either she was going to have to use a bed up [at the hospital], or social services would have to pick her up. And eventually, with a real big battle, they picked her up and adult services, as a vulnerable adult, and they got some B&B accommodation for her" – Ruby, PM006.

Another participant felt their concerns were only properly addressed when violence against women and children was suspected:

"I went to a meeting yesterday with a girlie I delivered last night and she's... like significant domestic violence, you know they're talking about putting her in a refuge, stuff like that and...so I guess in that case you have input in housing because actually the housing officer was in the meeting, and it's like, "well it's not safe for her to go back, even though she wants to, you know we need to protect this baby, and is this the safest place for her to go?" – Gemma, PM010.

8.3.3 Tackling income inequality

Midwives play a crucial role in supporting income maximisation as part of their public health role (Allen et al. 2018; NHS England 2023e). This support is essential as financial instability can significantly impact maternal and infant health outcomes (Rayment-Jones et al. 2019; Reece et al. 2023). Midwives often act as a primary source of information about maternity benefits when women first access maternity care by providing guidance on accessing financial support and other maternity benefits (Royal College of Midwives 2023). This information can help women navigate the complex welfare system and can increase the likeliness of women receiving financial support they are entitled to (ibid). By integrating financial advice and support into maternity care, midwives in this study were a key proponent in propelling forward specialist help.

As discussed in Chapter 7, the COVID-19 pandemic increased women's vulnerability to income instability and insecure housing. Migrant women seeking asylum in the UK were especially vulnerable, not only due to the effects of dispersal programme, but also because women seeking asylum have no recourse to public funds, which restricts access to most mainstream benefits and housing assistance (McKnight et al. 2019; Letley 2022). Jane (PM007) described how migrant women were being held back by the meagre allowances they received from the Government, which increased their chances of exploitation:

"[...] it's really hard, I think when women want to move things forward for themselves, you know, if they've got other children and, you know, maybe they want to work, but actually it's illegal for them to work, but they can't survive on the benefits, you know, the meagre allowance they get. So, then they end up working illegally and being exploited and then they get in trouble....it's just that self-perpetuating cycle...for them to get out of it – Jane, PM007.

These situations were especially 'tricky' [PM005] for midwives to navigate, as there was limited national guidance on how to address such issues. Midwives responses suggested they were often having 'to step up and provide support' [PM013] in place of specialised services.

Midwives reflected on the complexity of helping women 'who didn't have anything' [PM005] during this time. In this situation, all of the midwife participants discussed referring women to local charities in the hope they could help, or they would refer women for an Early Help assessment before issues escalated further:

"[...] lots of women I deal with just don't have anything, they need early help assessment forms just because their benefits have been cut, especially when the government started to be a lot harsher on benefits, that was a big problem and having to put family support workers in place to try and figure out how we got them things...especially if they're undocumented as well..." – Karla, PM005

"[...] the home support group are a fantastic advocacy group that work with women to help them sort out their rent arrears, their benefits, all the finance part of it...you're going to make a referral to the home support group if they're vulnerable right now..." – Amanda, PM008.

Efforts to address financial insecurity and the wider determinants of health were interwoven throughout interviews with midwives, despite them having not received any training on how best to approach their role within income maximisation. In essence midwives accounts reflected the wider issues England faced - influenced by years of austerity prior to the pandemic. As the pandemic escalated and social inequalities deepened, pregnant women faced heightened levels of maternity discrimination. The social security safety net that previously helped families in poverty now appeared to be failing families. One midwife reflected on the difficulties she knew some families faced:

"Obviously, there's big pockets of deprivation. And I think that what we're seeing a lot more of it recently and issues with people not being able to afford to live. That seems, I don't know whether it's just that we're picking up more of it or whether it is becoming a bigger problem" – Jane, PM007.

Midwives reflected on how these issues presented themselves, which included increasing levels of multiple, intersecting complexities:

"so, you're, you're basically talking to housing about it, you're trying to get her...help her to change her benefits to see if anything's a bit more financially better for them" – Denise, PM004

"[...] when you turn it over, there's usually domestic abuse, physical health, debts, food poverty, and rubbish benefits, housing - would you like support, yes, no? Comments about this, so I put rent arrears and debt, okay...right we need to address that. Then relationships, how many children do you have? But actually, what we want to know is how many children have you got at home...Doesn't mean those six children are living with her..." – Amanda, PM008

Being based at the Family Hubs in the heart of women's communities was vital to be able to propel care and support forward for families experiencing food poverty:

"Recently [during the pandemic] we've had some women walk up to clinic and say to us, 'well I haven't eaten in three days, I don't have any money for food.' It's like eugh, it just breaks your heart. The benefit of working in SureStart [Family Hubs] is just amazing, because you can just go straight to one of the support workers and say, 'can you sign this lady up, she needs food parcels,' and we can go from there..." – Natalie, PM012.

8.3.3.1 Falling through the gap and missing out

At times, midwives were surprised that some women had *'fallen through the gap'* [P020] in terms of being entitled to receive maternity benefits. Some midwives investigated this further. Iris (P020) described how her midwife made sure to investigate whether she was entitled to receive income-based, maternity benefits:

"[...] my midwife was really like, "oh," you know, "you should be able to get the Sure Start Maternity Grant, or you know, everyone has the opportunity to get money from the government or statutory money." And I was like, "Hmm I'm pretty sure, because I did the research, I will get nothing." And she was like, "really?" And so, she looked it up even in the office because she was quite surprised that we had fallen through the gap" - Iris, P020.

When asked about what information women received on maternity benefits, women had mixed views on the information they received. Responses suggested wide variation in practice, which in turn likely impacted midwives' confidence in their ability to influence this determinant:

"Oh yeah, they used to tell me about all the additional things that I might be like entitled to and things like that. And they've been, they've always left me like links or like leaflets that like had stuff on it just in case I couldn't remember what they told me and things like that..." - Robyn, P012.

"[...] to have that extra support [from the midwife] and to say, "well do you want me to phone them for you? Do you want to sit here, and we'll phone them together?" you know? Just comments like that was just putting me at ease so much, because I just, I get very frustrated very quickly with it all - Harriet, P020.

Sarah (P009) recalled receiving no information about maternity benefits. The outcome of this was that she did not know she was entitled to receive The Sure Start Maternity Grant - a one-off payment of £500 to families on low-incomes and in receipt of certain welfare benefits - until it was too late to apply. In addition, she only received Healthy Start vouchers to purchase certain health foods, after her health visitor enquired on her behalf:

"[...] No, I was never told about any of that... Obviously, I didn't know anything about the grants and obviously by the time I'd applied for that it was too late, so I never received it...it was so frustrating..." - Sarah, P009.

Later on in Sarah's interview, she reflected on how this impacted her reality. Not only did she miss out on being able to purchase essential goods for her baby, but she also experienced food insecurity as a result:

"I literally got income support and child benefit, so that was £115 every other week and then £20.70 on a Monday or something like that. So that's not really, I couldn't afford at that point to buy the food we needed and all the baby stuff..." - Sarah, P009.

A lack of pandemic preparedness in the public sector meant that even when midwives signed application forms, women experienced considerable delays in receiving benefits due to staff

shortages, sickness, and redeployment. This had the power to compound women's situations even further:

"[...] Yeah, I got a letter through last week to say that...COVID backlog, COVID backlog, there's been a bit of a backlog, the vouchers will be back dated, but yeah so, I'm not actually on, I'm not in receipt of them just yet. But I will be, but it's a struggle" – Harriet P020.

8.3.4 Electronic health records and the digital divide in maternity

At the time of data collection, the local maternity and neonatal system (LMNS) had transitioned to a new electronic health record (EHR) 'BadgerNet', meaning all NHS maternity services in the LMNS could share integrated data - streamlining care, and improving patient safety and quality. As is the case in any large-scale, digital transformation project, the implementation of BadgerNet during the COVID-19 pandemic caused anxiety amongst some staff and added additional layers of complexity into the working practises of staff. An integral part of the transformation was for women's maternity notes to become digitalised, with women accessing their records on their mobile phones via an app, called BadgerNotes. A Health Equity Assessment (Office for Health Improvement and Disparities 2024) performed prior to the 'go-live roll-out' of BadgerNet, determined that women who could not access the BadgerNotes app or for women who opted out, would still be able to have access to paper notes. However, some midwives were understandably concerned about the impact this might have on patient safety, digital exclusion, and its potential to widen health inequalities:

"[...] a lot of these women don't have access to the technology that is required. And that is going to be the biggest nightmare with BadgerNet as well..." – Fife, PM009

"[...] I think we'll have to see how it goes but I'd feel like it's maybe going to really push some people out. Urm especially our women of like ethnic backgrounds...you know if you're looking at the Asian community a lot of them don't have phones...a lot of them use their partner's phones, urm, you know we've had a person recently who was like, "I don't have a phone, I don't speak English," and I don't know if BadgerNet supports that? I don't know if you can change the language on it..." – Gemma, PM010.

To support the rapidly changing demands of modern maternity services, BadgerNet claimed to achieve better functionality and interoperability between systems (System C 2024). The EHR also claimed to support better data capture and quality through structured and unstructured data improved data analysis and evaluation functionality for local planning and delivery. The system also supported national reporting of the Maternity Services Data Set (MSDS) to NHS England (NHS Digital 2021b):

"It can do almost anything, I think it has huge potential to be really, really good. It does put a lot of emphasis, though, on the midwife. Again it's... you know it's only as good as the information that's input in the first place, you know..." – Samantha, PM014.

8.3.4.1 Assessment and management of social complexity data in electronic health records

Pregnancy is a social experience that unfolds differently across cultures and populations and is spiritually, philosophically, emotionally, and relationally transformative for women, families, and society (Walsh 2006, 2010). However, UK midwifery practice currently exists within a dominant, risk-averse, medical model, that focuses on the diagnosis and treatment of illness (Walsh 2007; Kirkham 2011; Renfrew et al. 2022). This is evident in the increasing rates of childbirth interventions including induction of labour and caesarean section (Care Quality Commission 2024; Sandall et al. 2024) without improvements seen in perinatal mortality and morbidity (Knight et al. 2022; Felker et al. 2024), poor retention of midwifery staff (Moncrieff et al. 2023), and successive reports into failings of maternity service across England (Ockenden 2021, 2022, 2024). In contrast, a biopsychosocial approach, embedded in the maternity care systems of the Nordic countries, integrates a 'health in all policy' in maternity, which addresses the psychological and social factors contributing to health and well-being, alongside medical care (Leahy-Warren et al. 2021). This approach is supported by a broader social system that leverages maternity services to promote overall wellbeing and social justice (Duberstein et al. 2021). While this approach provides an important reference point for discussing models of health and wellbeing, a detailed examination of its impact in relation to this doctoral study was beyond the scope of this research.

At each appointment, midwives in this study described how they documented their assessments in an electronic health record (EHR). Assessments included routine inquiries about mental health, utilising validated screening tools embedded in the EHR, such as the GAD-7 (Han et al. 2022) and the Whooley questions (Whooley et al. 1997). However, in the study setting, the EHR did not comprehensively support the assessment and management of social complexity data in any structured format or pathway of care. A lack of mandatory fields and standardised screening tools in the HER resulted in incomplete data and varied risk assessment practices:

"[...] so, I did a DASH, a domestic violence, like separate tool assessment, there's certain question that you ask and then if they say "yes," then you have to act on it. So, I did that, and that was really common that we used in NEST including – so DASH was one, and GAD, and the other mental health ones, they were quite good at getting it on paper of what we're looking at, rather than just though conversation. And I found that lot of professionals needed that as like a backup" – Denise, PM004

"[...] I think that we need to be assessing needs in a very different way than what we do. If we want to...if we really want to offer a holistic service for these women...we've either - just got to be midwives or we can make it more of a one-stop shop and actually...and actually...risk assess the needs and triage the needs differently...you know, a tick box, but

almost 'a getting to know you' risk assessment, and that's not current practice at the moment..." - Amanda, PM008.

A separate, electronic referral to the Multi-Agency Safeguarding Hub (MASH) might be considered if a woman felt they needed additional support, or if a midwife had observable concerns that a baby might be at harm in the family unit (NHS England 2024a). This included situations where a woman was already known to Children's Social Services (CSS), or was experiencing IPVA, substance misuse, or severe mental health issues (NHS England 2024a). A MASH referral involves a coordinated approach to safeguarding unborn babies and their mothers and should be completed in collaboration with women to aid transparency and engagement (ibid). A MASH referral brings together professionals from various agencies, including social services, healthcare, and the police, to share information and make informed decisions about necessary support and interventions to support a family. The goal is to ensure that all relevant information is considered and that appropriate safeguarding measures are put in place to protect the unborn child and family unit (NHS England 2024a). Whilst women in this study generally understood the rationale for such risk assessments, the thought of a safeguarding referral caused concern for some women. Responses from both participant groups suggested that screening for risks, rather than exploring the structural inequalities that may have contributed to women's individualised situations, perpetuated a risk-adverse, medical model of care and the surveillance of pregnant women:

"[...] when they [social services] got involved, we had an unannounced visit at our home, which caused more stress because there was no need for that. And they said, "well there's a risk of you harming her," and I said, "we've not done nothing to our child." I even said to them, "why the hell would I abuse my child that I tried for nine-years..." - Adrienne, P001

"[...] I feel that they should investigate the situation a bit more. Like the family home, like quality of life, things like that...it's things like that, that I think young mums should get a bit more - not attention - but support around those areas..." - Sarah, P009

*"[...] when the child services came around...they put on my report that I was adequately housed. *Shrugs* Even though it's a really tiny little place, and the midwives said, "no, she needs a one bed because with bi-polar it would be good for her to be able to put the baby in a separate room." They were having none of it, they were just like, "yeah whatever"..." - Harriet, P022.*

Midwives' nuanced responses suggested that the best approach when discussing CSS was to be transparent about the close working relationship between the two professions and their responsibility to share information with each other:

"It was best to explain that I had all of these different hats, so, safeguarding I couldn't ignore those things, but just making sure that they really understood that my role was intertwined with what was going on with social care...women do get it that you can't just ignore it..." - Karla, PM005.

Some women reflected on the positive impact that support from CSS and wider services had on their quality of life, noting that their midwife was the driving force behind efforts to enhance care and support for their families:

"[...] we were able, well the girls Dad was able to then get the help that he needed to stop his drug abuse - and his alcohol abuse and now so, since Alice's been born, he's now nineteen months absolutely clean. And obviously [the midwife] put that initial referral in, and that initial referral then opened up to the people that we needed..." – Michelle, P005

"Yeah, she just approached it, as us as family as a whole, not just me as a woman, it was as a whole, and it really helped us" – Millie, P008.

In some circumstances, the relationship between social care and midwifery could put a significant strain on the midwife-woman relationship, which could result in women disengaging with care. This was especially difficult to navigate when women perceived midwives to be *'in with the social workers'* (PM002) in the context of care proceedings, as this midwife participant explained:

"[...] it puts a lot of pressure and challenge on your relationship with them. Especially if there's been a meeting where it's been discussed that that's a likely outcome or a possible outcome [removal of baby] and you're sat there aware of what's going to happen and then say, "so can I see you next week for your thirty-six-week appointment." And they probably think, "well no, because you're in with the social workers," and at that point they feel ganged up on and they don't trust you anymore..." – Bella, PM002.

Furthermore, *'the system'* (PM001) lacked a trauma-informed approach to supporting women whose babies were being removed. This caused considerable concern for midwives involved in women's care:

"[...] it's about sometimes you have to be quite...argumentative sometimes and literally take them [social worker] out of the room and say, "no, she's not decent, she's in the middle of being sutured, it's not appropriate for you to come in at the moment." So that's quite hard..." – Bella, PM002

"[...] we 'the system' do so much for these women when they're pregnant and this unborn baby has no rights, and we make out that it's for the woman, that we're doing this all for the woman, but it's not really, it's because she's pregnant, isn't it? We make sure they've got a nice place to live and they've got...everything they need, and then we remove these babies, and they get nothing, they're left on their own..." – Dana, PM001.

8.3.4.2 Using data to plan and evaluate the impact of MCoC models

One of the greatest challenges for complex interventions such as MCoC is ensuring that programme and services are tailored to the needs of the target population and achieve the intended outcomes of reducing perinatal mortality and morbidity (Sidell and Douglas 2012; Sandall et al. 2024). The success of MCoC models depend on good planning, implementation, evaluation, and information sharing (McCourt et al. 2023; Gillibrand et al. 2024; Middlemiss et

al. 2024). However, effective planning requires information about the needs of the target population through the collection and analysis of outcomes, as well as evidence about which interventions are likely to work, in what circumstances, and with whom (Sidell and Douglas 2012; Rayment-Jones 2021). Midwives in this study were concerned about the lack of evaluation of the MCoC model in terms of understanding its impact on population health and the impact this had on strategic and local planning. Midwives also noted that processes and systems were not currently in place to support data analysis:

“[...] Urm, in terms of outcome data, relating to sort of deliveries and those sort of clinical outcomes, we haven’t actually collected any yet as a whole Trust...in terms of evaluation work, it’s still to be looked at...the other complicating factor, is BadgerNet. So, pulling, stats, pulling stats out of BadgerNet at the moment is a little bit difficult...just in terms of the data isn’t...filled in because they’re not mandatory then we don’t get the right data pulled through...” – Georgina, PM013

“[...] the only way for us to get anywhere in this business now is to have the cold hard facts and the data in front of us. So that’s what people are asking for, “well you know, how do you know that that makes any difference?” But actually, we need to know how many, and how many before and how many we’ve improved it by and what our predictions are. So, it’s about being, you know, being a bit more savvy I think, isn’t it, about collecting data and stuff” – Samantha, PM014.

Midwives also noted the importance of being able to critically reflect on the impact of MCoC. Analytics would help to identify where targeted interventions were needed the most:

“[...] it’s all well and good providing continuity and we’re told the outcomes are better and everything, but actually, locally, where’s our evidence on that side...? Let’s have a dashboard...where I could just look at my tab...had twenty births and these are the outcomes, and this is what worked or what might work.” So, we’ve proven...even without doing a full study...you know that the outcomes are better for them – Melanie, PM011.

8.3.4.3 Digital literacy and the demands for data from NHS England

Most midwives working in the MCoC teams had an acceptable level of digital literacy but had limited knowledge on how data was used for MSDS and wider reporting. In general, data reporting and auditing were seen as other people’s business. Each team kept basic statistics for monthly reporting, but this tended to be the responsibility of one midwife in each team who had a personal interest, rather than it being embedded in everyone’s practise. The current process was slow and burdensome; relying on Microsoft™ Excel Spreadsheets saved to local drives, which were prone to user error and increased poor data management practices:

“[...] Yeah so, we have a spreadsheet so we...we send the stats to [removed] and [removed]. So, it’s broken down into homebirth, BAME...plus language etc. I think they’re the main ones, they’re all broken down into boxes, so that’s the main statistics we take on, but we don’t do any others, other than smoking and those, those are the numbers” – Gemma, PM010.

"[...] obviously they have the smoking cessation through pregnancy don't they...Urr so they have their own statistics with regards to that, I don't think that goes anywhere, I'm probably 100% certain that doesn't go anywhere, at all" - Melanie, P011.

"[...] we've had lot of problems...where a whole lot of data has gone missing and we can't work out why or how, it's just disappeared off the spreadsheet" – Samantha, PM014.

Two senior midwives at the NHS Trust, noticed that the demands from NHS England had increased since the pandemic, with more focus on providing data on health inequalities and safeguarding. However, concerns were raised about the reporting capacity of BadgerNet and the implications this would have on capacity and capability:

"[...] in the last sort of six to nine months so, it's been reporting on women living in the lowest, most deprived decile, so the IMD1 areas...that's what we look at and reproduce on a monthly basis at the moment. We also have to submit data...so obviously...the differences between booked and received continuity of care...we've got some of those of BAME and IMD1s to see where those women are booked...but how much are actually getting that whole sort of wrap around care..." - Georgina, PM013.

"[...] So...if the government start asking for statistics on [safe housing], then BadgerNet will have to stick something in, you know...but can you imagine how big the bookings going to be, it's already like four miles long, isn't it?"...and we have to keep lots of statistics for safeguarding but there's lots of free text, so you put the free text stuff in, and then you can't pull a report from a free text box, it's doesn't, you know there's not a computer system that works like that..." – Samantha, PM014.

Poor interoperability between existing legacy IT systems also presented significant challenges, especially regarding national reporting of immunisations in pregnancy:

"[...] so currently we have Pharm Outcomes, which we put in last year, and we're using that, but we've also got BadgerNet. So BadgerNet was supposed to do what Pharm Outcomes did, but they can't get it to work. So, in the clinic, they've having to put everything on BadgerNet, and everything on Pharm Outcomes as well. And now they've said that they want us to use NIVs, which is the National Immunization something or other - which we don't have. So, there is no way the midwife can do it three times for each vaccination" – Samantha, PM014.

The fragmented sharing and collation of information between agencies compromised patient safety and undermined the goals of digital transformation, as Samantha (PM014) explained later in her interview:

"[...] what is quite difficult then is the information I get from the police, or we get some information in an email from a health visitor, or we get an email from somebody else, maybe one of the street walkers who have been out, and they've seen somebody that they know, is pregnant who hasn't reported to us. So, we get information from a hundred different places, so it's kind of the information gathering, isn't it? So, it's quite hard to kind of collate that in any sensible way" - Samantha, PM014.

Regardless of their seniority, midwives reported to have received only basic training in using BadgerNet, which meant that midwives only used functionalities they felt comfortable with. Some of the midwives also felt they lacked knowledge about the significance of local data to

plan and evaluate outcomes of women receiving MCoC. Often midwives learnt the nuances of Badgernet ‘*on the job*’ (PM005). This was further exacerbated by the pandemic when pressure was high, which may well have led to variation in digital literacy and how midwives’ approached their documentation. As previously discussed, midwives felt their professional development was often overlooked despite the significance of their role. This likely contributed to feelings of resentment and low morale. Karla (PM005) contrasted her experience with a male dominated safety-critical profession - aviation. Aviation staff would never be expected to ‘*hit the ground running*’ with the implementation of new digital technologies. In contrast, midwives are often expected to simply get on with it:

“[...] we were having a conversation recently about how we just all basically learnt how to use K2 and now we’re going to BadgerNet, which hopefully will make our lives easier, but you wouldn’t turn around to a pilot and say, “oh by the way, here’s your new Boeing 747, have a crack on and see if you can drive it,” yet that’s what’s expected from midwives. And we’re just expected to be able to hit the ground running with it” – Karla, PM005

Melanie (PM011) contrasted the poor training she received to use Badgernet with her experience of working in the banking industry. Melanie was given the dedicated time and training to become confident in using banking systems, but not with using the new EHR as a midwife:

“[...] if you worked in a bank, someone would hand over the role of what you do, how you deliver money and how you tally up your – I only say that because I used to work in a bank, but coming into this role, no one sat there with me and say, “right this is your package, this is how you use it and what you do,” and everything” Whether or not that’s because COVID hit us and...everything that I’ve experienced and what I’ve encountered has not been the routine...” – Melanie, PM011.

At the time of data collection, MSDS reporting primarily focused on several key measures but did not capture the wider SDoH. These data included the number of women placed onto a MCoC pathway, ethnicity, deprivation, and whether women received a defined amount of care contacts from a MCoC midwife (NHS Digital 2021b). Specifically, this was measured by the number of women who reached 29 weeks gestation in a given month and had been placed onto a MCoC pathway, either at antenatal booking or by 29 weeks gestation. To qualify as having received MCoC, women must have been seen by their named midwife or a team member for at least 70% of antenatal and postnatal appointments, as well as during intrapartum care, from this point until discharge (NHS Digital 2021b).

BadgerNet had limited functionality in which to capture structured data about the SDoH using Systematized Nomenclature of Medicine - Clinical Terms (SNOMED-CT) coding of non-clinical actions such as food poverty, fuel poverty, and housing insecurity (SNOMED International

2024). SNOMED-CT is a comprehensive, multilingual clinical healthcare terminology used to accurately record patient data in EHRs and shares information across different health systems (ibid). Clinical coding and auditing are crucial for informing strategic and local decisions about performance and service planning and for accurate National Tariff Payment System of NHS services (The Health Informatics Service 2024). Achieving balance in digital transformation is critical, yet data suggested that the procurement of BadgerNet may have been secured without sufficient due diligence to ensure its capability to support the service in evidencing impact of MCoC on local perinatal health outcomes. This assumption prompted me to contact NHS Digital (now integrated into NHS England) to clarify if and how SDoH data is captured in EHRs and how data is measured for strategic planning. Communications between myself and NHS Digital are presented in [Appendix 6](#).

8.3.4.4 Rising inequalities and inefficient data collection

As discussed previously, midwives expressed concern about the increase in food poverty and the rise of gender-based violence during the COVID-19 pandemic. Amid the cost-of-living crisis, which was squeezing the incomes of the poorest families, midwives reported anecdotally observing an increase in fetal growth restriction and maternal ill health. Midwives were aware of the impact of food poverty on maternal and infant health, yet participants felt powerless to address this SDoH beyond referring women to organisations such as local food banks. Midwives responses also suggested there was significant variation in how they recorded their observations about what women were facing and the actions they took. Some midwives reported recording their actions in the free-text sections in BadgerNet as there were no mandatory fields to report this data, whilst others reported they did not document anything at all. In essence, this left participants' feeling unsure about their role in documenting the actions they took, which in turn meant the actions they did take often went unreported. Addressing women's needs in the moment was considered more important than documenting their actions:

"No, in a nutshell - a very quick answer...we don't collect any of this data or report it...it's very intricate and very individualised and you know...you know whatever you might need to be involved you'll get involved, it's more practical stuff that I focus on rather than reporting on it you know..." – Ruby, PM006

A lack of standard operating procedures and guidelines to support midwives practice meant that midwives were often left guessing about what to document and what pathways to follow:

“So, again, historically, I think...I would say, there’s never been a structure in place for public health aspects of things, like capturing data on food, smoking, urm, outcomes - but there are no process in place at the moment” – Melanie, PM011

“It’s not collected by us, I don’t think we’ve ever been very good at collecting any kind of extra data, to be honest and that again will be something that is much more homed in I think over the next couple of years...So, I think it’s coming, again, and hopefully with the more digital systems, we’ll be able to collect that and it will be a much more efficient system...” – Samantha, PM014.

8.3.5 Understanding and influencing public health strategies

At the time of data collection, midwives were part of the national response to the COVID-19 pandemic. National policy, regional and local strategies, and organisational guidance evolved and adapted at paced and controlled the working practises of midwives in this study (Brigante et al. 2022; Hanley et al. 2022). This impacted MCoC midwives capacity to influence health promotion and disease prevention at a local level.

8.3.5.1 Contraception is a massive gaping hole of public health practice

One of the main concerns of midwives in the study was the lack of postnatal contraception services and the impact this would ultimately have on women’s reproductive autonomy. A number of midwives described their frustrations based on years of working in the area and witnessing the impact of cuts to sexual health services. This had worsened exponentially during the pandemic, as these participants debated:

“contraception is for me...the massive gaping hole of public health, it’s a huge problem here...” - Ruby, PM006

“Then we’ve got this massive announcement from [removed] County Council, have you seen what they’re trying to do...? They want to reduce their budget by thirty million pounds...they’re going to get rid of all the sexual health nurses, they want to reduce contraceptive services even further...” – Samantha, PM014.

Prior to the pandemic, the inpatient maternity service established a postnatal contraception pathway for midwives to supply certain prescription-only contraception to women under a Patient Group Directive. However, attempts to embed this into routine practice had been piecemeal and those with the greatest need, often women receiving caseloading care, did not receive contraception before discharge home. This left women vulnerable to unwanted pregnancies. Ruby (PM006) explained her frustration about this part of the system:

“[...] So on [the postnatal ward] she still didn’t get it. And you think, well you’ve then got all that – basically the lady’s not up to sorting anything out... because...you know...there can often be quite a lot of chaos around their life and for them to take themselves to get

contraception, there isn't space often for it...so yeah you just sort of think, "for god's sake, I've literally - why has that not been handed over?" – Ruby, PM006.

The pandemic brought these issues into stark focus and demonstrated a clear inequity in contraceptive access for women. The MCoC midwives knew they were uniquely placed to positively impact this area of public health, yet there were no strategic plans to commission a postnatal contraceptive service into MCoC provision. This decision was made despite evidence demonstrating that women from lower socioeconomic groups are at higher risk of having unplanned pregnancies and/or short pregnancy intervals (Jordan et al. 2021; Felker et al. 2024), both of which have wider implications on perinatal morbidity and mortality:

"So... yeah, I think anything down the contraception route. Or even just having a contraception trained midwife within the team would be really useful for us and the women" – Bella, PM002

"[...] all those vulnerable women who've had baby upon baby, upon baby removed and you're like, "come on, lets support you to try and get your life back on track by not going down this road again." What an ideal place for a midwife to be able to absolutely...be able to give that contraception and that protection to that woman for another five years" – Fife, PM009.

As discussed [Section 8.2.2](#), one of the requirements of the PAUSE programme is for women to consent to receive Long-Acting Reversible Contraception, such as the coil or injection. This requirement was designed to give women control over their reproductive autonomy whilst engaged with the programme. Amanda (PM008) pointed to the wider impact this could have on public health and the return on investment the Local Authority would see:

"[...] so anyway, so it's to stop them basically getting pregnant again and, I mean it's all down to money, isn't it...it's to save the local authorities money. Because actually, us stopping the pregnancies and also working with those women to make them...their self-esteem better and to make them feel better about themselves and to put themselves first, and to stop them getting pregnant, is actually going to cost less than what it does to put these children in care, through care proceedings and all of that " – Amanda, PM008.

Other midwives also described how common it was for them to see the same women year after year. Reasons quoted for this were multifaceted, but the overarching theme was that community contraception services were difficult to access and did not meet the needs of women facing multiple disadvantage. This aligns with current evidence on the inequity women face in accessing equitable reproductive healthcare (Department of Health and Social Care 2022; Wickens and Jefferies 2022), as Denise (PM004) discussed:

"[...] you don't want a small pregnancy interval really, for many things, especially these ladies that lead these lives and live in such small accommodation. I just think...it's really difficult because you find that they either have...abusive partners that then they leave, which is excellent, but then, unfortunately a theme I saw was if you've had one, you tend to kind of go to another one. So, then they're back into square one, which was really difficult – Denise, PM004.

Prior to the COVID-19 pandemic, the MCoC midwives could refer women to an outreach sexual health service, where nurses could provide contraception at home to the “*most vulnerable women in the area*” [PM010]. However, staff in this service had been redeployed in the pandemic response, creating a significant gap in services for the women who needed contraception the most. One participant suggested these issues perpetuated cycles of generational poverty, compromising women’s bodily autonomy and preventing women from having control over their lives:

“[...] I had some women that didn’t want to be pregnant or didn’t feel elated by it for certain reasons or worried that they were going to have history repeating themselves but couldn’t even access outreach...we found it was young, sometimes younger ones that didn’t have any education of contraception or unfortunately didn’t have a parental figure. So, they didn’t have anyone to go to...they’ve never had a Mum or maternal figure in their lives because they’ve been through care system – Denise, PM004.

In a targeted effort to impact women’s reproductive healthcare and improve the life chances of children across the city, some of the midwives demonstrated strong leadership skills and attempted to influence local strategy. Cultural misconceptions about the use of contraception could also create access barriers for some women. One participant saw this as an opportunity to improve health promotion on the topic and set up a group for Afghan families before the pandemic, namely, to dispel myths about reproductive healthcare and to increase social support for families in the area. Ruby set this up in collaboration with Family Hub staff. Ruby delivered the service in her own time as there was no funding to support the group. This demonstrates the wider degradation of women’s health services across the city:

“[...] I ran a separate Afghan group, and the key...work with that was to really kind of drill home some public health stuff. Things like contraception was one of the key things...and just sort of like controlling kind of family, if pregnancy [unclear overlap 18:07] and their choices and that was just utterly enlightening, like yeah. One classic quote from one lady is that her husband wouldn’t wear a condom because he would get fat. It’s just like, “oh, that’s interesting”...the lack of knowledge was just huge – Ruby, PM006.

8.3.5.1.1 Midwifery-led postnatal contraception service

Over the years, midwives in the study sought to engage hospital executives, commissioners, and the local council to secure funding for a targeted, midwifery-led postnatal contraception service aimed at reducing unwanted pregnancies and child removals in the area.

Unfortunately, their attempts had repeatedly failed to gain momentum. Midwives were frustrated that their efforts were not taken seriously, despite presenting evidence on the potential return on investment:

"[...] it always got pushed by-the-by...I remember going to the city council for a collaborative meeting and we were talking about the fact that all these vulnerable women who have all this input, all this input antenatally...the minute baby is out the woman is discharged...but from our perspective, we need to get onto this contraception issue, we have to...it could be preventative in numbers, definitely. I mean it's just; it's just a no-brainer. To give a woman the possibility to take control of her life would be so beneficial" – Fife, PM009.

"[...] one of the midwives put in a very brilliant proposal, she put in about caseloading midwives putting in contraception, having clinics and everything on that, very passionate about that. But COVID hit us and urm it was kind of put to us...that we have services over the city run by the council that support these mums, whatever...like you said, have your baby, bang there you go contraception in, then at least you know you'd have that," – Melanie, PM011

"[...] I think it's not something that they would take forward... if we had a service that would be easier for them to access, yeah oh gosh it would be amazing" – Natalie PM012.

8.3.5.2 Midwifery representation on the local Health and Wellbeing Board

The Health and Social Care Act (Anon. 2012) assigned local councils the responsibility to improve public health, deliver health protection services, and provide public health advice to their populations. This included the statutory requirement to establish a Health and Wellbeing Board in each Local Authority to bring together political, clinical, professional, and community leaders to direct population health priorities. In the study setting, the Health and Wellbeing Board concentrated on reducing health inequalities through their commissioning decisions. They delivered the Single Needs Assessment for the city—a holistic evaluation of the current and future health and social care needs of the community (Southern England City Council 2023). Local identified needs could be addressed by the Local Authority, the ICB, or NHS England. However, a report published by the Local Government Association, noted that central cuts to council funding made partnership working with a broad spectrum of key stakeholders, including the NHS, difficult (Local Government Association 2024). In the study setting, core membership of the Health and Wellbeing Board included medical representation from the local health system but did not include representation from nursing, midwifery, or the allied health professions.

This was confirmed when I attended an online committee meeting in March 2023 ([Appendix 6](#)). This represents a significant lost opportunity for public health practice, as the Board lacked the knowledge and experiences of these core professional groups. These findings were also echoed by the midwives in this study. When asked about how they worked in partnership with the wider system, midwives had no knowledge of the Health and Wellbeing Board. In essence, their narratives alluded to the fact that the midwifery profession continues to face challenges

in influencing the strategic direction of public health services and interventions in their communities:

“[...] Urm... I can’t partic- I, I know... no, probably is the straight answer to that. I mean I kind of... particularly I don’t know what the health and wellbeing board do... urm... I’m being abit vague, to be fair” – Ruby, PM006

“No. Should I? Is that a trick question? Could I benefit from it? Should I be involved? Can I be involved” – Melanie, PM011

“[...] No. I wonder if the SureStart centre is involved? The SureStart centre will work with families in a much broader spectrum I suppose I wonder if that’s something they know about? Yeah, no I’ve not come across it – Natalie, PM012.

8.4 Conclusion

In this chapter, the category ***‘we’re only really scratching the surface of the complexities women face’*** has been discussed to demonstrate the significant challenges MCoC midwives faced trying to tackle widening inequalities during the pandemic. With limited resources across the system, including from statutory and non-statutory services, and the VCSE sector, midwives were sometimes left picking up the pieces of services in order to address women’s needs.

Participants stories revealed a stark reality - the training midwives received failed to prepare them for the level of complexity they would deal with by working in the MCoC model. Despite this, midwives demonstrated remarkable resilience and agility, fostering strong, relationally attuned, and empathic connections with women. Working in the MCoC model promoted the chance of midwives developing an attuned midwife/women relationship. As metaphorical linchpins, propelling care forward and maintaining the integrity of the healthcare system, midwives attempted to influence the SDoH impacting women’s lives such as, housing and income inequalities, IPVA, contraception, and perinatal mental health. Targeted efforts to address perinatal inequalities in the area were threatened by the introduction of a new EHR, digital literacy, inadequate data collection and evaluation processes at Trust level, ineffective partnership working across systems, and a significant lack of midwifery presence at strategic level to influence local public health commissioning.

As a professional group, midwives are well placed to contribute to public health planning and delivery in their local systems, as they witness the effects of health inequalities in their everyday work supporting communities and understand the environments where women and babies are born, live, work and age. However, midwives continue to have limited power on their own to modify the SDoH. This chapter concluded with examples and recommendations to

improve this, such as the collection, interrogation, and reporting of data, with further investment in prevention and intervention measures to better support the life chances of women and children.

The next chapter, Chapter 9, will critically examine findings from this study within the broader evidence base.

Chapter 9. Discussion

9.1 Introduction

This ConGT examined the SDoH that impacted the lives of perinatal women in areas of high deprivation and their MCoC maternity care experiences. In addition, the research explored the experiences of MCoC midwives to better understand how MCoC midwives manage to tackle widening perinatal health inequalities. However, examining these domains revealed that the majority of participants in the perinatal women group had experienced traumatic events in their childhoods and/or adult lives, which intersected with gender-based discrimination and the wider determinants of health. These experiences had a cumulative and damaging effect on women's lives and often exacerbated levels of poverty, discrimination, and hardship across their lifecourse. Traumatic experiences were also found to negatively impact women's physical and psychosocial health.

Findings also provided evidence about the additional complexities women faced as a result of the COVID-19 pandemic, the mechanisms that underpinned improved outcomes in women receiving care within MCoC models, and the evolving public health role of NHS midwives who work in these models of maternity care.

The research was guided by the following research questions:

1. What SDoH impact the lives of perinatal women living in areas of high deprivation, and how do they manage these?
2. What do MCoC midwives know about the SDoH impacting the lives of women and babies living in deprived areas?
3. How do MCoC midwives address the SDoH and tackle perinatal health inequalities?

The two core categories emerging from the analysis, ***'sucking it up and getting on it'*** and ***'we're only really scratching the surface of the complexities women faced'*** were discussed in Chapters 7 and 8. In this chapter, I discuss several key areas that emerged and critically analyse findings within the existing evidence base. Most of the literature discussed is published after 2020, which contextualises findings in relation to the impact of the COVID-19 pandemic on maternity services and the emerging public health role of MCoC midwives in the context of widening perinatal inequalities.

9.2 Sucking it up and getting on with it

This research established that, in the face of adversity and frequent exposure to traumatic events, the women in this study developed a coping mechanism termed, '*sucking it up and getting on with it*'. This survival strategy was grounded in women's nuanced stories of how they survived ACEs such as parental neglect, abuse, bereavement, and abandonment.

Women also disclosed how they navigated traumatic events later in life, structural inequalities such as socioeconomic- and gender-based discrimination, and how they coped with having a baby during the COVID-19 pandemic.

As women transitioned into motherhood, they navigated the perinatal period whilst grappling with the reverberations of their past traumas. Their narratives illustrated a complex interplay between their historical experiences of attachment traumas and the negative impact these experiences had on their health, birth outcomes, and their experiences during the immediate postnatal period. Women living in areas of deprivation (IMD 1–3) were more likely to have experienced ACEs and traumatic events in adulthood compared to women living in IMD 4+. However, the small subgroup of women residing in IMD 4–5 included two single mothers who were receiving benefits and struggling to make ends meet while facing multiple disadvantage. This demonstrates the complexity of assessing socioeconomic status solely through area-level indices, as individual circumstances can diverge significantly from aggregate measures, and push women into poverty (Wallace et al. 2018; Reis 2019; Maternity Action 2025).

Despite fourteen participants being in employment, women described in-work poverty precipitated by the intersections of pregnancy, low pay, and discriminatory practices. Several participants were forced into early maternity leave during the COVID-19 pandemic under policies ostensibly designed to mitigate health risks. Policies that, in practice, reduced women's incomes and exacerbated financial stress. Poor statutory maternity pay further intensified instability. The relative value of statutory maternity pay has declined in England against median earnings and the minimum wage, rendering it insufficient to meet the basic needs of many families (Psarros et al. 2023b, 2023a; Maternity Action 2025). Women reported borrowing money to cover essentials, relying on family and friends, seeking help from charities of the Family Hubs, or going without so their children did not. These are not isolated hardships but systemic features of a misogynistic benefits system that fails to promote or protect maternal and infant health or offer economic security

during a critical life stage for women and their families (Psarros et al. 2023b, 2023a; Maternity Action 2025).

Findings in this study are supported by evidence which also underscores the profound impact of ACEs on perinatal health (Millar et al. 2021; Roberts et al. 2021; Kern et al. 2022; Mackle et al. 2023; Mamun et al. 2023; Brunton 2024; Suarez and Yakupova 2024). In 2023, a systematic review and meta-analyses by Mamun et al. (2023), revealed there to be a strong association between ACEs, pregnancy complications such as gestational diabetes and depression, and adverse birth outcomes such as preterm delivery and low-birth-weight babies. Findings highlighted the global pervasiveness of trauma as a public health issue and underscore the need for future research to determine whether trauma-informed maternity care improves outcomes. Similar findings have also been reported in studies by Kern et al. (2022) and Brunton et al. (2024). In another systematic review and meta-analysis, Kern et al. (2022) demonstrated that women with a history of ACEs had a 27% greater chance of having a preterm birth, a 42% greater chance of having a low-birth-weight baby, and a 37% greater risk of gestational diabetes compared to women without ACE histories. Moreover, evidence from a systematic review in 2024 conducted by Brunton et al. (2024), found that childhood sexual abuse (CSA) was associated with higher cortisol levels in pregnancy and an increased risk of suicidal ideation. A history of ACEs also increased the risk of women developing PTSD symptoms, especially when combined with IPV in pregnancy. Women with histories of CSA or childhood physical abuse (CPA), also had higher risks of experiencing pregnancy complications, interventions during labour and birth, and an increased risk of their babies requiring admission to neonatal intensive care (Brunton 2024). In this doctoral study, women who experienced ACEs were also more likely to experience poor intimate and familial relationships, birth trauma, poor physical health, and expressed difficulties with bonding with their babies in the postnatal period.

9.2.1 Reactivation of survival strategies in the perinatal period

Qualitative research further illuminates how ACEs and traumatic experiences in later life can be reactivated during pregnancy and childbirth. Existing studies have consistently found that abuse, particularly sexual abuse, is strongly associated with adverse perinatal mental health and physical complications (Brunton and Dryer 2021; Millar et al. 2021; Roberts et al. 2021; Lissmann et al. 2023). In a classic GT study by Roberts et al. (2021), researchers examined the maternity care experiences of six women-survivors of CSA in the UK. Findings

revealed the strategies women developed to survive CSA could be reactivated in pregnancy and childbirth as a way to cope with, and survive, the sometimes-unconsented procedures women face as part of their maternity care. Research participants described losing control and lacking bodily autonomy in situations such as fetal monitoring and intimate physical examinations. The GT developed in Roberts et al. (2021), coined, '(Re) activation of Survival Strategies during Pregnancy and Childbirth following Experiences of Childhood Sexual Abuse' explained how survivors of CSA coped with their maternity care experiences. Women's behaviours and responses to procedures were often misinterpreted or ignored by healthcare professionals and their bodies objectified. Participants described using emotional numbing as a coping mechanism via dissociation. Moreover, the researchers' concluded that women's reactions were involuntary survival strategies triggered by situations perceived to be threatening. Therefore, the experience of pregnancy and childbirth can present as a rupture in women's psycho-social-emotional wellbeing. This presents a challenge for overstretched NHS maternity services, where successive reports have demonstrated workforce shortages and underfunding has led to services that lack resources for personalisation and culturally sensitive care (Ockenden 2022; Care Quality Commission 2024; Darzi 2024; Illingworth et al. 2024). Findings in Roberts et al. (2021) support findings that emerged in this doctoral study. For example, participants with experience of ACEs and traumatic events in later life were more likely to report their labours and birth experiences as retraumatising. In the context of this doctoral study, traumatic memories and somatisations were more likely to be triggered when women did not have their named MCoC present with them during labour. This increased the likeliness of women receiving care from multiple, unknown midwives and obstetricians (as was more common during the COVID-19 pandemic due to staff shortages in the MCoC teams), birth plans being ignored, reactions to procedures misinterpreted as women being difficult, and women receiving a lack of personalised care. This highlights the significance of the midwife-woman relationship and continuity of care as a preventative, public health intervention. Findings from this doctoral study also extend evidence from Roberts et al. (2021), by revealing how attunement acted as an integral mechanism to mitigate the possibility of re-traumatisation. In principle, establishing an attuned midwife-woman relationship is more likely within MCoC models. However, during the pandemic, a lack of preparedness and insufficient assessment of demand and capacity led to disruptions in continuity of care. Moreover, a blanket policy to increase caseloads within MCoC teams was implemented

without adequate planning or consideration of the unintended consequences for women facing multiple disadvantage, like most of the women in this doctoral study.

An interesting finding in this study revealed that the handover from midwifery to health visiting and primary care could also reactivate survival strategies and feelings of abandonment among women with experience of ACEs. After forming a close attachment to their MCoC midwife, some participants described feeling abandoned when discharged from midwifery care. These findings underscore the potential value of screening for ACEs and the SDoH, alongside routine screening for mental health and social care involvement. Such screening could inform the development of targeted MCoC models for women facing multiple disadvantage and support earlier prevention and intervention strategies to address increasing complexity and poorer outcomes in these groups.

The concept of attunement, as previously discussed in [Chapter 8 - Section 8.2.5](#), derives from disciplines such as psychology and psychotherapy (Finlay 2015; Talia et al. 2020; Watson and Wiseman 2021). Attunement refers to the process by which an individual becomes responsive to and aligned with another's emotions and needs, often through nonverbal communication, and is pivotal in understanding the dynamics of interpersonal relationships (Finlay 2015; Talia et al. 2020; Watson and Wiseman 2021). This doctoral study identifies the process of attunement between midwives and women as a novel contribution to midwifery knowledge. Attunement fostered a deeper understanding of women's lived realities and the subtleties of their behaviour and responses to care. The experience of relational attunement was integral to informing and extending care and support across the wider maternity care system.

As previously discussed, evidence demonstrates that women's survival strategies can be misinterpreted by NHS maternity services, leading to objectification and disrespectful care that disregards women's human rights (Roberts et al. 2021; Mackle et al. 2023; Niles et al. 2024). In my study, the concept of attunement helped to further midwives understanding of women, which in turn supported and informed midwives efforts to advocate for women's rights. Amidst the chaos of the COVID-19 pandemic, an attuned midwife-woman relationship could create a sense of cohesiveness and confidence in the quality-of-care women received. Furthermore, attunement emerged as being an integral mechanism that fostered safety and trust in the system and provided space for women to experience themselves and their transition to motherhood. These considerations are significant for

midwifery knowledge, as they build on existing understanding of the mechanisms underpinning the positive outcomes associated with MCoC and offer novel interpretations of the impact of relational continuity for perinatal women.

9.2.2 Becoming a mother and regaining a sense of control

The participants in my study revealed that becoming a mother had powerful implications on their relationship with themselves and their children. Some women revealed they regained a sense of control over their lives by becoming a mother, whereas other women with a history of ACEs – especially those who experienced parental abandonment and the death of their mothers in childhood - reported problems with attachment, poor perinatal mental health, and cumulative and intersectional social complexities. Eight women-survivors of sexual assault in a UK-based qualitative study by Lissman et al. (2023), found that participants' preferences for becoming a mother were often motivated by their desire to retain a sense of control and to feel safe. Many of the study participants said it was important for staff to know they were survivors of sexual assault, but that none were asked about their histories. Researchers recommended that maternity services should prioritise training on the impacts of trauma and experiences of sexual assault as part of working towards being 'trauma-informed' (discussed in [Section 9.3.1](#)). Investment in trauma-informed training is a fundamental step in equipping staff with the foundational knowledge and skills they need to care for all women but especially for women with a history of trauma (Lissmann et al. 2023).

Some of the women in my study reported IPVA, including sexual assault, but only disclosed '*just enough*' [P013] information about their past traumas to their midwives. Participants also shared how the baby's needs may be prioritised over and above their own, which could impact women's sense of agency and control over decisions about their care. One participant in my study reported dissociating and feeling like she was '*crying-out-for-help*' [P012], but staff did not recognise this until she reached crisis point. These findings are supported by research from Lissman et al. (2023) and align with Young's (2017) concept of pregnancy embodiment, which argues that discourse surrounding pregnancy often omits subjectivity by failing to adequately account for individual personhood and perspectives. Similarly, Rothman (1991) writes that women are not '*flowerpots*' (p.125) in which babies are planted but are social beings with a relationship to themselves and their pregnancy. This metaphor underscores the urgent need for substantial improvements in how maternity

services support women with trauma histories. It also highlights the importance of equipping MCoC teams with robust demand and capacity planning, ensuring they can effectively create opportunities for women and midwives to build attuned, trusting relationships. As the evidence from this doctoral study suggests, these factors are likely to foster greater disclosure and enable more personalised, embodied care that truly places the needs of women and families at the centre of maternity services.

9.2.3 Carrying the imprints of trauma

Evidence is clear that human's carry the wounds of past traumatic experiences in their bodies throughout their lives (Felitti et al. 1998; van der Kolk 2014; Frederickson et al. 2024; Miller et al. 2024; Walker-Mao et al. 2024). The perinatal period has also been shown to be a unique period in which women can experience reactivations of their previous experiences in the form of poor health, worse birth outcomes, and even re-traumatisation in situations that are felt to be threatening (Felitti et al. 1998; van der Kolk 2014; Frederickson et al. 2024; Miller et al. 2024; Walker-Mao et al. 2024). In my study, this was shown to manifest in women's health and their intimate relationships, including their relationship with themselves and their midwives'. Evidence from this doctoral study demonstrated that this could lead women to feeling disconnected and fragile, especially in the postnatal period. For example, some women recounted how their childhood traumas resurfaced, exacerbating their health and the contexts and conditions of their lives. Whilst women living in areas ranked IMD 1–3 were more likely to disclose a history of multiple disadvantages, such as poverty and social exclusion, women in IMD 4–5 areas also reported significant mental health challenges following traumatic events. This demonstrates that trauma is not limited to those in the most deprived communities; it transcends socioeconomic boundaries and affects women across all social divisions. Recognising trauma as a universal risk factor underscores its importance as a major public health concern requiring inclusive, trauma-informed approaches (Nagle et al. 2022; NHS England 2023e, 2023c; Benton et al. 2024).

As women in this study attempted to manage the demands of new motherhood in a world that was becoming increasingly precarious, the COVID-19 pandemic further complicated these dynamics, adding additional layers of isolation and anxiety. Evidence from this study demonstrated that the coping mechanism women adopted – ***sucking it up and getting on with it*** - while functional in the short term, contributed to a higher prevalence of mental

and physical health issues and negatively impacted women's experience of pregnancy, birth, and motherhood (Farrow and McEwan 2024; Niles et al. 2024; Watson et al. 2024).

9.2.4 Intersectionality

This doctoral research is inherently feminist in its inquiry as it examined the impact of trauma and the SDoH on perinatal health and wellbeing and also identified how MCoC midwives work to tackle widening inequalities. As previously discussed in [Chapter 4 - Section 4.4](#), intersectionality served as an important conceptual lens for this research. I understood intersectionality to be a critical constructivist paradigm that aligned with the principles of ConGT by drawing attention to how multiple systems of oppression, power, and privilege intersect to shape women's lived experiences (Hill Collins and Bilge 2016; Kassam et al. 2020; Hayvon 2024). This perspective also informed my awareness of power dynamics within healthcare systems and among stakeholders, emphasising how these dynamics are embedded in historical and cultural contexts relevant to perinatal health. The literature on intersectionality informed my interpretation of findings, particularly in recognising how trauma and the SDoH are cumulative and intersect with gender, race, class, and disability (Hill Collins and Bilge 2016; Williams and Lewis 2021; Ajayi et al. 2024).

A significant finding in this study revealed that most women had experienced ACEs and/or traumatic experiences later in life. Due to the sensitive nature of the topic and how much women were comfortable to share with me; it is likely that I too only **'scratched the surface'** of the multiple issues women faced. Traumatic experiences appeared to have a cumulative effect on women, but especially for women who experienced traumatic events in their childhoods. Participants with ACEs were more likely to report multiple other intersectional inequities such as socioeconomic deprivation, gender-based violence and abuse, housing insecurity, maternity discrimination, and social service involvement.

As analysis has shown, women both tacitly implied and overtly described the detrimental effect that previous traumatic experiences had on their physical and psycho-social health. Due to their social positions relative to their household incomes, many women in this study experienced discrimination in the workplace and at home. This meant that some women shouldered the majority of unpaid labour, including homeschooling their children whilst also being pregnant and/or looking after other young children during national lockdowns. This was especially challenging for women who were single mothers and shouldered these burdens alone. Class, culture, and protected characteristics, such as pregnancy and learning

difficulties, all increased experiences of multiple disadvantage and shaped the unique experiences of women in this study.

Midwifery, a predominantly female profession, is also known to experience gender-based discrimination, which in turn impacts midwives' ability to challenge the status quo and enact meaningful improvements in perinatal health inequalities (Kai et al. 2007; Mainey et al. 2022; Theobald et al. 2022; Naughton et al. 2024). Section 9.3 will now examine these issues in more detail.

9.3 Scratching the surface of the complexities women face - MCoC midwives knowledge about trauma and the SDoH and how they tackled widening perinatal health inequalities

This research has also explored the significant challenges MCoC midwives faced during the COVID-19 pandemic. Participants' efforts to address the cumulative and intersectional challenges faced by women were undermined by a range of meso-level systemic factors. These included inadequate demand and capacity planning, poor pandemic preparedness, weak data collection and evaluation processes, ineffective partnership working across health and care services, and a significant lack of midwifery representation at strategic level - limiting midwifery influence on local decisions about population health prevention and interventions.

Literature consistently underscores the high prevalence of trauma in society, such as ACEs, VAWG, and domestic homicide (Drexler et al. 2021; de Klerk et al. 2022; Tran et al. 2022; Lefever-Rhizal et al. 2023). The true picture, as we have seen from the stories of participants in this study, often exceeds documented instances within the maternity care setting. As highlighted in the literature reviewed in this thesis and supported by findings from this research, trauma's pervasiveness can have profound consequences for women and their babies. It is associated with increased risks of perinatal complications (Lefever-Rhizal et al. 2023), perinatal mental health disorders (Choi et al. 2020; Hall et al. 2021; Tran et al. 2022), and other adverse birth outcomes (Tran et al. 2022). These factors contribute to a cascade of poor social and health outcomes and impose substantial costs on individuals and society (Ayers et al. 2024; Miller et al. 2024; Runyon 2024).

The insidious nature of trauma has been positioned as a significant public health issue, which operates at the intersections of individual, relationship, community, and society. Many argue that addressing trauma necessitates a public health framework in order to understand risk and protective factors for trauma and its aftermath (Magruder et al. 2017; Alderwick et al. 2024; Egede et al. 2024). Such a framework could elucidate how trauma affects maternal health, infant development, and the overall wellbeing of families, highlighting the need for prevention across multiple levels (Magruder et al. 2017; Alderwick et al. 2024; Egede et al. 2024).

Midwives in this doctoral study expressed their concerns about being under-prepared to deal with the level of complexity families faced. Indeed, this research found that midwives

were often '*scratching the surface of the complexities*' women and children faced even with an attuned midwife-woman relationship. The rhetoric surrounding midwives public health role - and the training, if any – was not prioritised at local or national level. Nevertheless, expectations on them as professionals, and of the MCoC model itself, remained high. As a consequence of inadequate professional development, this left midwives' and women vulnerable to inconsistent practices and inequitable access to interventions and support services. The analysis suggested, that in some cases, this impacted the degree to which Proportionate Universalism was actualised in the MCoC model. For instance, Amanda's (PM008) knowledge about what trauma and the SDoH actually looked like in reality was entirely transformed by temporarily stepping outside of midwifery and working for the Local Authority with the PAUSE programme. Working with PAUSE and supporting women whose babies had been removed from their care deepened her professional curiosity and strengthened her ability to form attuned relationships. Amanda's positive experience appeared to be shaped by the quality of trauma-informed education and training she received for the role, training that far exceeded anything provided during her time as an MCoC midwife, despite working with a similar level of need.

Amanda's experience illustrates 'what good looks like' for women and families and highlights the potential for shared learning from other disciplines within the context of MCoC models.

Given the prevalence of ACEs and trauma identified in this study, the next section examines the literature on trauma and trauma-informed care as an approach to addressing perinatal inequalities and its relevance to MCoC models.

9.3.1 What is trauma?

Trauma has been studied for over a century, but it was not until the 1980's and 1990's that the concept gained enough interdisciplinary support and evolved into a distinct disciplinary field (van der Kolk 1985, 1989; McFarlane and van der Kolk 1996; van der Kolk 1997). Initial interpretations of trauma centred on events that threatened life or bodily integrity, or involved close encounters with violence and death, commonly recognised in combat veterans and victims of political terror (Herman 1992, 2022). Decades of interdisciplinary research since then has developed our understanding of how people can experience trauma symptoms in other circumstances. Evidence has shown surprising parallels between

private horrors like CSA and public horrors like war (Herman et al. 1989; van der Kolk et al. 1994a; van der Kolk et al. 1994b; Felitti et al. 1998; Brunton 2024). Interest in trauma and its impact on health and social outcomes increased following the publication of a landmark paper on ACEs, by Felitti et al. (1998). This study enrolled nearly 10,000 participants and is one of the largest investigations into childhood abuse and neglect. Researchers found a strong link between the extent of exposure to abuse or household dysfunction during childhood and multiple risk factors for leading causes of death in adults (Felitti et al. 1998). Findings from this study have shaped subsequent research on trauma globally and informed international policy on the development for trauma-informed services.

Leading Dutch American psychiatrist and researcher on trauma, Dr Bessel van der Kolk, defines trauma as an event that overwhelms an individual's ability to cope, causing lasting changes in the mind and body (van der Kolk 2014). He emphasises that trauma is not just about the event itself, but how the individual experiences and processes it on an individual level (ibid). Furthermore, the Substance Abuse and Mental Health Services Administration (SAMHSA) in the USA, defines trauma as an event, series of events, or set of circumstances that are experienced as physically or emotionally harmful or life-threatening (Substance Abuse and Mental Health Services Administration 2014). Furthermore, experiencing trauma can be overwhelming, leading to long-lasting effects that significantly alter perception of self, others, and the world (Substance Abuse and Mental Health Services Administration 2014). These issues include myriad health problems, mental health disorders, and substance use issues, and are also linked to poor social outcomes like homelessness, violence, crime, substance abuse, and poor interpersonal relationships (Banaj and Pellicano 2020).

The concept of trauma has also begun to take on new meanings in diagnostic and cultural contexts. Diagnostically it is considered important to differentiate trauma if symptoms cause substantial harm to the individual, as is the case for PTSD (Karatzias et al. 2022). When diagnosing trauma, organisations like the American Psychiatric Association and the WHO, consider it crucial to use the term only if individuals are impacted by specific events, such as war, oppression, and exploitation and lead to clinical disorders or significant stress (American Psychiatric Association 2022; World Health Organization 2024a). However, cultural interpretations of trauma reflect how society has begun to understand the term, which has shifted focus to individuals' accounts of the harm they have experienced -

emphasising the importance of lived experiences rather than clinical diagnosis of the concept (Kaneko 2019).

Medical trauma, like birth-trauma, specifically relates to responses triggered by the physiological and psychological aspects of a diagnosis, treatment, or procedure that leads to pain, fear, or distress (International Society for Traumatic Stress Studies 2025). In the UK, the National Institute for Health and Care Excellence did not formally recognise birth as being a potentially traumatic event until 2014 (National Institute for Health and Care Excellence 2014). Prior to this, misogynistic medical and societal assumptions about birth, assumed that women could not experience birth as traumatic, despite evidence to the contrary (Docherty 2023). Evidence demonstrates that up to 40% of women in the UK experience birth as in some way traumatic (Docherty 2023). Even in the context of this doctoral study, conducted some eight years after publication of the NICE guidance (National Institute for Health and Care Excellence 2014), women described how their behaviour and responses during labour could be misinterpreted and/or their birth plans ignored by some healthcare professionals. This could increase the reactivation of survival strategies learnt from past trauma experiences for some women, such as dissociation and somatisations.

Findings from this doctoral study also support and build on findings from the first UK-wide inquiry into birth trauma, led by the All-Party Parliamentary Group on Birth Trauma (All-Party Parliamentary Group on Birth Trauma 2024). Launched in 2024, the inquiry aimed to investigate the cause of traumatic births and develop policy recommendations to tackle rates of birth trauma in NHS maternity services. The report, *'Listen to Mums: Ending the Postcode Lottery on Perinatal Care'*, called for radical improvements to maternity services including, standardising relational-based, high quality care, increasing funding for maternity services, and enhancing mental health support for mothers. It also emphasised the need for better trauma-informed training for healthcare professionals, including support for partners, and ensuring mothers' voices are heard in policymaking (All-Party Parliamentary Group on Birth Trauma 2024). The recommendations would contribute to improved perinatal care and reduce birth trauma but have yet to be implemented by the Government into maternity policy in any tangible way.

The UK charity, 'Make Birth Better', were a key stakeholder in the birth trauma inquiry. The charity define birth trauma as symptoms of trauma related to birth and/or circumstances

around birth, but stress that society has mistakenly focused solely on the birth event in isolation (Make Birth Better 2024). Perinatal trauma is said to be a more accurate term, that encompasses the entire perinatal pathway, including pre-conception, which can be fraught with additional issues for women and their families, and early pregnancy, when women are more likely to suffer in silence with poorly understood conditions like hyperemesis gravidarum (Make Birth Better 2024). Losing control and intense fear are critical factors in experiencing perinatal trauma (ibid). Pregnancy loss can also have a profound and lasting impact on women's health, and as we have seen from findings in this doctoral study, services during the pandemic were insufficient in supporting women through their experiences of trauma and loss. Importantly, this type of trauma can impact women regardless of age, gender, socioeconomic status, race, ethnicity, or sexual orientation. However, marginalised groups – like some of the women in this doctoral study - endured not only the direct effects of perinatal trauma but also faced additional layers of discrimination. These experiences can intersect and amplify trauma encountered throughout women's lives and can reactivate old survival strategies just so women can cope with what life has thrown at them.

9.3.2 Adverse Childhood Experiences and Trauma-Informed Care

Trauma experienced in early life, referred to more widely as ACEs – which occur before the age of 17 - are particularly harmful (Felitti et al. 1998; American Society for the Positive Care of Children 2022). Trauma experienced in later life, including IPV, sexual assault, warfare, oppression, and natural disasters are also significant (van der Kolk 2014). A number of women in this study disclosed experiencing interpersonal traumas both in their childhood and in later life and their narratives highlighted the potential impact on them and their babies.

While trauma can result in PTSD and other trauma-related disorders, not all trauma experiences are pathological or fall under the category of a disorder. Nonetheless, research shows that women who have experienced trauma can face adverse outcomes in the perinatal period, with imprinted effects across the lifecourse (Reiss et al. 2019; Frederickson et al. 2024; Walker-Mao et al. 2024). These issues include chronic health problems, mental health disorders, and substance use issues, and are also linked to poor social outcomes like homelessness, violence, relationship issues, and substance misuse

(Felitti et al. 1998; van der Kolk 2016; Banaj and Pellicano 2020; Marmot et al. 2020a; Marmot et al. 2020b).

The concept of trauma-informed care (TIC) was first articulated in the mental health arena by Harris and FalLOT (Harris and FalLOT 2001). This arose from findings that indicated a considerable proportion of people seeking mental health care were also survivors of physical and sexual abuse (Harris and FalLOT 2001). By adopting a trauma-informed approach (TIA), services adapt to recognise how trauma can shape people's life chances, realities, and the way in which they interact with health and care services. The detrimental effects of trauma on functioning and wellbeing, as well as health-related behaviours, can significantly hinder a person's willingness and ability to engage with services intended to support them (van der Kolk 2014). TIC represents a fundamental shift in how professionals and services interact with their patients. However, as findings from this doctoral study demonstrated, there was a lack of integration of this evidence or evaluation of what TIC models might work for perinatal women and understand what circumstances.

Nevertheless, evidence on TIC seeks to address underlying individual and structural causes on health and wellbeing, rather than merely treating surface-level symptoms. TIC has been found to reframe essential diagnostic inquiry in the mental health arena from "What is wrong with you?" to "What happened to you?" (Substance Abuse and Mental Health Services Administration 2014; Knight 2019). This perspective acknowledges that any person seeking services or support might be a trauma survivor and emphasises that systems must recognise, understand, and counter the effects of trauma to promote healing and prosperity (Goodman et al. 2016).

At the core of TIC in the mental health space, is the recognition that the emotional, psychological, and social repercussions of trauma can create barriers for people seeking and engaging with services (Barrett 2019). Furthermore, even when trauma survivors do access services, interactions with providers who lack an understanding of trauma, may inadvertently exacerbate feelings of disengagement and reinforce existing issues, such as substance abuse and poor mental health. A TIA speculates that employing a 'trauma lens' can spotlight the root causes of poor health, maladaptive behaviours, and social challenges, ultimately leading to more effective interventions and support systems (Barrett 2019).

In Western contexts, TIC has gained considerable traction in international policy. In the USA, initiatives have been established to integrate TIA across various levels of governance -

federal, state, and community - reflecting a growing recognition of the importance of understanding trauma in shaping health and social services (Melz et al. 2019). Similarly, in the UK, the Scottish and Welsh Governments are actively pursuing strategies to embed a TIA into public policy, commissioning, service provision, and professional practice (NHS Education for Scotland 2021; Welsh Government 2021b; NHS Education for Scotland 2023). The Scottish Government has developed the *'Trauma-Informed Practice Knowledge and Skills Framework'*, which aims to provide guidance and training for professionals across various sectors, including health, education, and social services (NHS Education for Scotland 2021). The framework emphasises the importance of understanding trauma's impact on individuals and encourages the integration of trauma-informed principles into everyday practice. Additionally, Scotland has established a National Trauma Training Programme, which focuses on equipping all public sector workers with the skills necessary to recognise and respond to trauma effectively (NHS Education for Scotland 2021, 2023). This initiative is part of a broader commitment to improving mental health and well-being as outlined in the *'Mental Health Strategy 2017-2027'* (Scottish Government 2017).

In Wales, the Welsh Government launched *'A Healthier Wales'* (Welsh Government 2018) and the *'Whole School Approach to Mental Health and Wellbeing'* (Welsh Government 2021a), which incorporates trauma-informed principles within educational settings and population health practice. These policies aim to integrate health and social care services to better meet the needs of individuals and create environments for children where educators and support staff are trained to recognise and respond to trauma. Thereby creating supportive, relational-based atmospheres conducive to learning and healing.

The English Government has made less progress on embedding a TIA in all policies but has made commitments particularly in the context of health and social care. The *'Reforming the Mental Health Act'* (UK Government 2021) and the *'Children and Young People's Mental Health Green Paper'* (UK Government 2018) emphasised the need for a system that recognises and responds to trauma. These policies highlight the importance of integrating trauma-informed principles into mental health services, promoting a more integrated approach to care. Additionally, the English government has indicated a commitment to improving mental health support and has allocated funding for initiatives aimed at enhancing access to TIC. For instance, the *'NHS Long Term Plan'* (NHS England 2019) includes provisions for mental health services that are responsive to the needs of people

who have experienced trauma. However, as findings from this doctoral indicated, some women found access to specialist perinatal services challenging. As maternity services can also themselves be the cause of the trauma women experience (All-Party Parliamentary Group on Birth Trauma 2024), this demonstrates how far maternity services are from being a trauma-informed service. In some circumstances in this doctoral study MCoC midwives '*stepped up*' [PM002] to provide the practical and emotional support that other specialist services were not providing effectively during the COVID-19 pandemic. However, midwives' were not equipped with right skills and knowledge in which to provide the level of specialist care women needed.

9.3.3 Implementation of Trauma-Informed Care in maternity services

For the midwife participants in this doctoral study, it was clear that attempts to sensitively manage and address trauma on an individual level was threatened by a lack of knowledge and education. Midwives described feeling ill-prepared to deal with the level of complexity women faced. It has been suggested in the literature that adopting a TIA in maternity care will facilitate the development of tailored interventions to address interpersonal trauma and tackle other intersectional inequalities. However, in England a consensus has not been reached as to how a TIA could be applied to maternity care (Birthrights and Birth Companions 2019; Birthrights 2022; All-Party Parliamentary Group on Birth Trauma 2024; Make Birth Better 2024).

For women affected by trauma, the journey towards recovery, personal growth, and resilience can take many forms, often involving the development of coping mechanisms, such as '*sucking it up and getting on with it*', in order to protect themselves and their babies from further harm. Women survivors of trauma and structural inequalities thrive, when maternity care systems and providers, remain mindful of their conscious and subconscious language and behaviours (Birthrights 2014; Birthrights and Birth Companions 2019; Birthrights 2022; All-Party Parliamentary Group on Birth Trauma 2024). Recent international evidence highlights women from GEM backgrounds, women from disadvantaged communities, indigenous people, and women with disabilities experience higher rates of trauma exposure and intersectional discrimination within maternity systems (Andersson et al. 2024; Birger et al. 2024; Miller et al. 2024; Niles et al. 2024; Thomas 2024; Toke et al. 2024). In practice, many women have faced forms of trauma that often go unrecognised and unrecorded (Roberts et al. 2021; Collins and Skarparis 2024). Therefore,

everyone engaging with maternity care deserves to be treated with enhanced sensitivity and with a concerted effort to balance power dynamics and promote opportunities for trust and safety to be developed between women and healthcare professionals. It is crucial that clinical recommendations and resources for both healthcare professionals and service users emphasise the significance of TIC at both individual and systemic levels of care (Andersson et al. 2024; Cole et al. 2024; Frederickson et al. 2024).

There is a wealth of evidence exploring different approaches to implementing TIC in maternity care and the known challenges of system-wide adoption, implementation, and sustainability. Given the reasonable assumption that trauma is a pervasive public health concern and that women have experienced myriad traumas in their lives, a consensus-based article by Johnson et al.(2023), suggests a gradual integration of a TIA through inquiry about adversity and resilience factors, using open-ended questions and structured measures. A central goal of TIC is the avoidance of both traumatisation and re-traumatisation. Survivors in particular may be impacted by subsequent trauma when navigating maternity care systems: at times with active awareness, and at other times unconsciously reactivated (Johnson et al. 2023). As we have seen in this doctoral study, even within a trusted and attuned midwife-woman relationship, midwives are not always aware of previous traumatic experiences. Sometimes the effects, such as heightened arousal, difficulty maintaining eye contact, or physically withdrawing consent by moving away from the provider, are noticed first (LoGiudice et al. 2023). Successfully integrating TIC into clinical practice, organisational policies, and standard-setting documents, requires careful consideration of various aspects of care. Key areas of focus include language use, screening processes, intimate examinations, mandates for chaperones, and the recognition of clinician trauma (Johnson et al. 2023). When discussing coping strategies with trauma survivors, Johnson et al. (2023) recommend it is essential to adopt a strengths-based perspective that promotes healthy coping while avoiding a deficit framework that pathologises women's coping strategies.

A trauma-informed approach mandates that providers create an environment conducive to open dialogue about trauma history (LoGiudice et al. 2023). This involves normalising discussions around sensitive topics, providing explicit consent for intimate examinations, and empowering patients through choices in their care. Additionally, the importance of recognising clinician trauma cannot be overlooked, as midwives may also carry their own

trauma experiences (Chrzan-Detkos and Murawska 2023). Education programmes should encompass strategies to address secondary trauma, ensuring that midwives are supported to reflect on their own experiences while providing care (Patterson et al. 2019; Toohill et al. 2019; Lowden 2023). Ultimately, the adoption of TIC may well support the healing of perinatal women but also the wellbeing of midwives and other maternity care staff.

Routine enquiry into psychosocial issues are integrated in variable ways in midwifery practice. Evidence suggests that screening is often limited to poor questioning rather than validated screening tools (Lefever-Rhizal et al. 2023). Findings from this doctoral study support this observation by highlighting a significant lack of validated screening tools to support routine enquiry about trauma and the SDoH. Moreover, from my own anecdotal experience in midwifery, routine enquiry about perinatal mental health is supported by validated tools integrated in EHRs, such as the Whooley questions for depression screening (Whooley et al. 1997) and GAD-7 for generalised anxiety disorder (Han et al. 2022), but screening for trauma and the SDoH relies on broad questions about demographics and social complexities. Currently, trauma and SDoH metrics are inconsistently applied in UK EHRs, partly due to the poor integration of evidence on the SDoH into maternity policy and the lack of consensus on which validated tools are fit for purpose in UK contexts (Allen et al. 2018; Marmot et al. 2020a; Phelan 2023; Eliason et al. 2024).

A quality improvement project (QI) conducted by Lefever-Rhizal et al. (2023), aimed to improve rates of trauma disclosure and personalised care planning for women in the USA. The intervention included providing training for all maternity care staff, based on SAMHSA's model on TIC (Substance Abuse and Mental Health Services Administration 2014). The model includes six guiding principles to achieving a TIA. The training aimed to increase professionals' awareness of the impact of trauma in the communities they served and offered solutions to address social injustice. The six principles are:

1. fostering a sense of safety;
2. trust and transparency;
3. peer support;
4. collaboration and mutuality;
5. empowerment voice and choice;
6. attention to cultural historical and gender issues.

In addition to implementing the six principles, TIC also encourages routine screening for all maternity care users, regardless of whether women disclose a previous history of trauma or not (Lefever-Rhizal et al. 2023). This is most effective in a trauma-informed context where all staff are trained to consistently apply the values and principles of TIC in their daily practices. Trauma screening can also include combined approaches, such as screening with validated tools, general inquiry, or providing universal education to women about the root causes of structural inequalities, the potential impact of trauma in the perinatal period, and available sources of support (Lefever-Rhizal et al. 2023). Although none of these methods have been shown to be superior in recognition or acceptability, qualitative research also indicates that women survivors want to be asked about their trauma histories (Tran et al. 2022; Horan et al. 2023; Montgomery and Chang 2023). Moreover, women often do not disclose trauma during the first inquiry, but relational-focused MCoC can provide trusted environments and increased opportunities for women to feel safe enough to disclose their experiences (Sperlich et al. 2017; Thomas 2024).

The American College of Obstetrician and Gynecologist's, Reproductive and Sexual Coercion Questions (American College of Obstetricians and Gynecologists 2013), the Edinburgh Postnatal Depression Scale (Levis et al. 2020), and the Primary Care PTSD Screening (PC-PTSD) tool (Prins et al. 2015) were used to support routine enquiry at specific time points in the perinatal journey in a study by Lefever-Rhizal et al.(2023). These validated tools were used to identify psychosocial issues and PTSD. With the help of system and community partners, screening was followed by personalised care planning that respected the rights of women to choose what interventions and support they felt were right from them. Results from Lefever-Rhizal et al. (2023) demonstrated an increase in disclosure from 5% to 30% and identification of PTSD from 0% to 7% after implementation of the QI project. Personalised care planning and acceptance of help increased from 8% to 67%, with midwifery staff rating the new process as highly valuable.

9.3.3.1 Training and education

Care of women who have experienced CSA can be challenging and has not been part of undergraduate/pre-registration curricula in the UK, nor in specialist training for obstetricians (Montgomery and Chang 2023). Many participants in the study, like midwives in this doctoral study, felt unprepared to care for survivors with lived experience of CSA (ibid). CSA has been described as one of society's most serious public health issues (Roberts

et al. 2021; Bradshaw 2023; Brunton 2024). As discussed in [Section 9.2.1](#), women-survivors of CSA may experience reactivation of their abuse and may feel scared and isolated during their childbearing journey. TIC can facilitate healing and improve outcomes for survivors, but healthcare professionals often lack the knowledge and skills to provide such care. Montgomery et al. (2023) researched this gap in knowledge in a UK-based, qualitative study, that sought to identify clinicians training needs and explore the experiences of survivors of CSA within maternity care. The study was designed in consultation with The Survivors Trust— a national umbrella agency that supports more than 120 member organisations across the UK and Ireland providing specialist services for survivors of rape, sexual violence, and CSA— as well as with other key stakeholders in a South London NHS Trust (The Survivors Trust 2025). Thirty-seven healthcare professionals and students participated, comprising twenty-five students of midwifery, health visiting and medicine - nine midwives, health visitors and doctors with specialist obstetric training. Eight women with lived experience also took part in focus groups. Many practitioners felt unprepared to care for those with lived experience of abuse and their learning needs were varied. Survivors reported sensing the discomfort felt by healthcare professionals, which reinforced their reluctance to disclose. Staff reluctance to ‘ask the question’ mirrors women’s reluctance to disclose. The need for a learning resource to support healthcare professionals was acknowledged. An outline for an educational programme, produced following the focus groups, was endorsed by participants with lived experience of abuse. The proposed resource, which included interactive elements such as short films and animations, clinical scenarios, and case studies, was well-received by participants. One participant described:

‘[...] I think this is a great project actually because this is pushing this further forward. This is opening up the world that this actually happens. This is something that happens but there is somebody trying to change it for women, so I think it’s brilliant’ - (pg. 5).

Findings from Montgomery et al. (2023) confirm similar findings in my study, where midwives felt they were **‘only scratching the surface of the complexities women face’** but extends my findings further by triangulating findings with students of healthcare disciplines, registered clinicians, and women-survivors of CSA. Findings from my doctoral study and Montgomery et al. (2023) demonstrate there is a critical need for education on ACEs like CSA and the wider SDoH in pre-registration training and the professional development of qualified staff. If trauma-informed education was mandated and incorporated into the *‘NMC Standards of Proficiency for Midwives’* (Nursing and Midwifery Council 2024), it is

reasonable to suggest, that a trauma-informed workforce could help to moderate the effects of trauma and the potential for re-traumatisation in the perinatal period.

In 2021, Gentry et al. (2021) conducted a rapid evidence review to determine if ACEs should be routinely screened for and mapped this evidence against the UK National Screening Committee (UKNSC) programme criteria (UK National Screening Committee 2015). Evidence was identified from meta-analyses for associations between ACEs and a wide range of adverse outcomes (Wilson and Jungner 1968). However, there was no consistent evidence available on the most suitable screening tool, setting of administration, and time or frequency of use in practice. However, routine enquiry among adults was found to be feasible and acceptable to both service users and professionals in various settings. Additionally, a wide range of potentially effective interventions was identified. However, limited evidence was available on the potential for screening, routine enquiry to reduce morbidity and mortality, or the potential for harm as a result of screening. Based on the application of available evidence to the UKNSC screening criteria, Gentry et al. (2021) concluded there remained insufficient evidence to recommend the implementation of a national ACEs screening programme. Therefore, the authors recommended that further research is required to determine whether routine enquiry can improve morbidity and mortality and improve population health and wellbeing.

These findings are in contrast to wider debates about the impact of screening for ACEs and other psychosocial traumas (Vinikoor-Imler et al. 2011; Walker et al. 2020; Tran et al. 2022; Watson et al. 2022; Walker-Mao et al. 2024). Evidence from this doctoral study also demonstrated the cumulative and intersectional impact of trauma and the wider determinants of health. Given that inequalities are widening in England (Dorling 2024), the short-term impact of the pandemic on perinatal morbidity and mortality (Knight et al. 2020; Felker et al. 2024), the increase in VAWG (World Health Organization 2024d) and domestic homicides (Rasmussen et al. 2023; Taylor and Bates 2023), it is reasonable to suggest that routine screening in maternity care could well contribute to reducing prevalence and impact through early intervention. The implementation of routine screening could also support MCoC midwives professional development and equip the wider maternity services with the competence and confidence to tackle widening, gender-based inequalities.

9.3.4 Social Determinants of Health framework in maternity care

The concept of SDoH, which this doctoral study explored from a perinatal perspective, is central to understanding health inequalities (Lathrop 2020; Birtles 2022; Hayvon 2024). A consistent finding across multiple research studies is the pervasive impact of SDoH on health outcomes, particularly for disadvantaged populations. Studies demonstrate inequities in maternal health (Dawson et al. 2021; Fitzhugh et al. 2021; Ellehave et al. 2023; Peahl et al. 2024) (Preis et al. 2022; Peahl et al. 2023) and underline the need for targeted interventions to tackle widening perinatal inequalities. The SDoH have also been shown to account for over 40% of health outcomes in the general population (World Health Organization 2024b; Centres for Disease Control and Prevention 2025). The effects of social complexities are even more profound for perinatal women, whose health is intimately linked to that of their infants and families (Robertson et al. 2021). The WHO's commission on the SDoH highlighted the role of the SDoH in driving rates of illness and inequality (Commission on Social Determinants of Health 2008). Despite this the concept's practical application in healthcare settings is often inconsistent (Dhlamini 2023). Existing research underscores the importance of interdisciplinary approaches to addressing health inequities, drawing on theories such as social justice and equity, diversity, and inclusion (EDI) frameworks (Hayvon 2024). It also highlights the complex interplay of structural and social factors - including poverty (Fenney and Buck 2021), ethnicity (Khan 2021), and geographical location (Dawson et al. 2021) - that shape unequal health outcomes.

While numerous studies highlight the urgency of addressing these factors in healthcare, significant challenges remain in effectively integrating SDoH considerations into policy and clinical practice (Allen et al. 2013; Allen et al. 2018; Marmot et al. 2020a). These findings were also reflected in this doctoral research, particularly in relation to the challenges midwives faced in the absence of routine screening tools and pathways of care.

The idea of health care systems intervening to address the SDoH is not new. In the USA, various frameworks have been developed, demonstrating potential improvement approaches (Fitzhugh et al. 2021; Novilla et al. 2023; Peahl et al. 2024). For example, in 2019, the National Academies of Sciences, Engineering, and Medicine (NASEM) committee developed a five-part framework outlining potential actions to identify and address the SDoH (National Academies of Sciences 2019):

- Awareness: identifying social risks, such as food insecurity or housing instability, and assets of defined patients and populations;
- Adjustment: focusing on adapting clinical care depending on patients' social circumstances;
- Assistance: reducing social risk by connecting patients with relevant social support;
- Alignment: identifying the existing social services and supports in the community to facilitate synergies and partnerships;
- Advocacy: promoting policies to address health and social needs – for example, advocating for increased investment in social security to help protect people's health.

However, no equivalent framework exists in England to support understanding of the various approaches currently being tested or promoted within the NHS.

In 2022, the Health Foundation, a UK based health and care think-tank, proposed four categories that could support NHS action on addressing the SDoH (Buzelli et al. 2022). In each area, policy and system-level changes were recommended, such as better data collection and analysis of individual SDoH data, community involvement in decision making, staff capacity, and training. Evaluation is also needed to understand the potential benefits and risks of NHS action (Buzelli et al. 2022). At all levels it is proposed that NHS staff and organisations can use their power and resources to advocate for wider social policy change to improve health and reduce inequities. The size and reach of the NHS means it has the potential to act as an 'anchor institution', harnessing its role as an employer, purchaser of goods and services, and a powerful political institution to benefit local communities, including supporting unrepresented communities to build a career in the NHS (Buzelli et al. 2022). The suggested framework has been adapted and described in Table 12.

Table 11. A framework for NHS action on the social determinants of health adapted from Buzelli et al. (2022)

	Individual level	Population level
Within the NHS	Adapt NHS care to account for patients' social needs For example – use data on patients' housing conditions to inform treatment and medication decisions	Use NHS resources to improve social conditions in the community For example – widen access to high quality employment in the NHS for more deprived groups

NHS in partnership	Connect patients with resources to address social needs For example – link patients to food banks or advice about benefits	Aligning local resources to improve population health For example - joint planning between the NHS and local partners to identify and respond to local needs

Implementation of the above framework depends on a combination of system-level changes, such as prioritising the implementation of SDoH data and I would argue more nuanced data collection on trauma experiences, community involvement, staff capacity and training. The first set of approaches focus on adjusting to the way care is provided to account for individuals' social needs. More disadvantaged groups, like many of the women in this doctoral study, often face greater barriers to accessing high quality care (Felker et al. 2024). Women's social circumstances like work schedules, housing conditions, and cultural traditions, and beliefs about pregnancy and childbirth may make it harder for women to benefit from some forms of preventative care without additional support (ibid). Moreover, systematic understanding of patients' social contexts - as we have seen in the findings from this doctoral study where poor data collection and funding impacted the ability of MCoC midwives to target interventions - may help reduce these barriers and improve clinical decision making. For example, information about cultural beliefs towards health, housing, or food insecurity may influence decisions about maternity care access (Macias-Konstantopoulos et al. 2023; Quattri 2023; Eliason et al. 2024). The framework presented by The Health Foundation supports findings in this doctoral study (Buzelli et al. 2022). Midwives traditionally worked in close partnership with the Family Hubs prior to the pandemic, but system wide pandemic unpreparedness, directly impacted the level to which organisations and staff could deliver targeted services together. Whilst the pandemic created opportunities for midwives to '*step up*' [PM013] and provide whatever women needed due to reduced cross-organisation collaboration, it could have also posed unintended risks to women and midwives, including burnout and the strain from having such little training on how to manage the level of complexity women were faced. Midwives in this study, like those in Griffiths (Griffiths et al. 2013; Griffiths 2019), tended to stay involved because the need was so great - influenced by their own values and their professional responsibility to safeguard women and children. However, participants varied practice existed within a system that only neglected to capture routine data on trauma and

the SDoH data but failed to prioritise their professional development. Increased awareness may also support midwives in advocating for policy changes to improve community social and economic conditions, drawing on the extensive insights they gain from their frontline experiences and practical knowledge.

In the USA, health care systems are increasingly adopting routine screening to understand potential social risks and identify appropriate onward referral (Eder et al. 2021). Emerging evidence also suggests that SDoH screening are feasible and generally acceptable to patients and clinicians (Byhoff et al. 2019; Eder et al. 2021). However, there are also risks to consider which could exacerbate inequities further. Research suggests that screening for social risks can contribute to fear and discomfort for patients, and concerns exist among clinicians about identifying social issues they lack tools to address (De Marchis et al. 2020). Findings from this doctoral study expand upon this evidence in the context of midwifery, as midwives revealed they were generally ill-prepared to deal with the level of complexity women faced.

Research from the USA also suggests that the integration of screening and the resultant action required to address the SDoH, presents challenges related to time constraints, resource allocation, and workflow integration (Fitzhugh et al. 2021; Birtles 2022; Novilla et al. 2023). Gaps remain in incorporating screening into pathways of care and EHRs for making clinical decisions and predicting health outcomes. Current strategies are largely directed at moderating individual-level social needs versus addressing community-level root causes of health inequities (Fitzhugh et al. 2021; Birtles 2022; Novilla et al. 2023). Studies conducted by Fitzhugh et al. (2021) and Birtles (2022) explored the implementation of screening tools and referral pathways using QI methodologies. In a study by Fitzhugh et al. (2021), the authors used multiple methods of data collection including observation, interviews, focus groups, and workshops, to identify and prioritise components for the development of sustainable SDoH screening and referral pathways. The focus was on addressing food insecurity due to the availability of on-site food provision and additional community resources at a maternity care provider. Key findings included an increase in women's satisfaction, including positive feedback about the relationship women developed with their healthcare professional. Clinicians also viewed the screening and referral process positively. Four patients screened positive for food insecurity; three received onward referrals, and one received an on-site food package. Suggestions for improvement included

involving social workers in maternity appointments, providing training on referral pathways and available community assets, and offering women food vouchers. Participants also identified the need to further develop universal screening processes and tailored information provision, including the integration of screening tools and referral pathways into EHRs, to support more equitable health care.

These findings were also supported in Birtles (2022). This study assessed the Profile for Maternal and Obstetric Treatment Effectiveness (PROMOTE), an innovative self-assessment screening tool for social complexities designed to alleviate screening barriers. These included addressing the difficulties clinicians can face in directly questioning patients about their experiences. The [PROMOTE](#) tool consists of nineteen questions, informed by clinical and theoretical evidence about the impacts of the SDoH on perinatal health and wellbeing. Semi-structured interviews and focus groups were conducted with twenty-two midwives, nurses, and obstetricians, which focused on the PROMOTE tool and its impacts on care. Interviews suggested that completion of the PROMOTE tool before appointments helped clinicians to detect vulnerabilities and offer appropriate referrals and treatment. Without the PROMOTE tool, clinicians felt they may have risked missing valuable information and the conversations required to drive forward further support. The tool was also found to be useful in promoting disclosure and establishing trust between providers and women. However, the acceptability of the tool from women's perspectives was not explored, which impacted the external validity of the findings. Findings from Birtles (2022) offered insights into the breadth and depth of the impact of such tools and provided guidance on the implementation of validated tools in the practice setting.

Studies also suggest that digital screening tools may enhance the efficiency and effectiveness of SDOH assessment (Preis et al. 2022; Peahl et al. 2023). Midwives in this doctoral study described various ways they interacted with the HER - which included certain screening questions for SDOH and previous traumatic experiences. However, their practice was not consistently supported by validated tools to guide conversations and referral pathways. Furthermore, findings from this doctoral study suggest that women also believed it was important for their midwives to know about their social needs. Women in this study were also generally comfortable to share information about the context and conditions of their lives if they knew further support was possible.

A study by Peahl et al. (2023) in the USA also supports findings from this doctoral study. In Peahl et al. (2023) researchers developed an adapted screening tool based on the Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences tool (PRAPARE), and also surveyed women's preferences for addressing their social needs using both an original short-form tool and the adapted PRAPARE tool (The National Association of Community Health Centers Inc. (NACHC) et al. 2014). A total of 215 women completed a survey in the study. Participants were predominantly White (167; 77.7%) and multiparous (145; 67.4%). Unmet social needs were prevalent with both the short-form tool (77.7%) and PRAPARE (96.7%). The sensitivity (79.3%) and specificity (71.4%) of the adapted tool were high for detecting any social need. Most participants believed that it was important for their maternity care professionals to know about their social needs and over half of participants felt comfortable sharing their needs even when assistance was not available. Free-text themes reflected considerations for integrating social needs into routine maternity care. A digital short-form version of the adapted screening tool also performed well when compared with the gold standard adapted tool. The PRAPARE tool, when paired with an action toolkit, helped clinicians to identify and address upstream determinants of poor health outcomes and higher healthcare costs. Collaborations included partnering with local farmers to address food poverty and addressing housing insecurity by working in close partnership with housing associations and local councils. Peahl et al. (2023) suggest that insights from the research can inform commissioning strategies and business case development - clarifying service gaps and guiding decisions about whether to invest in additional internal capacity or to strengthen partnerships with community providers. However, the researchers cautioned that future work is still required to operationalise efficient, effective, patient-centered approaches when addressing social needs in pregnancy (Peahl et al. 2023). Although organisations may not possess all the necessary services to respond comprehensively to the SDoH, systematic collection of SDoH data is still critical for understanding local population health needs. Whilst the PRAPARE tool is widely implemented across the USA, to the best of my knowledge, an equivalent tool is not available in the UK and reflects the concerns expressed by participants in this doctoral study.

In the NHS, social prescribing programme are available (Benson et al. 2021; Calderón-Larrañaga et al. 2021). Social prescribing approaches have been developed in some parts of

the NHS for decades, such as in primary care. Social prescribing involves the identification of patient's unmet social needs and then connecting them with services in the third and voluntary sectors in their local communities (NHS England 2025). However, these approaches are often weakly defined, and there is little strong evidence and no clear national framework to guide the choice of healthcare based social interventions (Hayes et al. 2011; Bickerdike et al. 2017; Gottlieb et al. 2017). Considering the difficulties women and midwives faced in this doctoral, this highlights a significant gap in current maternity care provision and offers the potential for an existing approach to be evaluated in the context of MCoC.

9.3.5 Midwives public health role – so what and where next?

The findings from this doctoral study and the wider literature, have demonstrated that social complexities are growing in England (Knight et al. 2018; Marmot et al. 2020a; Dorling 2024; Watson et al. 2024). Widening inequalities between the richest and poorest in society have, for the first time in decades, led to a decline in life expectancy for women from the most deprived communities and impact the life chances of babies born to mothers from the poorest households (Marmot et al. 2020a; Lee et al. 2022; Goldblatt 2024). Women and children in the 21st century are thus facing more challenging lives than previous generations (Dorling 2024). Growing social complexity, shaped by entrenched structural inequalities and political inaction, is reshaping the expectations imposed on MCoC midwives and maternity services, frequently placing them under increasing pressure within an already strained system (Renfrew et al. 2014; ten Hoope-Bender et al. 2014; Van Lerberghe et al. 2014; Shaw et al. 2016; Langins and Llop-Girones 2024; World Health Organization 2024c). Based on the findings of this doctoral study and a critical review of the wider literature, I argue that the midwifery profession - and the NHS more broadly - has not evolved at a pace commensurate with increasing social complexities, partly due to neoliberal ideologies that continue to shape assumptions about health and who is deemed deserving of care (Humber 2017; Marmot et al. 2020a; Marmot 2023; Bayliss et al. 2024). In a post-pandemic era, the NHS continues to firefight due to economic restraints and the systems' wider capacity and capability to react to the changing needs of society (Suleman et al. 2021; NHS Providers 2024). Working in this environment, as the midwives in this doctoral study described, are unable to fully engage in preventative work that could well influence the health outcomes and experiences of women and children facing multiple disadvantages. MCoC midwives in

this study worked tirelessly to meet the needs and expectations of their communities, even within a resource-constrained system that - despite notable investment in digital transformation - continued to underutilise data on trauma and the SDoH to guide targeted interventions. Midwives revealed that data was poorly collected, interrogated, and evaluated to understand the impact of the MCoC model on local population health. This added to the complexity midwives worked with. Whilst participants described reacting to trauma and the SDoH in the moment, they were still ***‘only scratching the surface of the complexities women faced’*** due to a lack of investment in their education and training.

During the period of data collection, the NHS was under extreme pressure as a result of the COVID-19 pandemic. This context substantially limited midwives’ ability to advance the policy, service, and community-level reforms they identified, as necessary. However, midwives stayed involved, often because the need was so great, and they were one of the few professional groups to continue to provide face-to-face care. This ultimately led to burnout and feelings of resentment, which may well have impacted on the quality and consistency of care women received.

In the face of growing health challenges that are rooted in systems of structural inequalities, such as the gender-based traumas women in this doctoral study faced, the midwifery profession is well-poised to address these inequalities. New paradigms of thinking and interdisciplinary collaborations have been conceived as potential solutions to improve our current understanding about public health nursing and midwifery practice. In a review by Srof (2022), the author examined the interdisciplinary concept of ‘peacebuilding’ in the context of nursing practice in the USA. The interweaving of health and peace were highlighted through exploration of historical and contemporary ideas on promoting social justice in public health nursing. Lederach, an international leader in peace, justice, and conflict studies, defined peacebuilding as a comprehensive concept that encompasses, generates, and sustains the full array of processes, approaches, and stages needed to transform conflict toward more sustainable, peaceful relationships (Lederach 2005). Peacebuilding is essential work in any context where SDoH limit opportunities for human prosperity.

Regardless of the setting for peacebuilding, peace-responsive initiatives work to:

1. improve social cohesion and resilience,
2. improve access to equitable health services,
3. build trust
4. facilitate cooperation and shared decision making (Lederach 2005; Rosa and Kelly 2019).

Development of peacebuilding as a theoretical construct in nursing and midwifery is therefore relevant and an interesting perspective to explore. Furthermore, Woehrle (2019) states that a common interest between peacebuilders and health professionals is the focus on moving individuals and communities from places of trauma and disruption to spaces of nurturing. Srof (2022) introduces Lillian Wald (1867–1940), a pioneering American nurse known for her efforts to promote social justice and foster collaborative relationships to advance health and human rights. Early in her career - Srof writes - Wald moved into the community she served. She responded to her communities needs by initiating school health programmes, perinatal services for women, and community recreation programmes. Wald also influenced policy and economic development through her involvement on various community boards (Srof 2022). Her work exemplifies how a vision for population health, combined with strong community relationships, can enhance healthcare access and improve health outcomes across a wide range of social and health services. Wald's contributions are foundational to modern efforts in promoting social justice, addressing the SDoH, and advancing health equity (Srof 2022). Wald's efforts align with findings from this doctoral study (ibid), which demonstrated how committed MCoC midwives were to improving health disparities in their local communities. However, their efforts to influence policy and practice were threatened by a lack of data, funding, and capacity building in which to engage with strategic partners across their communities. Even the senior midwives who took part in this study, faced difficulties. The fact that midwives '*stepped up*' [PM002] to what women needed, highlights their commitment to social justice activities. Nevertheless, research findings also demonstrated that multiple external forces, including the pandemic, prevented midwives from being able to enact the change they knew communities needed.

The concept of peacebuilding in nursing by Srof (2022) also supports findings in my study which demonstrated that an attuned midwife-woman relationship enabled midwives to

become familiar to the needs of their local communities. One participant described the impact of co-creating a family support group for the local Afghan community, with the help of staff from a local Family Hub. This participant promoted social justice and peace in her local community by addressing health inequalities and supported coordinated care across acute and community healthcare settings. From a social justice perspective, this participants' peacebuilding work created a space for social cohesion to flourish and for staff to dispel common myths about contraception, immunisations, and infant feeding. This participant, like many others, stayed involved because the need was so great, but it was not without its consequences. Relying on the goodwill of individual staff to develop targeted services and deliver these services in their own time is not sustainable but clearly demonstrates the actions and commitment of MCoC midwives' to address issues with attention to ethical principles of justice and equity. Propping up health promotion services like this is not the role of MCoC midwives and requires Government commitment and investment.

Women and midwife participants in this study described the importance of creating, establishing, and cultivating safe relational spaces in which to develop an attuned relationship. The importance of relationships on an individual level, where midwives were attuned to the spoken and unspoken needs of women in their care, addressed the basic social problem of establishing trust and emotional safety, whilst also negotiating structural forces that influenced perinatal health inequalities. An attuned relationship was the foundation upon which all other actions and interventions could either flourish or fail and facilitated the midwife as a metaphorical linchpin. This is a novel finding and demonstrates that midwives hold together multiple threads of care, whilst propelling care forward into the wider health and care ecosystem.

The importance of emotional safety and attunement as mechanisms that support relational care in continuity models of care has also been explored in the qualitative literature. In a ConGT study by Kassam and Marcellus (2022), the author's examined how Canadian public health nurses cared for refugee women during the perinatal period. Like participants in my study, participants in Kasaam and Marcellus (2022) described an overall process of creating safe relational spaces to address the basic social problem of establishing trust with women, while managing external meso and macro-level influences. Findings from Kasaam and Marcellus (2022) revealed the strategies that nurses used to enhance health equity, which

were expressed through 'burning with passion', 'connecting while looking beyond', 'protecting from re-traumatization', and 'fostering independence'. Findings from this study align with findings in this doctoral study and extends critical caring theory to include considerations of sociopolitical and economic influences on nursing practice. However, findings from my study specifically build on Kassam and Marcellus (2022) by offering new insights into the role of attunement in the midwife-woman relationship. While MCoC midwives navigated the complex sociopolitical, economic, and organisational level issues created by the COVID-19 pandemic, midwives were still able to skilfully attune to the women in their care.

Another GT study conducted in New Zealand by Griffiths (2013), examined the causal mechanisms impacting the effectiveness of MCoC models in areas of high deprivation. The core theoretical framework 'staying involved, because the need seems so huge', explained the significance of the attuned midwife-woman relationship and the level of commitment midwives displayed in meeting women's needs (Griffiths et al. 2013). Midwives provided, what Griffiths coined as being 'total midwifery care', which extended beyond the provision of routine clinical care, to include an emphasis on addressing the wider SDoH. Routine clinical care alone was unable to meet the social complexities women faced, which included food poverty, housing insecurity, high rents, and low-paid, insecure work. Midwives were unwavering in their support, often going above and beyond their duties, providing advocacy, support, and navigation of the maternity care system. Sometimes midwives described using their own transport to help women attend appointments with wider system partners, as women often struggled with poor public transport links. Some midwives also reported buying material goods for women and providing domestic help in women's homes. Participants in Griffiths' study (2013) believed their support enhanced women's lives, increased engagement, and impacted outcomes, hence, 'staying involved because the need seemed so huge'. These findings are echoed in findings from this doctoral. Midwives expressed how they often '*stepped up*' [PM002] to address what women needed due to a lack of community provision as this was withdrawn due to social distancing restrictions. The strategies and techniques participants used in my study were often outside the remit of their professional role but largely focused on extended advocacy, obtaining material goods, and also taking women to safe spaces. Their commitment to social justice was challenged due to a lack of resources and knowledge on the best methods of action, but their commitment to making a meaningful impact is clear from their

narratives. Findings from this doctoral study therefore build on evidence from Griffiths (2013), by providing unique insights in the context of midwifery practice in England, and the tools and techniques midwives used to address the trauma and SDoH that women faced.

More recent programme of research conducted in the UK, by Rayment Jones et al. (2021; 2021a, 2023) and Fernandez-Turienzo et al. (2019b; 2021) have also developed our understanding of the mechanisms underpinning MCoC models. Research by Rayment Jones et al. (2021; 2021a, 2023), examined the effectiveness of two specialised models for women with social risk factors in areas of high deprivation in London. The realist evaluation examined two different MCoC models, one community and one hospital-based team. Like the findings from this doctoral study, Rayment Jones et al. (2021; 2021a, 2023) identified a complex, interconnecting web of system, resource, and individual mechanisms working behind the scenes to influence the quality and outcomes of care women experienced. The quality of the trusting relationships midwives built with women enabled them to guide women through an unfamiliar maternity care system. Midwives working in a community-based model of care were more attuned to women's psychosocial needs, which was facilitated by the option of flexibility and place of appointments. This included seeing women in their own homes to develop a better understanding of the context and conditions of women's lives. Midwives were able to act quickly on their professional curiosities and clinical findings and had an in-depth knowledge of community assets. Midwives also revealed multiple advocacy strategies to help women regain trust in the system. Women responded with increased feelings of safety and trust in their maternity care, improved help-seeking behaviours and behaviour change, and increased disclosure of the issues they were facing (2021; 2021a, 2023). This in turn improved engagement with services in the local community and created more opportunities for women to form supportive social networks. The authors' recommend that future research should examine the complexity of mechanisms underpinning community-based care and how these might lead to improving equity in different contexts (Rayment-Jones et al. 2021a). Findings from this doctoral study expand on the theories discussed here, by identifying specific mechanisms within the MCoC model that improved women's experiences during the COVID-19 pandemic, such as attunement and the midwife as a metaphorical linchpin. These mechanisms also proved to be effective strategies for addressing perinatal health inequalities. Despite the challenges MCoC midwives faced, they exhibited exceptional resilience and adaptability, forming strong, empathetic, and relationally attuned

connections with women. Acting as metaphorical linchpins, midwives propelled care forward and upheld the healthcare system's integrity.

Targeted efforts to address perinatal inequalities were undermined by inadequate data collection, limited digital literacy, weak evaluation processes at Trust level, ineffective cross-system partnership working, and a notable absence of midwifery leadership at strategic levels where public health commissioning decisions are shaped. Yet midwives are uniquely positioned to contribute to public health planning and implementation within local systems, as they witness the impacts of health inequalities in their daily practice and work closely with women and families in the environments where they are born, live, work, and age. Despite this, midwives' ability to influence the SDoH remains constrained without system-level support. This thesis has highlighted opportunities to strengthen their contribution - particularly through improved collection, analysis, and reporting of data, alongside greater investment in prevention and early-intervention measures to better support women and children to thrive and not just survive.

9.4 Conclusion

This chapter critically examined the SDoH shaping the lives of the participants in this study and explored how MCoC midwives navigate these complexities to reduce health inequalities. The findings reveal that while MCoC models offer mechanisms for improved outcomes, women's experiences are deeply influenced by cumulative trauma, gender-based discrimination, and structural disadvantage - factors that extend beyond the scope of maternity care alone. The additional pressures introduced by the COVID-19 pandemic further amplified these challenges, underscoring the need for integrated, trauma-informed approaches within maternity services.

These insights highlight the evolving public health role of midwives and the potential of MCoC models to mitigate inequalities, albeit within a system that is still '*scratching the surface*' of entrenched social and health disparities.

The next chapter will draw together these findings to present the overall contribution of this thesis, discuss implications for policy and practice, and outline recommendations for future research aimed at addressing the persistent and complex nature of perinatal health inequalities.

Chapter 10. Conclusion

10.1 Introduction

This thesis explored how traumatic experiences and the SDoH shape the lives of perinatal women and how MCoC models respond to these challenges. By examining women's lived experiences alongside the perspectives of MCoC midwives, the study revealed the complex interplay between structural disadvantage, trauma, and maternity care during the COVID-19 pandemic.

Findings show that perinatal health inequalities are deeply rooted in cumulative disadvantage and intersecting forms of discrimination, further compounded by the COVID-19 pandemic. While MCoC models demonstrate potential to improve outcomes through relational, trauma-informed care, they operate within a system that continues to *'scratch the surface'* of entrenched inequalities.

This chapter synthesises these insights to articulate the study's overall contribution, evaluate its strengths and limitations, and outline implications for policy, practice, and education. It also identifies priorities for future research and concludes with a call to action for policymakers, commissioners, and providers of MCoC. Finally, [Section 10.8](#) reflects on the emergence of trauma as a significant theme. This reflection has been intentionally positioned at the end of the thesis as it was not an original research objective but emerged as one of the most significant themes - foregrounding women's experiences within the broader context of their lives and the public health literature.

10.2 Research strengths

The methodological advantages, disadvantages, and challenges have been presented in [Chapter 4](#). How I upheld the quality, rigour, and conduct of this ConGT study was discussed in [Section 5.8](#). Certain limitations were presented in [Chapter 5 - Section 5.5.4](#), which focused on the limitations at the time of authoring the research protocol. Additional strengths and limitations of this study are detailed below.

As discussed in [Section 5.8](#), assessing the credibility of a ConGT is characterised by several key principles.

10.2.1 Credibility

The credibility of a ConGT study is assessed by a number of components, including how researchers engage in developing a deep understanding of the research phenomenon by spending sufficient time in the field and engaging closely with participants (Charmaz 2006, 2014a). A strength of this study lies in the methodology itself, and richness of the data generated.

To enhance credibility and to meet the needs of the study population, I spent considerable time designing the study with multiple stakeholders. I also engaged in comprehensive data collection and analysis methods, including member checking with two participants (PM013 and PM014) who took part in follow-up meetings. Findings needed to resonate with participants and individuals sharing comparable experiences, conveying the depth and complexity of their lived realities while maintaining interpretive significance. Both participants reviewed and commented on the emerging findings to ensure they were believable and accurately represented their perspectives. Although follow-up interviews with perinatal women were not possible due to time and resource constraints, each subsequent discussion allowed exploration of emergent findings with new participants. Their insights helped develop more focused questions and comparative analysis procedures. Furthermore, I reflected on my own preconceptions and thoughts in the form of memos, where I acknowledged my influence on the research process.

Methods of triangulation were also employed in this study, including the convergence of data from multiple sources, such as in-depth interviews with perinatal women using NHS maternity services and NHS midwives working in a MCoC model, document analysis, and observational knowledge by attending meetings with external organisations. Theoretical triangulation involved situating the categories within the extant literature in order to critically analyse the findings.

10.2.2 Resonance

The findings should make sense to participants and others in similar circumstances, capturing the fullness of the studied experience (Charmaz and Thornberg 2020). Constant comparative analysis and member checking with participants enabled me to check, confirm, or refute existing findings with participants and informed the development of categories. Although I was unable to formally validate the resultant theoretical categories with

participants, the iterative processes of constant comparison and theoretical sampling facilitated ongoing engagement with new participants. This allowed for the discussion of emergent findings and the formulation of increasingly focused questions, thereby capturing diverse experiences and ensuring that the categories were theoretically rich and sufficiently grounded to explain the phenomenon.

10.2.3 Usefulness

Analysis should offer interpretations that people can use in their everyday lives, sparking further research ideas and practical applications (Charmaz 2017a). This research provides knowledge grounded in the lived experiences of women and midwives who faced unprecedented challenges during the COVID-19 pandemic and provides useful insights for future research, policy, education, and practice about the pervasiveness of trauma and the root causes of health inequalities. This research also reveals important insights into the provision of maternity care during a global health crisis and how the evidence on the SDoH and trauma was enacted in an NHS MCoC model.

10.3 Research limitations

Limitations of this study include the fact that it was conducted in one city in the South of England, so may not be generalisable to other countries, however insights provide a nuanced and rich understanding of what women and MCoC faced during the COVID-19 pandemic in England. Other limitations are discussed in detail below.

10.3.1 Data collection and recruitment bias

The transition to digital data collection methods during the second and third national lockdowns in England meant that only women who were aware of the study through social media or via their midwives were able to participate. This shift, though unavoidable given the constraints, potentially introduced recruitment bias. The reliance on digital platforms may have excluded women from the most disadvantaged backgrounds, who might not have had access to these technologies or the emotional bandwidth to engage in research. Despite the popularity of the recruitment strategy, this limitation skewed the sample, which could affect the generalisability of the findings. Due to the impact of time and funding for interpretation services, I was unable to involve women who did not speak English. Women who do not speak English and women from GEM backgrounds experience disproportionate rates of perinatal morbidity and mortality in England (Felker et al. 2024).

Whilst my sample involved three women from different GEM backgrounds, future research should include dedicated funding to increase race and language equality in order to inform the development of culturally sensitive models of maternity care. By highlighting this gap and suggesting future research to address it, I adhered to Charmaz's principle of contextual understanding and reflexivity, recognising the importance of inclusivity (Charmaz and Thornberg 2020).

10.3.2 Impact of financial incentives

The provision of a financial incentives to encourage participation may have introduced bias and additional power dynamics. Participants might have been motivated primarily by the incentive rather than an intrinsic interest in the study, which could have influenced their responses, and the authenticity of the data collected. This aspect raises ethical considerations about the power imbalance between the researcher and participants, which can impact the co-construction of knowledge—a cornerstone of ConGT research. By openly discussing this potential influence in [Chapter 5 - Section 5.2.2](#), I have adhered to Charmaz's emphasis on reflexivity and ethical considerations of transparency.

10.3.3 Impact of the COVID-19 pandemic

As previously discussed, the COVID-19 pandemic had a pervasive impact on this study, affecting every aspect of its delivery and completion. The transition to remote interviews, necessitated by lockdown restrictions, resulted in the loss of subtle non-verbal cues that would have been observable during in-person interactions and could have enriched the interpretation of the data. While this method enabled the study's completion, it compromised the depth of interaction that in-person interviews might offer. Additionally, the pandemic introduced stressors that likely impacted me as a researcher and the participants, potentially affecting the co-construction of knowledge and the emergence of the ConGT categories. Despite these constraints, I adapted at pace by conducting interviews remotely using Microsoft™ Teams, Zoom, or over the phone - demonstrating the flexibility of ConGT.

10.3.4 Theoretical saturation and researcher reflexivity

The principles of theoretical saturation and emergence were contentious and fraught with complexity during the study. My preconceptions and my own experiences of ACEs influenced the interpretation of data, leading to concerns about what was emerging. This

reflexivity, while critical, underscores the challenges of conducting sensitive research and highlights the emotional labour of ConGT. By reflecting on these challenges and discussing them in [Section 10.8](#), I embraced Charmaz's principle of reflexivity by acknowledging the complexity of the process (Charmaz 2014a).

10.3.5 Time constraints and administrative challenges

The study faced significant delays due to the extended time required for research delivery, administrative tasks, and data analysis using NVivo. Other critical determinants of health, including the impact of religion and spirituality on women's coping strategies, were also not thoroughly examined due to time constraints.

While NVivo provided a powerful tool for in-depth data analysis, the protracted time investment required to master the software delayed my progress. My concurrent clinical responsibilities within the NHS further intensified these time constraints, creating a significant challenge in balancing professional obligations with academic commitments. Despite these hurdles, the use of NVivo demonstrated adaptability and a commitment to thorough data analysis and aligned with the principles of constant comparative analysis and theoretical sensitivity (Charmaz 2014a).

10.3.6 Resource constraints

The inherent limitations in time and resources associated with doctoral study, coupled with the fact that this study was conducted by a single researcher, constrained the study's scope and scale. Conducting the study as a lone researcher was challenging. My commitment, perseverance, and adaptability reflect the flexibility and reflexivity central to ConGT (Charmaz and Thornberg 2020). Future research should incorporate a larger sample size and a more extensive research team to strengthen the robustness and enhance the generalisability of the findings. Additionally, deviations from traditional GT processes, including my approach to constant comparative analysis, may have affected the methodological rigor of the study. However, I believe my level of engagement with the ConGT process, and my reflexivity mitigates these concerns.

10.3.7 Theory development

This ConGT study has presented two core categories that examine the basic social processes of the two participant groups in a specific context, however this ConGT study did not succeed in presenting a substantive theory that effectively integrates the two core

categories. Whilst there are multiple epistemological debates about the renderings of what constitutes a GT (Glaser 1992b, 2001; Coşkun 2020), Charmaz suggests that the presentation of core categories is a valuable contribution to knowledge, as they allow researchers to highlight significant relationships in the data without necessarily forcing the data into a substantive theory (Charmaz 2006, 2017a). Reflecting on my experiences over the lifecycle of this PhD - having two participant groups created challenges during comparative analysis and at times, I felt that achieving the goal of a substantive theory was paramount over achieving a ConGT that would be useful for advancing midwifery knowledge. However, this created the tendency to force the data and, as I have previously discussed in [Chapter 5 - Section 5.7.2](#), this rendered the data completely unworkable. It was not until I let go of these assumptions that I was truly able to 'see' the data and the development of the core categories could emerge. Investing in the process of emergence led me to the development of core categories, that I believe provide valuable and unique insights into the lived experiences of perinatal women during the COVID-19 pandemic and how addressing widening inequalities is enacted in a MCoC model.

By acknowledging and addressing the theoretical limitations of this ConGT, I demonstrate reflexivity, flexibility, and a commitment to ethical research practices. Future research should also look to build on the core categories presented in this thesis in different contexts and contribute to furthering our understanding of the emerging public health role of MCoC midwives within the NHS.

10.4 Contributions to knowledge

This doctoral study builds on current knowledge about the pervasiveness of gender-based trauma and how these experiences interact with and exacerbate perinatal inequalities and the SDoH. The key contributions to knowledge derived from this doctoral study are detailed below:

10.4.1 Contextual understandings

- The exploration of how the COVID-19 pandemic exacerbated the challenges faced by women during the perinatal period, offers crucial insights into the need for well-resourced and agile MCoC models that can respond, at pace, during global health crises. This study highlights how the COVID-19 pandemic exacerbated existing health inequities, particularly in the context of years of Conservative Government austerity measures and it contributes to the understanding of how systemic

underinvestment affected the health outcomes and experiences of many participants in this study.

- This research highlights the major influence of ACEs and traumatic experiences in later life on perinatal mental health and the potential impact on attachment between women and their babies. This understanding can inform both policy development and models of maternity care aimed at supporting women facing multiple disadvantage. This research also demonstrates the significant role MCoC midwives play in establishing an attuned and trusted relationship with women who have a history of traumatic experiences.
- Findings from this research highlight significant shortcomings in how SDoH data is collected and used to target interventions in the NHS at provider level. The limitations of current EHRs to record and interrogate data on factors such as housing, financial instability, and food poverty, reveal the need for improved data management practices that can inform public health strategies, commissioning, and the development of targeted interventions. SDoH data can enhance our understanding of the multifaceted challenges women face, enabling maternity care providers to advocate more effectively for women's needs within a public health framework.

10.4.2 Theoretical conceptualisations

- The categories developed in this study offer new insights and fresh perspectives on the cumulative nature of trauma and the wider SDoH experienced by women during the COVID-19 pandemic, and how MCoC midwives worked to tackle widening inequalities. The categories provide new conceptual understandings of how these mutual experiences coalesced during the COVID-19 pandemic and the barriers women and midwives faced to drive forward change.
- The core category '**sucking it up and getting on with it**' described the survival strategies women develop in response to experiencing interpersonal traumas and additional adversities during the perinatal period. This theoretical framework offers a new perspective on maternal behaviour and resilience, highlighting the need for trauma-informed maternity care that addresses attachment-based trauma along with tackling the SDoH. This research has demonstrated the cumulative and intersectional nature of trauma and the SDoH. While the literature on

intersectionality strongly influenced my thinking, particularly in recognising how trauma and the SDoH are cumulative and intersect with gender, race, and class, I did not explicitly apply intersectional theory to my methodology or data analysis. Rather, it functioned as a guiding frame that shaped the feminist orientation of this study and my interpretation of participants' experiences. Future research should examine how intersectionality can support the development of services that seek to address the root causes of health inequalities.

- This study provides novel insights into the mechanisms that underpin the known benefits of MCoC models for women facing multiple disadvantage. This research has established that relational attunement between MCoC midwives and women enhances quality of care and professional curiosity - allowing for better identification of psychosocial issues. This finding offers a nuanced and novel interpretation of the dynamics of trust and empathy in therapeutic relationships within the context of maternity care. By integrating diverse, interdisciplinary forms of evidence from neuroscience, psychology, and psychotherapy, specific mechanisms emerged from the analysis that have not previously been applied in a midwifery context.
- Analysis suggested that the MCoC midwives in this study also served as a linchpin, metaphorically speaking, in that they held together myriad, sometime invisible threads of care, and were the driving force behind efforts to drive care forward into the wider interdisciplinary and multi-agency team. Despite the challenges posed by limited training and resource, this novel contribution provides a conceptual framework which underscores the necessity of involving midwifery in public health strategy.
- This study underscores the critical contribution that MCoC midwives can make to public health, while simultaneously highlighting systemic challenges faced by maternity services in addressing the SDoH, largely due to midwifery's limited integration within the broader public health infrastructure. This research highlights the potential for midwives to act as a metaphorical linchpin within the wider public health workforce, facilitating access to services and resources that address the broader health and social needs of women and families.
- The study identifies significant gaps in midwives' training concerning public health, trauma-informed care, and the management of complex social needs. This finding

emphasises the urgent need for a national programme of targeted education to equip MCoC midwives with the necessary skills to address the complex challenges faced by women during the perinatal period.

- The findings of this study have also illustrated how years of Conservative Government austerity measures led to reduced resources for data collection and public health initiatives. This demonstrates the need for systemic improvements to maternity services, including prioritising the integration of midwives into public health strategy policy and commissioning - especially during crises like the COVID-19 pandemic. Findings have also exposed the limitations of EHRs in collecting data on trauma and the SDoH and their impact on birth outcomes. This highlights the need for improved data management practices and systems and demonstrates the importance of integrating SDoH assessments into maternity care pathways.

10.5 Future directions for research

This doctoral study has provided several opportunities for future research, which are summarised below.

- A trauma-informed and structural inequalities framework is essential for addressing perinatal inequalities. Future research should evaluate the effectiveness and applicability of combining an intersectional perspective with trauma and SDoH to address perinatal inequalities. This approach should be system wide. This research has shown that midwifery and maternity services cannot tackle structural inequalities and advocate for social justice in isolation. A broader political and societal shift in attitude is necessary to address widening inequalities in England.
- Future research must examine the complex mechanisms that underpin community-based MCoC models. By examining how these mechanisms operate in various contexts, researchers can uncover pathways to improving equity in maternity care and patient experiences. This exploration is crucial to understanding how community-based approaches can address and mitigate disparities in different settings. By prioritising this area of research, we can develop evidence-based strategies that ensure all women receive equitable, high-quality care, regardless of their background or circumstances.
- Future research should focus on developing and evaluating innovative, scalable, and sustainable interventions that address both individual and systemic barriers to health

equity. A strong emphasis on interprofessional collaboration, culturally competent care, and policy-level reform is crucial for achieving meaningful progress.

- Processes for routine screening and tailored information provision are areas to continue to strengthen for establishing equitable health care.
- Assessing the fidelity, acceptability, and impact of social prescribing in maternity services as an intervention to address the SDoH.
- Research must address power dynamics and be accountable for producing impactful knowledge. Future research should challenge existing social and structural power relations that contribute to current health disparities and injustices.
- This study revealed that the handover process from midwifery to health visiting and primary care can reactivate survival strategies and feelings of abandonment for some women. Future research should focus on exploring these concepts in more detail to understand the most effective strategies to support women with the transition between services.
- Future research should look to build on the core categories presented in this thesis in different contexts and contribute to furthering our understanding of the emerging public health role of MCoC midwives.

10.6 Implications for policy

This research has uncovered several areas for policy reform and improvement:

- Policy development must involve maternity staff enhance commitment levels, improve care quality, and promote staff wellbeing, and retention.
- The COVID-19 pandemic exacerbated issues for women by removing additional community-based services and opportunities for social support through antenatal education classes. This also coincided with an increase in IPVA for some women. Therefore, a national, rigorously evaluated antenatal education programme is essential. This programme should be accessible, inclusive, and grounded in trauma and attachment theory, focusing on maternal and infant mental health.
- This study supports findings from the Birth Trauma enquiry (All-Party Parliamentary Group on Birth Trauma 2024) and advocates for revolutionising maternity services. An attuned midwife-woman relationship within a trauma-informed system that aims to promote social justice may help prevent the increased morbidity associated with giving birth in the current maternity care system.

- This research advocates for re-evaluating maternity care policies and training programmes to better support midwives in their public health roles. Integrating comprehensive training on trauma and the SDoH can lead to improved perinatal outcomes.
- The study contributes to the body of knowledge on integrating midwifery into public health. Policy should look at increasing collaboration between midwives and public health organisations to enhance care delivery and improve health outcomes, particularly for marginalised communities.

10.7 Concluding remarks and implications for midwifery practice – A call to action

This doctoral study has several implications for midwifery practice. These have been consolidated and summarised below as specific calls-to-action:

- We urgently need to implement a strengths-based, TIA in maternity services. The most appropriate modality for a UK-context needs to be explored and evaluated, considering the structural inequalities women in this study faced. To bring about a system-wide TIA, training should be embedded in pre-registration training and continual professional development and should form part of the corporate responsibility of every NHS organisation, in an effort to foster a compassionate, trauma-informed culture. As evidence from this study has shown, the cumulative and intersectional nature of trauma and widening perinatal inequalities, requires an approach that is grounded in the epistemology of diverse fields such as neuroscience, psychology, and psychiatry on the psychosocial and physiological impacts of trauma, including the impact of attunement in relational-based models of care.
- As a minimum, all midwives working in MCoC models should be provided with advanced counselling and coaching skills as part of the Core Competency Framework (NHS England 2023a).
- We must also prioritise the psychological safety and wellbeing of MCoC midwives who work in these models of care. For example, to process the level of complexity MCoC midwives work with, midwives should have regular, protected time for restorative supervision with a clinical psychologist. Examples of this exist in some NHS Trusts but are piecemeal, fragmented, and often deprioritised due to demand and capacity concerns. Embedding clinical psychology into maternity care as a core service for staff, would facilitate reflective, safe spaces for midwives to explore their experiences,

reduce burnout, and improve staff retention. Clinical supervision can also equip midwives with the requisite skills to hold the level of complexity and responsibility they face with compassion for themselves and their work.

- We must put an end to the disruption of continuity-carer in maternity care. As findings from this research have shown, the postnatal period (for example), is a critical period in which the symbiotic mother-infant dyad is dependent on multiple internal and external forces. The disruption and abrupt cessation of the midwife-woman relationship in MCoC models, and ineffective transitions of care to health visiting and primary care can create further inequalities. This study has shown that women who experienced attachment related traumas in earlier life, reported feelings of abandonment, which directly impacted their mental health and wellbeing. By leveraging digital health technologies, such as telehealth platforms and secure communication channels, we could ensure consistent communication between women and their midwives, whilst considering issues such as the demand and capacity of MCoC models.
- A call to action for the NHS to implement a national strengths-based, trauma-informed training programme for MCoC midwives. This training should include the theoretical and practical knowledge midwives need to deliver TIC, increase midwives knowledge in population health and their public health role, and methods for providers to conduct and evaluate community assets. This aligns with the NHS *'Three Year Delivery Plan'* (NHS England 2023e), which emphasises staff retention, education, and development. It is essential that the system supports midwives in undertaking specialist training to prepare them for their roles and responsibilities, ensuring they are not *'pushed into the deep end'* [PM006] like some of the participants in this study experienced.
- To effectively improve population health in the local community, team leaders should have reduced caseloads. This will allow them to focus on vital tasks such as community assets mapping, promoting equity, and developing strategic initiatives. Midwives should be an integral part of developing local public health strategy, including representation at strategic level. By dedicating their efforts to these areas, MCoC team leaders can make a significant impact through activism and lobbying for necessary reform.
- We must prioritise creating opportunities for women to meet the entire MCoC team. This could be achieved through group antenatal care sessions, parental education programmes, and drop-in clinics. By fostering these connections, women are more

likely to meet the team members who will support them throughout their journey, ensuring a more cohesive and positive experience. Additionally, it is essential to build both physical and psychologically safe environments for staff and patients. This includes providing secure and welcoming spaces where staff feel supported, and women feel respected and protected. By prioritising these safety measures, we can create a positive and empowering environment that enhances the overall maternity care experience.

- We must involve maternity staff in strategy and policy development, to enhance their job satisfaction, and ensure the continuous improvement of care quality. When staff have a voice in shaping strategies and interventions that affect their daily work, they feel more valued and engaged (NHS England 2023e). This involvement can boost morale and job satisfaction but also contributes to improved staff wellbeing and retention. By prioritising the inclusion of maternity staff in policy-making processes, we can create a more supportive and effective healthcare environment that benefits both staff and the populations we serve.

10.8 Reflecting on the emergence of trauma in the dataset

As discussed in [Section 5.7.3](#), I purposely left this reflection at the end of the thesis, as I felt it would obscure how the reader first receives the findings chapters. As discussed throughout this thesis, the emergence of trauma occurred after comprehensive cycles of constant comparative analysis, theoretical sampling, and analytical techniques, such as memoing. Advanced analysis techniques also included performing data visualisations in NVivo software, where I was able to visualise women's use of literal and figurative language about trauma across the entire dataset. This revealed other, more abstract suggestions about the presence of trauma and the culminative effect trauma seemed to have on the context and conditions of women's lives.

Women who experienced ACEs appeared to be disproportionately affected across multiple domains of health and wellbeing. This was confirmed by comparing individuals' demographic and case classification data collected during interviews and then exported into Microsoft™ Excel for analysis, along with renderings of raw interviews, memo data, and other analytical queries that NVivo can facilitate.

Word tree diagrams are one such query I performed in NVivo, which provide researchers with visualisations of the various contexts in which specific words or phrases about a topic are referred to in participant interviews. In the context of this study, I explored how

participants talked about trauma and any related terms, an example of which is illustrated in [Appendix 4](#).

An interesting observation during this process, revealed that women used literal language about 'trauma' when they were mostly referring to their birth experiences, however their nuanced responses and implicit meanings within the rest of their interviews, implied that traumatic experiences across the lifecourse were a major factor complicating all other SDoH. Conversely, stress and trauma histories also seemed to unite women's resistance and their capacity to '**suck it up and get on with**' the issues they faced in the perinatal period.

My interview with a midwife participant named 'Amanda' (PM008) was the most significant point of departure in my theory development. Until this point, I had not fully appreciated the pervasive nature of trauma or its intersection with participants' experiences, which compounded the discrimination and inequalities they faced and shaped their engagement with maternity services. Up until this point my preconceptions infiltrated the analysis, but in surrendering to the process of emergence my preconceptions were challenged, sparking fresh insights in the data and fostering a new direction for theoretical sampling, comparative analysis, and focused coding.

I wrote multiple memos after Amanda's (PM008) interview, examples of which are provided in Figure 20. I also compared existing datum with each other, asked new participants more focused questions, and reflected on 'trauma' as one of the possible core categories and what this suggested in the context of this study.

Figure 19. Memo on trauma after interview with 'Amanda' (PM008)

Interview with PM008. ^{Got at home bank deli drinking a coffee writing this}

Teams interview with [REDACTED]
[REDACTED] had been at work this morning, supporting women in her caseload. [REDACTED] is a midwife, who worked in one of the NE ST teams for sometime before taking a position [REDACTED]

Date 14/04/21.
Time

[REDACTED] works with women who are at, or who have already had their children removed from their care. Women in the programme must have LARC fitted + commit to the 18 month programme of support from a practitioner on a one-to-one basis. The practitioners work with women to meet their

Free yourself from all those wretched ideas,
from that mania for explaining everything
and only doing what others will approve of.

BY THE RIVER PIEDRA I SAT DOWN AND WEPT

social + physical needs,
 getting them into work,
 education, suitable housing,
 help them access trauma
 informed psychological
 supports, work on their
 intimate relationships,
 autonomy etc:

Date _____
 Time _____
 self -
 session,



I developed a number of
 focused questions for
 [redacted] but mainly the
 conversation was directed
 by her, as I found she
 answered a lot of my
 questions before I needed
 to ask them.

[redacted] reported that she
 was always quite progressio-
 nally curious as a NEST
 (nurse), working to under-
 stand the realities of women's

It is always easier to hear an insult and not respond
 than to have the courage to engage in combat
 with someone stronger than yourself.

THE DEVIL AND MISS PRYM

*VERY IMPORTANT Being a midwife prevented
Having the impact on
women's psychosocial lines that
this participant wanted to have.
lines, but that being a ^{↳ prevented} midwife to these women
only enabled a partial ^{↳ prevented} action
view. She reported, that ^{Days} ^{↳ prevented} impact
it wasn't until she became ^{change}
a ^{practitioner} did ^{↳ + therefore}
she really understand ^{achieving}
deprivation + the levels people ^{equity}
go to survive. Are childbearing
women have had their
babies removed all of the 
statutory support they once
received, the income benefits
+ practical help just vanishes.

Understanding women, working
with them to gain reproductive
+ bodily autonomy, along with
developing self-esteem +
confidence were her driving
force. ^{practitioner} reported that
her safeguarding knowledge
+ confidence in working truly
interdisciplinary with organisations

God created the desert so that man could smile
when he saw the palm tree.

THE ALCHEMIST

had moved in this role.

Date

Time

The future of caseleading midwives safeguarding + public health responsibility requires:

- The NHS to give teams control of their caseloads + work
- Contraception outreach with sexual health + maternity
- Training (bespoke) in the realities of safeguarding / working with at risk women
- MDT, cross boundary working. Will HCS facilitate this?
- Management to understand + advocate for feasibility in how midwives work to reduce health inequalities. Why can't midwives go to where the women want them to go, if this is the only

it is not a sin to be happy.
THE PILGRIMAGE

way they will engage with services. Don't leave us better than nothing - kid midwives of the burden of guilt / responsibility women disengage. Rather, is blaming midwives, it's the system itself which women distrust over their midwives (usually).

* [redacted] intends to go back into her caseleading role when the pilot phase of PAUSE finishes. Her passion is maternity safeguarding so she hopes the career will develop in this direction. Her wealth of knowledge + passion is commendable.

A blessing rejected becomes a curse.

THE ALCHEMIST

Comparative analysis of the first interview I completed with a perinatal woman named 'Adrienne' (P001), further demonstrated the impact of ACEs and traumatic experiences in later life. Adrienne's use of literal and figurative language about her most recent life experiences prior to this pregnancy presented an interesting point of departure for the research. Without much probing, Adrienne described why CSS were involved in her most recent maternity care. She revealed fragments of memories from her own childhood, as well as the experience of having her first daughter removed from her care eleven years ago:

"[...] yeah, so I was in care when I was little myself, I was removed from my parents...then when I was 24 – my eldest daughter was adopted. Urm, eleven years ago. And then because I fell pregnant with Michelle [her second child], social services were automatically called in. Because one I was a care leaver and two my child was adopted previously".

Adrienne then went onto imply that she had learnt to separate herself from these painful memories by telling herself a different narrative about her family's existence, *'I don't have any family no more...they live up North, and I disowned them'*. Shortly afterwards, I asked Adrienne if she had found CSS supportive during their recent interactions and she declared, *'I had no support off them (CSS), and I don't really want support from them because I hate them'*.

Adrienne had recently given birth to her second child. Adrienne and her wife conceived via self-insemination. Using unregulated sperm donation, they met a man via a private Facebook™ group for lesbian couples that connected them with men willing to be sperm donors. When Adrienne fell pregnant and accessed maternity care, she declared that CSS were *'automatically called in'*. Adrienne recalled how this pregnancy had been shrouded in anxiety, it was *'a very anxious moment'*, where she was *'panicking and worrying'* all the time about CSS involvement (her daughter was under a Section 17, Child in Need Plan with her Local Authority).

By the time our interview took place - during the second national lockdown in England - Adrienne's daughter was seven months old. Adrienne had already experienced two further pregnancy losses with the same sperm donor, despite being in lockdown. She attributed her pregnancy losses to the stress CSS were continuing to put her and her wife under. Adrienne was distrustful of CSS:

"[...] all along with social services, who were involved since they knew I was pregnant again [...], because I was seven weeks pregnant and the amount of stress that they put me under and my partner, they actually caused me to miscarry. Because I even said to the Early Pregnant Unit "would it have been because of the cortisol hormone that's wriggling through my body?" And they actually advised me and said, "yes it would be because you've been under so much stress," - they could see how much stress I was under".

After comparative analysis of Adrienne's interview, I memoed about my emergent observations. Table 12 is an example of the memos I wrote about the concepts of stress and

trauma. This memo provided a compelling basis for some initial coding and points of departure for the rest of data collection and analysis.

Table 12. Reflective memo about the presence of stress and trauma in Adrienne's (P001) interview

Reflective memo about the presence of stress and trauma in Adrienne's (P001) interview

Concepts such as distress, anxiety, shame, and childhood trauma held significant space in Adrienne's interview. Without any direct questioning about trauma, Adrienne revealed deeply disturbing stories of early childhood neglect and abuse, her adolescence, having her first baby removed from her care shortly after birth and more recently, her experiences of giving birth to her second child under the care of one of the MCoC teams. Adrienne experienced multiple, traumatic events as a child, including being removed from the care of her parents and spending the rest of her childhood under the care of her Local Authority. She also experienced teenage pregnancy and the traumatic experience of having her first baby removed. Unsurprisingly these traumatic events led to physical and mental ill-health. She lived with the effects of unresolved traumas, and they had a significant impact on her body and her psyche.

The essence of Adrienne's narrative revealed that she was deeply traumatised from life experiences. She appeared stressed and agitated at times during our interview, which suggested her past experiences continued to shroud her experiences. It was clear she found it difficult to trust people in positions of authority, such as CSS and maternity service. I gently probed about CSS. Adrienne 'hated' them for their part in the traumatic moments of her life:

"I hate them [...] I was in care when I was little myself and because of that... when I was 15 – my eldest daughter was adopted. Urm, eleven years ago. And because I fell pregnant with Michelle, social services were automatically called in. Because one I was a care leaver and two my child was adopted previously".

Adrienne's feelings of hatred extended to her blaming CSS for the miscarriage she experienced earlier in the year - after her and her wife were accused of physically assaulting their daughter (her second child). It seemed important for Adrienne to tell me this story; she might have been trying to make sense of the experience. Shifting blame to someone or something else dulled the visceral pain of pregnancy loss and provided her with a version of truth that she was okay with, therefore protecting herself from further harm:

"the amount of stress that they put under me and my partner, they [social services] actually caused me to miscarry".

Later in Adrienne's interview, we discussed her relationship with her named MCoC midwife. Upon accessing maternity services, Adrienne was allocated to one of the MCoC teams due to her intersectional experiences of trauma, multi-agency involvement, being care experienced, and due to her mental health history (she had a diagnosis of complex PTSD and borderline personality disorder).

Adrienne had an unpleasant experience with her first midwife, who she felt was homophobic and judged her for using unregulated sperm donation. Adrienne appeared to have felt discriminated and judged her whole life and the negative experience with her first midwife triggered earlier feelings of distrust and powerlessness that she likely experienced as a child. Rather than disengaging with her maternity care, which women are more likely to do when they feel threatened by the judgemental care they receive, she bravely negotiated with the team to change to a different midwife. Defending her right to receive non-judgemental care. This resolved the issues for Adrienne, feeling safer in the therapeutic space with the new midwife, who 'did not have no judges or grudges' against her and her wife. The interpersonal skillset and values of the first midwife, or lack of in this situation,

had the power to re-traumatise Adrienne. The relationship with the new midwife, however, was based on mutual trust and respect. Adrienne felt safe and seen, '*she made me feel at ease [...] she just made me smile*', something which other people in her life had not made her feel. On opposing ends of the spectrum, it seems that trauma and safety are key concepts that I will explore in subsequent interviews.

-End-

Chapter 11. Appendices and references

11.1 Appendix 1. Supplementary material for scoping review

Scoping Review search strategies - Concept/Keyword search in 'MySearch' via EBSCO

The final keyword search strategy performed in 'MySearch' platform. Literature search performed on 31st August 2019.

1. Population - TI (title) Pregnant* OR Antenatal* OR ante-nata* OR ante natal OR antinatal OR anti-natal OR "anti natal" Pregnant* OR Prenatal* OR pre-nata* OR "pre natal*" OR "Early N2 motherhood" OR "early N2 mother-hood" OR "early N2 mother hood" OR Parent* OR Postnatal* OR post-nata* OR "post nata*" OR "post partum" OR post-partum OR "postpartum"
2. Population - AB (abstract) Pregnant* OR Antenatal* OR ante-nata* OR ante natal OR antinatal OR anti-natal OR "anti natal" Pregnant* OR Prenatal* OR pre-nata* OR "pre natal*" OR "Early N2 motherhood" OR "early N2 mother-hood" OR "early N2 mother hood" OR Parent* OR Postnatal* OR post-nata* OR "post nata*" OR "post partum" OR post-partum OR "postpartum"
3. Concept - TI experiences OR perceptions OR attitudes OR views OR feelings
4. Concept - AB experiences OR perceptions OR attitudes OR views OR feelings
5. Context - TI Depriv* OR Destitut* OR "Economic* disadvantage*" OR economic*-disadvantage OR "Financial hardship" OR financial-hardship OR "Hard-up" OR "hard up" OR "Income disadvantage* OR income-disadvantage*" OR "Lack of money" OR "Low* income*" OR low*-income* OR "Low* socio-economic" OR "low* socioeconomic" OR Marginali* OR Poor* OR Povert* OR "Social class" OR "social determinant*" OR "social securit*" OR "Social* depriv*" OR social*-depriv* OR "Social* disadvantage*" OR social*-disadvantage* OR "Social* marginali*" OR "welfare".
6. Context - AB Depriv* OR Destitut* OR "Economic* disadvantage*" OR economic*-disadvantage OR "Financial hardship" OR financial-hardship OR "Hard-up" OR "hard up" OR "Income disadvantage* OR income-disadvantage*" OR "Lack of money" OR "Low* income*" OR low*-income* OR "Low* socio-economic" OR "low* socioeconomic" OR Marginali* OR Poor* OR Povert* OR "Social class" OR "social determinant*" OR "social securit*" OR "Social* depriv*" OR social*-depriv* OR "Social* disadvantage*" OR social*-disadvantage* OR "Social* marginali*" OR "welfare"
7. 1 or 2
8. 3 or 4
9. 5 or 6
10. 7 and 8 and 9
11. Limit 10 to year = 2008-2018
12. Limit 11 to English

Subject heading search in CINAHL

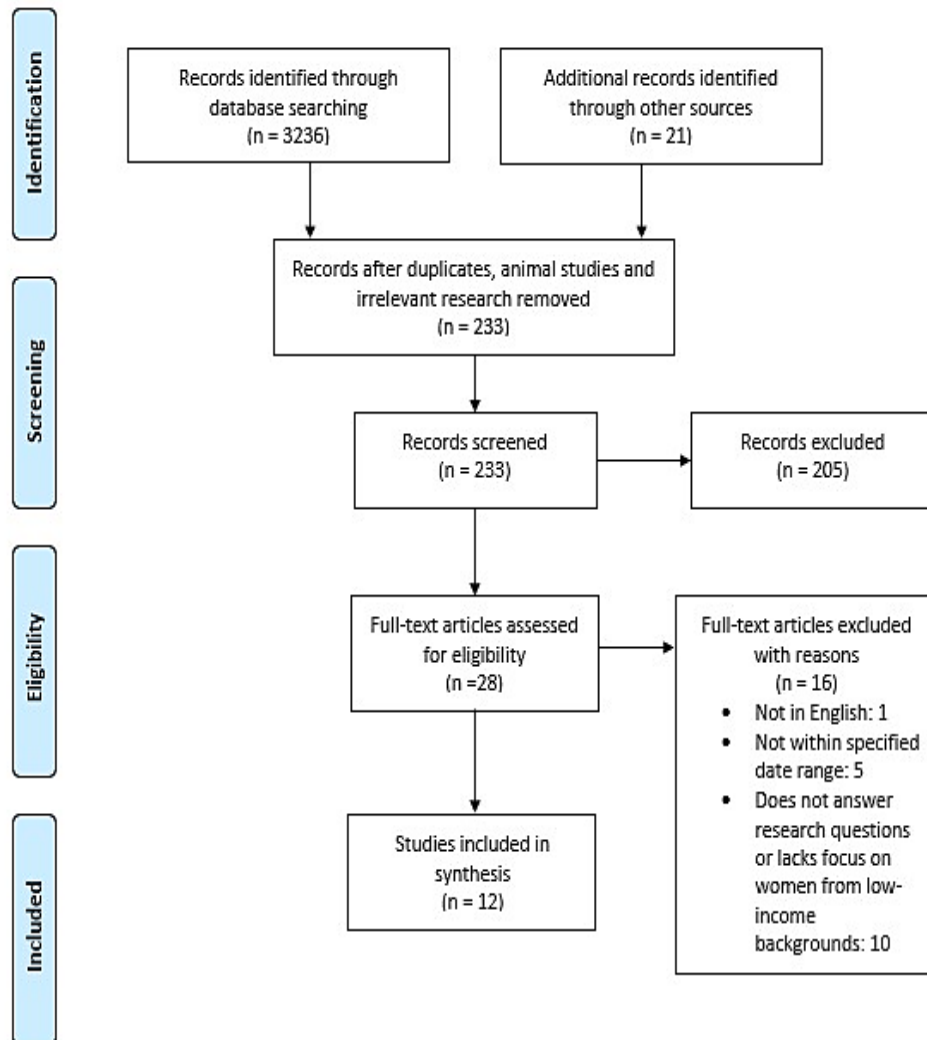
The final subject heading search performed in the bibliographic database CINAHL via EBSCO.
Literature search performed on 31st August 2018.

1. Exp women
2. Exp mothers
3. Exp parents
4. Exp pregnancy
5. Exp postnatal period
6. Exp poverty
7. Exp social welfare
8. Exp social determinants
9. Exp emotions
10. Exp behaviour
11. Exp health
12. Exp health status
13. Exp life style
14. 1 or 2 or 3 or 4 or 5
15. 6 or 7
16. 8 or 9 or 10 or 11 or 12
17. 13 and 14 and 15
18. Limit 16 to year = 2008-current
19. Limit 17 to English

PRISMA flow diagram



PRISMA 2009 Flow Diagram



PRISMA Flow Diagram for Scoping Review C. Clayton v1.0
 From: Moher D, Liberati A, Tetzlaff J, Altman DG, The PRISMA Group (2009). Preferred Reporting Items for Systematic Reviews and Meta-Analyses: The PRISMA Statement. *PLoS Med* 6(8): e1000097. doi:10.1371/journal.pmed1000097

For more information, visit www.prisma-statement.org.

Characteristics of studies included in scoping review



Characteristics of
papers included in scc

11.2 Appendix 2. Study protocol and supplementary documents

Protocol – The Mi-CARE Study



Protocol_Mi_CARE_Study_v1.3_19032021.pdf

NHS HRA HSCW Ethics Approvals



Miss Charlotte E Clayton
PhD Researcher and Midwife
Bournemouth University
Royal London House, R202
Christchurch Road
Bournemouth
BH1 3LT

20 July 2020

Dear Miss Clayton



Email: approvals@hra.nhs.uk
HCRW.approvals@wales.nhs.uk

HRA and Health and Care Research Wales (HCRW) Approval Letter

Study title: The role of a Midwifery continuity of CARE model in reducing health inequalities in childbearing women and babies living on a low-income.

IRAS project ID: 262369

REC reference: 20/SC/0183

Sponsor Bournemouth University

I am pleased to confirm that [HRA and Health and Care Research Wales \(HCRW\) Approval](#) has been given for the above referenced study, on the basis described in the application form, protocol, supporting documentation and any clarifications received. You should not expect to receive anything further relating to this application.

Please now work with participating NHS organisations to confirm capacity and capability, [in line with the instructions provided in the "Information to support study set up" section towards the end of this letter.](#)

How should I work with participating NHS/HSC organisations in Northern Ireland and Scotland?

HRA and HCRW Approval does not apply to NHS/HSC organisations within Northern Ireland and Scotland.

If you indicated in your IRAS form that you do have participating organisations in either of these devolved administrations, the final document set and the study wide governance report (including this letter) have been sent to the coordinating centre of each participating nation. The relevant national coordinating function/s will contact you as appropriate.

Please see [IRAS Help](#) for information on working with NHS/HSC organisations in Northern Ireland and Scotland.

How should I work with participating non-NHS organisations?

HRA and HCRW Approval does not apply to non-NHS organisations. You should work with your non-NHS organisations to [obtain local agreement](#) in accordance with their procedures.

What are my notification responsibilities during the study?

The standard conditions document "[After Ethical Review – guidance for sponsors and investigators](#)", issued with your REC favourable opinion, gives detailed guidance on reporting expectations for studies, including:

- Registration of research
- Notifying amendments
- Notifying the end of the study

The [HRA website](#) also provides guidance on these topics, and is updated in the light of changes in reporting expectations or procedures.

Who should I contact for further information?

Please do not hesitate to contact me for assistance with this application. My contact details are below.

Your IRAS project ID is 262369. Please quote this on all correspondence.

Yours sincerely,

Maeve Ip Groot Bluemink
Approvals Specialist

Email: approvals@hra.nhs.uk

Copy to: *Mrs Julie Northam*

List of Documents

The final document set assessed and approved by HRA and HCRW Approval is listed below.

Document	Version	Date
Copies of advertisement materials for research participants [Study Facebook page.]	v1.0	02 April 2020
Copies of advertisement materials for research participants [Poster Public]	v1.0	19 February 2020
Copies of advertisement materials for research participants [Poster Midwives]	v1.0	19 February 2020
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [BU Sponsor indemnity]	v1.0	01 August 2019
GP/consultant information sheets or letters [Mi_CARE_Study_GP_Letter_v1.0_02072020]	1.0	02 July 2020
Interview schedules or topic guides for participants [Interview Schedule, Public]	v1.0	06 February 2020
Interview schedules or topic guides for participants [Interview Schedule, Midwives]	v1.0	06 February 2020
IRAS Application Form [IRAS_Form_03042020]		03 April 2020
Letter from funder [Letter from funder]	v1.0	16 December 2019
Letter from sponsor [BU Sponsor Letter]	v1.0	02 April 2020
Organisation Information Document [Local Organisation Information Document]	v1.0	31 March 2020
Organisation Information Document [Delegation Log]	v1.0	27 March 2020
Organisation Information Document [CI Declaration]	v1.0	27 March 2020
Other [Data Management Plan]	v1.0	23 March 2020
Other [Responses_REC_HRA_262369_Charlotte_Clayton_1_v1.0_10072020]	1.0	10 July 2020
Participant consent form [Mi_Care_Study_Consent_Public_example_v1.1_07072020]	1.1	07 July 2020
Participant consent form [Mi_Care_Study_Consent_Midwives_Example_v1.1_07072020]	1.1	07 July 2020
Participant information sheet (PIS) [Mi_CARE_Study_PIS_Midwives_Summary_v1.1_07072020]	1.1	07 July 2020
Participant information sheet (PIS) [Mi_CARE_Study_PIS_Midwives_v1.1_07072020]	1.1	07 July 2020
Participant information sheet (PIS) [Mi_CARE_Study_PIS_Public_Summary_v1.1_03072020]	1.1	03 July 2020
Participant information sheet (PIS) [Mi_CARE_Study_PIS_Public_v1.1_03072020]	1.1	03 July 2020
Research protocol or project proposal [Protocol_Mi_CARE_Study_v1.1_02072020]	1.1	02 July 2020
Schedule of Events or SoECAT	1 (assessed)	31 March 2020
Summary CV for Chief Investigator (CI) [CI CV]	1.0	14 February 2020
Summary CV for student [Charlotte Clayton CV]	v1.0	14 February 2020
Summary CV for supervisor (student research) [Professor Ann Hemingway CV]	v1.0	02 December 2019
Summary CV for supervisor (student research) [Dr Mel Hughes CV]	v1.0	02 December 2019
Summary CV for supervisor (student research) [Dr Stella Rawnsdon CV]	v1.0	02 December 2019
Summary of any applicable exclusions to sponsor insurance (non-NHS sponsors only) [BU Sponsor indemnity exclusions]		01 August 2019

NIHR Portfolio Adoption letter



NIHR Portfolio
Adoption Letter Charl



Portfolio adoption
CRN support.pdf

Local Research and Development Confirmation of Capability and Capacity



UHS_Confirmation_C
&C_07102020.JPG

The Mi-CARE Study poster for recruitment of perinatal women



Mi_CARE_Poster_Pub
lic_v1.3_19032021.pdf

Outline of study social media page for members of the public

The following excerpt is from content submitted to the REC committee that approved The Mi-CARE Study. The content is written in future tense.

As discussed in sections A13 and A27-1 of this ethics application, 'The Mi-CARE Study' will adopt multiple recruitment strategies and has developed publicity materials to reach a wide audience in the case setting. One such publicity method is for the study to have its own Facebook™ page - @TheMiCareStudy. The page is intended for participants in the 'childbearing women' group. It will be used to advertise the study and provide additional information to help potential participants make informed decisions about taking part. The page will be managed by the CI and will comply with Sponsor and Facebook™ data protection policies.

The Facebook™ page will be shared via the social media pages of the Children's Centres and the midwifery caseloading teams. Women will initially self-assess their own eligibility and will be invited to make contact with the research team directly via the private message function, telephone, or email. The CI will then make contact with the potential participant to discuss the study and will confirm their eligibility before proceeding any further.

Provided in the figures below, are outlines of the content developed so far. The page has not been published and is awaiting ethics approval. By nature of the pace and impact of social media, posts will be created and updated in accordance with the study protocol and as recruitment and data collection develops.

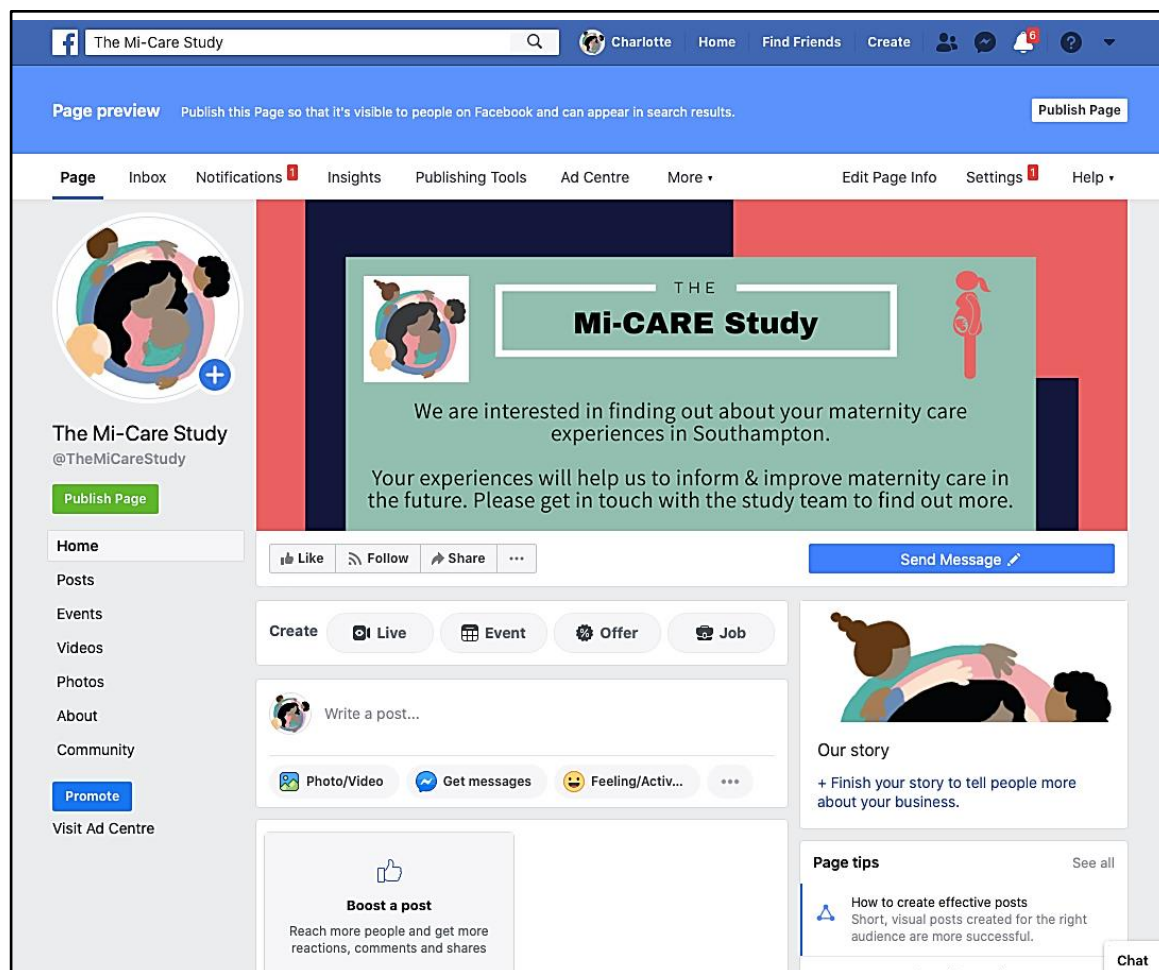


Figure a. The Mi-Care Study Facebook™ page - Initial public view.

The Mi-Care Study
@TheMiCareStudy

Home
Posts
Events
Videos
Photos
About
Community
[Promote](#)
[Visit Ad Centre](#)

Like **Follow** **Share** **...**

The Mi-Care Study
5 hrs · 🌐

Do you live in Southampton and have personal experience of maternity care in the local area? 🧑🏽🧑🏻🧑🏼

Would you like to take part in a research interview about your maternity care to help inform and improve services for others?

If so, and you would like to find out more please get in contact with the research lead, Charlotte Clayton on:

- 07787377432
- Email claytonc@bournemouth.ac.uk
- Or send a direct message to the team on the study Facebook page 😊

THE Mi-CARE Study

Would you like to take part in a research interview about your maternity

Page tips [See all](#)

How to create effective posts
Short, visual posts created for the right audience are more successful.

[See all Page tips](#)

📶 1 post reach this week

See Pages Feed
Posts from Pages that you've liked as your Page

About [See all](#)

- 📞 07787 377432
- ✉ [Send message](#)
- 🌐 [Education website](#)
- ✎ [Suggest Edits](#)

Page transparency [See More](#)

Facebook is showing information to help you better understand the purpose of a Page. See actions taken by the people who manage and post content.

📅 Page created - 29 January 2020

English (UK) · English (US) · Polski · Español · Português (Brasil) [+](#)

Chat

Figure b. Top 'pinned' post advertising the study.

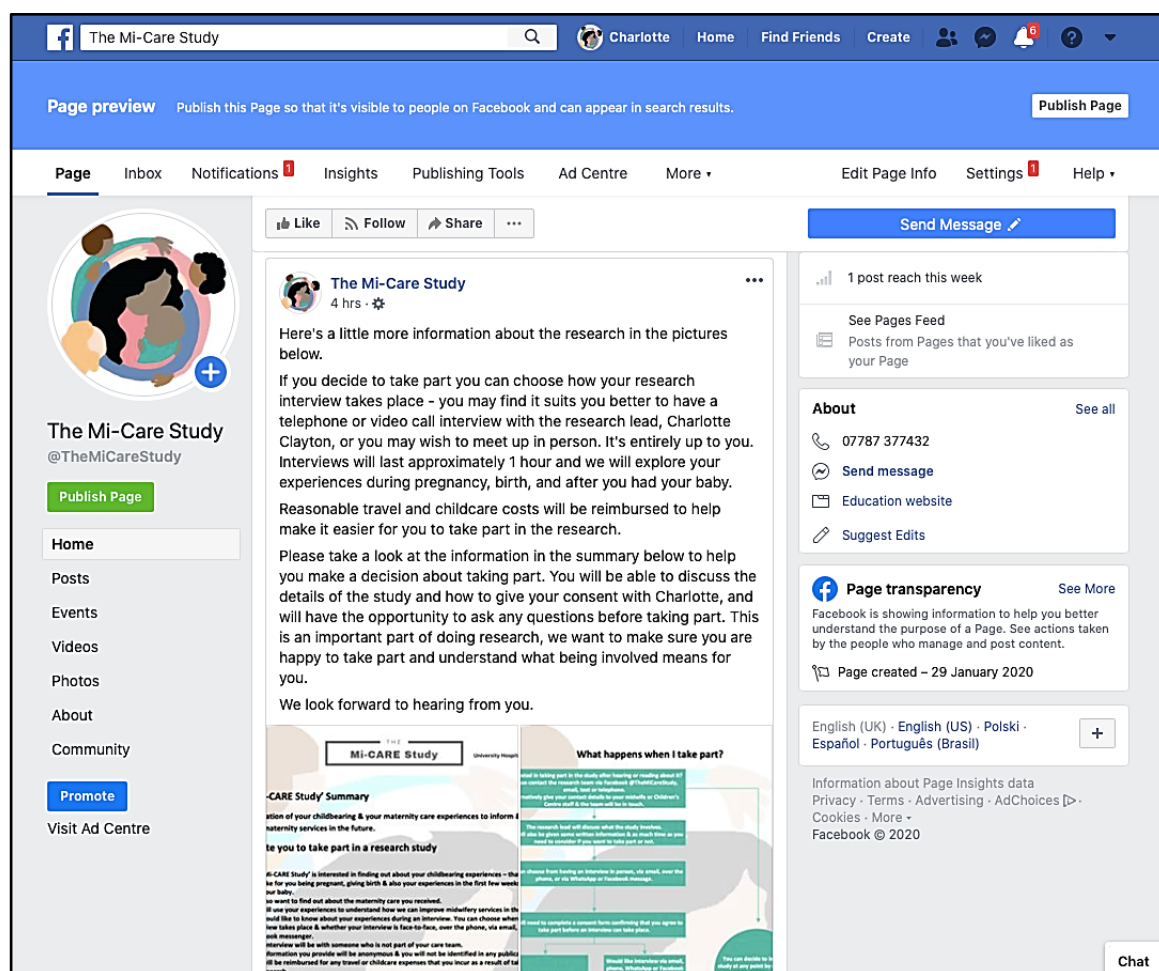


Figure c. Further information about the study including summary PIS

Participant Information Sheets – Perinatal women



Mi_CARE_Study_PIS_Public_v1.4_1903202



Mi_CARE_Study_PIS_Public_Summary_v1.4



Mi_Care_Study_PIS_Public_flow_07082020

Recruitment posters for midwives



Mi_CARE_Poster_Midwives_v1.1_06082020

Participant Information Sheet - midwives



Mi_CARE_Study_PIS_Midwives_v1.3_24102



Mi_CARE_Study_PIS_Midwives_v1.3_24102



Mi_Care_Study_PIS_Midwives_flow_07082020

Consent process



Mi_Care_Study_Con
sent_Public_v1.4_1903



Mi_Care_Study_Con
sent_Midwives_v1.3_24

Interview Schedules



Mi_CARE_Study_Inter
view_Schedule_Public



Mi_CARE_Study_Inter
view_Schedule_Midwi

GP letter



Mi_CARE_Study_GP_L
etter_v1.2_190320

Data Management Plan (DMP)



DMP_Mi_CARE_Stud
y_v1.0_23032020.pdf

Development of research questions



All%20questions%20
together%20-%20tim

Contract between Bournemouth University and third-party transcription service – Data Processing Schedule



Data_Processing_Sch
edule_Transcription_1

BU Sponsorship



S_Wignall_Confirmati
on_of_BU_sponsorshi

11.3 Appendix 3. Example of coding of transcripts and coding frameworks

Coding of interview transcript with highlighting and coding stripes

And then upstairs is like the most unbelievable example of multiagency working that can ever come across. Urm, historically... we had... urm... there... there was family support that were being managed, there's urm, like urm staff who would be involved with trying people work and into training. Urm all sorts of different staff who were employed under the government but different roles and just basically all the different agencies that support improvement really. There was language going on, urm... so there was, there were the family support workers were really great because you could often kind of pull then scenarios and along with that, the health visitors for that area were based at SureStart

Urm the, over the years the family support workers roles more or less disappeared only a few now and... with the urm with children's social services. They've got the, sort of social worker teams and then they've got the Early Help level. And the Southampton City moved the Early Help... level into our SureStart centre. So, those workers are now with

Interviewer: And were the family support workers, did they kind of get absorbed into the team or were they completely different roles or-?

Ruby: Urr, kind of... I, I can't say individually what happened, but I think we lost a lot of support workers, I think that was the long and short of it. How they kind of got absorbed into their role, jobs and it was such a shame because we had very specific, like we had, one worked with a huge asset called Mina, she was, although she was from, I think she was she spoke Dari and Farsi, so she was a real superb link with all the Afghan ladies. So we did a huge amount of work with the Afghan ladies urm, which we can talk about a bit more if you want to. Urm... so the family support workers have sort of diminished in numbers and all down to government cuts and streamlining but the sad thing is, you sort of think the ones who are sort of doing the nitty-gritty with families, and they are the ones that are perhaps the wayward and ending up in prison because they're kind of right in the midst of the family

PAUSE

Job Centre

Health Visiting Teams

Health and Wellbeing Boards - they're not something I've come across, is that a trick question

GP

Family Nurse Partnership

Emergency services

Doula - ineffective and unsafe

Courts

Misconceptions of Sure Start

Children's Centres - all the different agencies that can help support improvement work together

Charitable organisations

Other health and care organisations and professionals women have contact with

Collaboration and relationships with other healthcare professionals and services - we talk to each other

Communication and relationship between midwives, team members, and organisations

Communication and relationships

Midwives knowledge about the SDH, how midwives address women's needs, women's lives and their

We need to be able to meet vulnerable women wherever they like and provide them with more time

Travel & transport around women's communities

MCoC teams being integrated with HV, FNP etc makes such a difference, some teams have this, other

It's gone full circle - we used to look after women based on where they lived, then risk criteria and now

Being located in the centre of the community at Children's Centres promotes engagement with health

Geographical

The impact of MCoC targets - a few places have wholesale rolled out MCoC and had to stop it

Staffing, workforce, recruitment, working in this way etc

Financial

Women get 'shunted' to MCoC from standard care which creates difficulties for us and the women

We don't reflect the communities we serve - we're a group of 'White women'

Developing understanding of local community as

The city is broken up into environments and different ethnicities congregate in different areas

Coding Density

Example of initial coding without matrix framework

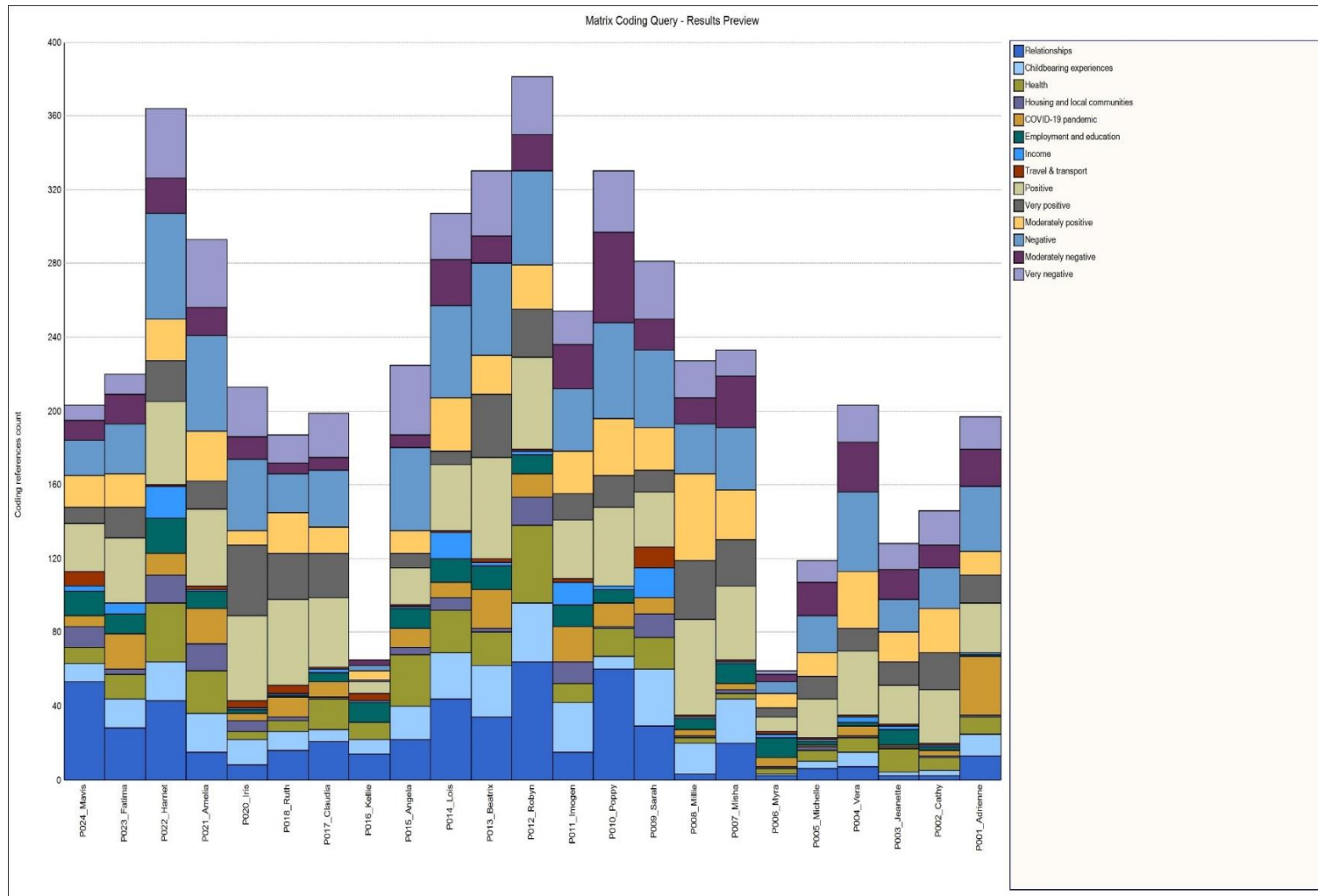
Phase 1 - Initial 'in-vivo' codes from transcripts

Name
"can you get someone to call me - because I'm struggling," and nothing.
"when you've had Jack," and because he's supposed to be staying around here a week after because obviously having the section I need to rest, she goes, "he will realise then what he's done."
"you went out drinking with another woman, you were staying around her house for a weeks on end, and you have no respect for me. She tried to attack me, you allowed it."
All my friends say, "you're such a push over when it comes to him"
And at the minute I'm trying to see, go through my records, I feel like I'm strong enough to see it now,
And I was just like "wow" and I was like, "why are people doing this for me, like-I just feel that I'm a burden but when people go out of your way to do stuff like that you realise, actually you're not a burden and they do care"
And I would be there to support that person, because like I say we've been together fifteen years,
And I'm not now, I just know, I couldn't have him like that. No way.
And like this pregnancy like, I was really scared but it's been a breeze~
And literally when she, when I read it, and I thought, "oh God, what am I doing~"
And the first time it came around it was like, all these... all these people are going to die, it's like the plague
and the one time you're going to fall pregnant is when there's a pandemic, and you'll fall pregnant in a pandemic when there's no one about. But it hasn't felt like there is no one about!
And then I asked him the other day, I was like, because I was running low on cash, and obviously I'm paying for everything here
And then the first time it was just really like, slick professional, "I'm the midwife, "this is what's going to happen, dur, dur dur," but this time it's more like... I don't know it's been more like a family friendship and everyone supporting each other, li
And they didn't care about the fact that they're doing all this to me, and then they referred me to College Keep, they put me on three different medications that caused, what was it, cardiac arti- no.
anything that she's doing she spoke to me about
as you can probably tell, I like talking so I, I just thought maybe becoming a therapist or like a councillor
At one stage I wouldn't even leave the house, my anxiety was so bad
at the moment I've just... focusing on my children and their wellbeing and see what happens in the future
because when I was in care and my sister kicked me out on the Friday night and on the Saturday
But everything's been like, sometimes you know in life you feel that you're a burden but when all that stuff happened, I think I was... like my friends were like, oh, we'll go around my sisters house for a curry and a movie night, and I'm like, "okay," and I
But good old lockdown.
But if I hadn't pushed my doctors for that...do you know what I mean, I could have just dropped dead in the street. Which is really scary.
But just to really go into it and then to just sit and listen to me
but making sure mentally that I'm well and okay as well. Because if someone's pregnant it doesn't mean that mentally and physically that they're doing well unless you ask them. Because if you don't ask them, you don't know.
But then like, I'm loosing my support network
But they just give you these tablets, and they don't even check on you like... they just literally - and then with the midwives and that I'm like, even with the medication they're like, "are you taking your medication still~
but this time it's more like... I don't know it's been more like a family friendship and everyone supporting each other, like a network of people supporting people,
everything I've had going on, like I've had some woman try and stab me in the street
he can see the kids whenever he wants, but I don't want to keep letting them down,
he can't, he won't, and he'll just disappear,
He doesn't think he's done anything wrong, and he just goes, "oh you kicked me out."
he hadn't breached his bail, social services breached it by putting me there with him and they lied
he kind of went off with this other woman, drinking and stuff
he ruptured his spleen, and he was in intensive care on his fortieth, someone died next to him and obviously that's going to be enough stress for anyone.
He was acting weird, she was acting weird
he's caused all of this and he can't see it. He's just so oblivious to everything he's done
he's having his own little breakdown so -I need to take them out of that situation.
He's supposed to come around today, and he tells our daughter and then he doesn't show up
How's your support been from mental health...crap!
I and my kids deserve better
I can ring them at twelve o'clock at night and they'd speak to me

11.4 Appendix 4. NVivo visualisation techniques

Matrix coding

Matrix Coding queries enable visualisation of coding intersections between two lists of items. Matrix coding queries to ask a wide range of questions about patterns in your coded data and gain access to the content that shows those patterns. For example, depending on how you coded your data, you could compare Positive and Negative attitudes towards different themes. I used the matrix coding query below to explore the interviews files of perinatal women to see what topics participants discussed in their interviews coded to 'women's daily lives' parent code, but I could also do this for the entire interviews. I also included sentiment coding and as you can see 'relationships', health, and COVID-19' were important to the women I interviewed.



Example of focused coding matrix

Phase 2 - Focused Coding with childbearing women

Name	when we die it's our children who will sort of bring us and take us to heaven with them
Diet	- I don't drink, I don't smoke, my thing's food and just... like... yeah I don't think that's a bad thing but – Our vices - I just had no energy really, so I just ate chocolate - I tried to eat the healthiest I could as well - The first trimester I was on bland food like chicken and bread and a bit of toast - The hormones put me off my veg
Employment	
Co-workers	- it was sort of my decision not to tell, tell everyone in the office - obviously everyone knew and it's wasn't something that you could properly hide from people
Employment - issues women face	
Childcare	- I work nights and obviously he works days, and we cover each other that way - It didn't quite work out at that point in time that it was an option - It doesn't make sense to pay childcare
Employers	
Threatening employers	- put me on enforced maternity leave! - the manager took my mum into a storage cupboard and shouted at her for telling me
Unsupportive employers	- I didn't feel the employer was as supportive as they should have been - I loved my job but I found the care and time I got from the management was seriously lacking - they wouldn't allow me to go within work hours. - told me I had to come into work else I wouldn't be paid - working whilst pregnant with Poppy very stressful
Impact of being off sick	- I was signed off by the doctor, being pregnant because of my anxiety he signed me off - I'd taken maternity leave early because I didn't want to take sick pay - I'm going to hand in my notice and then they can get more staff - with me being off sick they've still got to pay me, but then they're short staffed.
Impact of COVID on work	
COVID impact on partner's work	- he sort of works in a factory where they actually make goods for food, so he's had to work really - he's suffered a pay loss but been eligible for the grants - not particularly, no, he's just been working as usual
COVID impact on women's work	and I was like okay when I'm not being told...

Focused coding matrix with quotes

Phase 2 - Focused Coding with childbearing women

Name	Files	References	Description
I've had to make really difficult	1	1	
it was duplication around the ch	1	1	
it was just such a difficult conver	1	1	
it's nice for people to tell you th	1	1	
that was obviously a life changin	1	1	
the most devastating result that	1	1	
the person sitting next to me wa	1	1	
you're guaranteed heaven beca	1	1	
they would book my c-section e	1	1	
we didn't have the kind of excite	1	1	
we weren't going to give him so	1	1	
Birth stories	2	2	Instances where women discuss their birth stores. These do not appear to answer rese
Birth stories - Conflicted	0	0	
COVID-19 birth stories	1	2	
With COVID and everything I wa	1	1	
Birth stories - Neutral	1	3	
Plans for birth	2	5	
I just want to keep - make sure t	1	1	
it was nice to have option of bot	1	1	Options for birth were presented as exactly that, not forced to choose one way or ano
planned to my desire really and	1	1	
It was my choice and that was w	1	1	
Birth stories - Positive	5	13	
Impact of midwife	0	0	Taking control of process of birth - guiding the woman through
Born Before Arrival - BBA stories	0	0	
BBA stories - positive	1	4	
That was actually the calmest ex	1	1	EMCS unexpectedly positive.
It was just calm which was lovely	1	1	Unplanned EMCS was actually a positive experience amongst the negative aspects of
Because of the consistency and I	1	1	
It was very, very quick. She staye	1	1	
Luckily, they just gave me an epi	1	1	
Amy was quick to call Francesco	1	1	MW actively involved partner in the immediate moments after birth.
I really needed to know someone	1	1	Birth story - what this woman needed from her MW.
made me want to follow her inst	1	1	Myra appreciated being led by her midwife during labour.
Birth stories - Negative	6	21	
COVID-19 pandemic	0	0	
COVID-19 - impact on women's lives	1	2	Wanted to go to the shops but was not able to do so during Covid-19 pandemic
Restrictions on social support	0	0	Childcare, family, friends.
Family	2	2	
For the first whole lockdown	1	1	First lockdown in the UK impacted families significantly in terms of childcare or lack of
It's been hard not being able	1	1	COVID - impact on social support
Friends	2	8	

General development Chronology of interviews P008_Millie P008_Millie External influ

we know where this is going to end and just get it over with

Reference 4 - 0.15% Coverage

you couldn't, couldn't, you could have written it, it was just awful.

<Files\Interviews with childbearing women\P006_Myra> - 5 4 references coded [1.97% Coverage]

Reference 1 - 0.65% Coverage

I didn't realise my urge to push down was the "actual pushing" urge

Reference 2 - 0.44% Coverage

I didn't remember much of the birth experience

Reference 3 - 0.35% Coverage

Parts came back to me as time went on

Reference 4 - 0.53% Coverage

I now realise quite how awful the situation was for her

<Files\Interviews with childbearing women\P007_Misha> - 5 3 references coded [0.77% Coverage]

Reference 1 - 0.14% Coverage

I just thought, you know, I'm a complicated case, I've got a c-section booked

Reference 2 - 0.10% Coverage

I'm probably going to be a bother going onto labour ward

Reference 3 - 0.52% Coverage

Misha: Yeah, it was just kind of a phase where I just had no idea and I didn't want to be silly and just end up going to labour ward and they sending me home going, "ah no you're... you know it's just Braxton Hicks, go home sort of thing", so yeah it was, yeah, one of those moments.

<Files\Interviews with childbearing women\P010_Poppy> - 5 1 reference coded [1.85% Coverage]

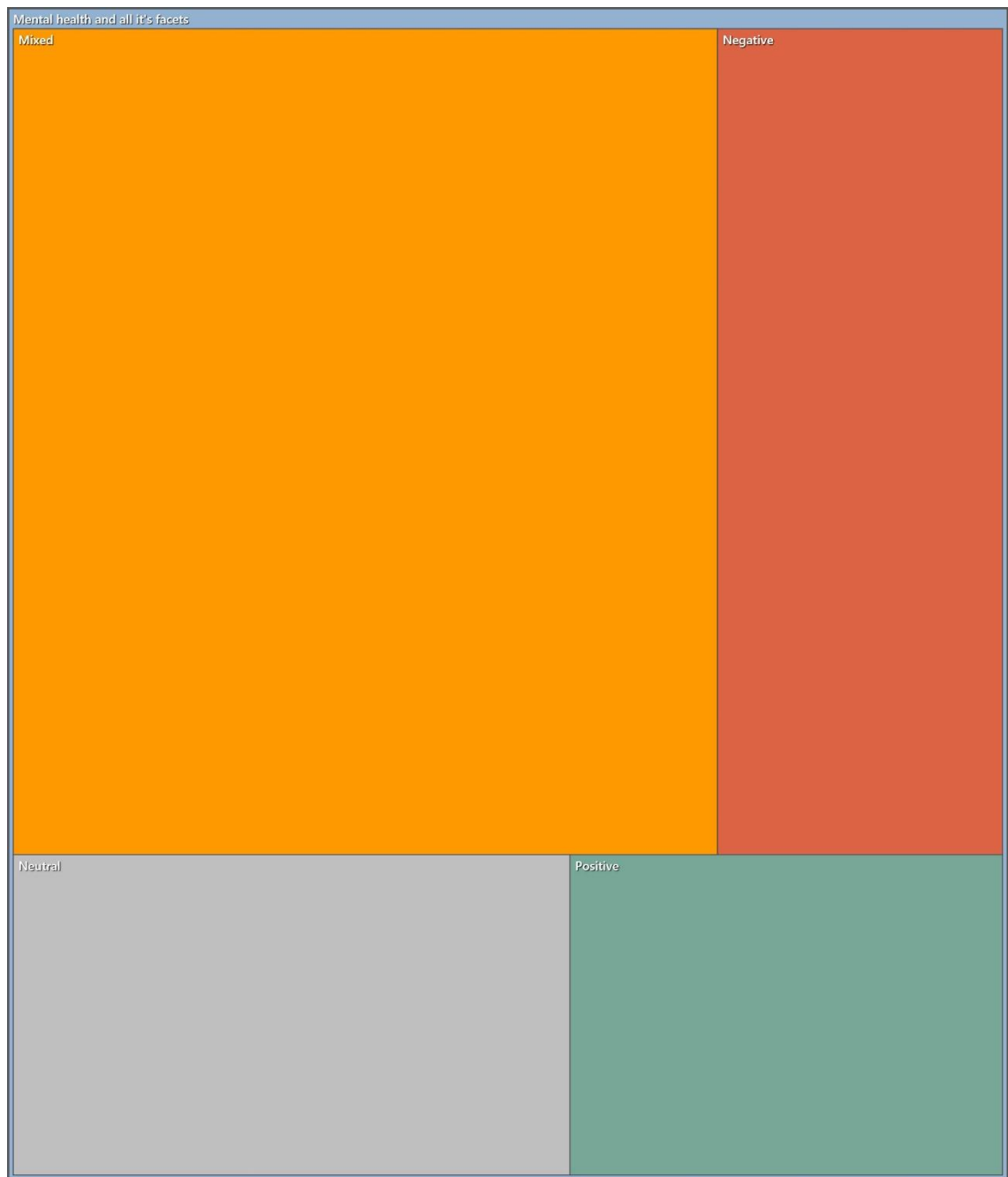
Reference 1 - 1.85% Coverage

-and in a panic but this time, even when I went to the day unit they were like "honestly when you have a section that was a breeze since the first time because obviously the first time I was in labour thirty-six hours, I was having needles put left right and centre, and taking all these different measurements and then being rushed into theatre and needles put into my neck, I couldn't feel myself breath, it was horrible. Yeah like literally I went in at ten to two and she was born at two. So, it was like literally quickly just get her out. But they don't, obviously when it's an emergency they don't talk to you about what's going to happen and how, it's just literally like get you in, because they're got to get your baby out. And I hadn't planned that, it was an emergency, but this time around, honestly, I've done research, I've done my books and I've spoken to so many people that

Hierarchy coding

See the individual links above to the NVivo website for information on each visualisation option. Hierarchy charts visualise a hierarchy, helping you to see patterns in your coding or view the attribute values of cases and files.

Create a hierarchy chart by clicking Hierarchy Chart in the Charts group on the Explore tab. I used this to explore the parent code 'women's daily lives' with aggregation to explore all child codes/sub-categories:



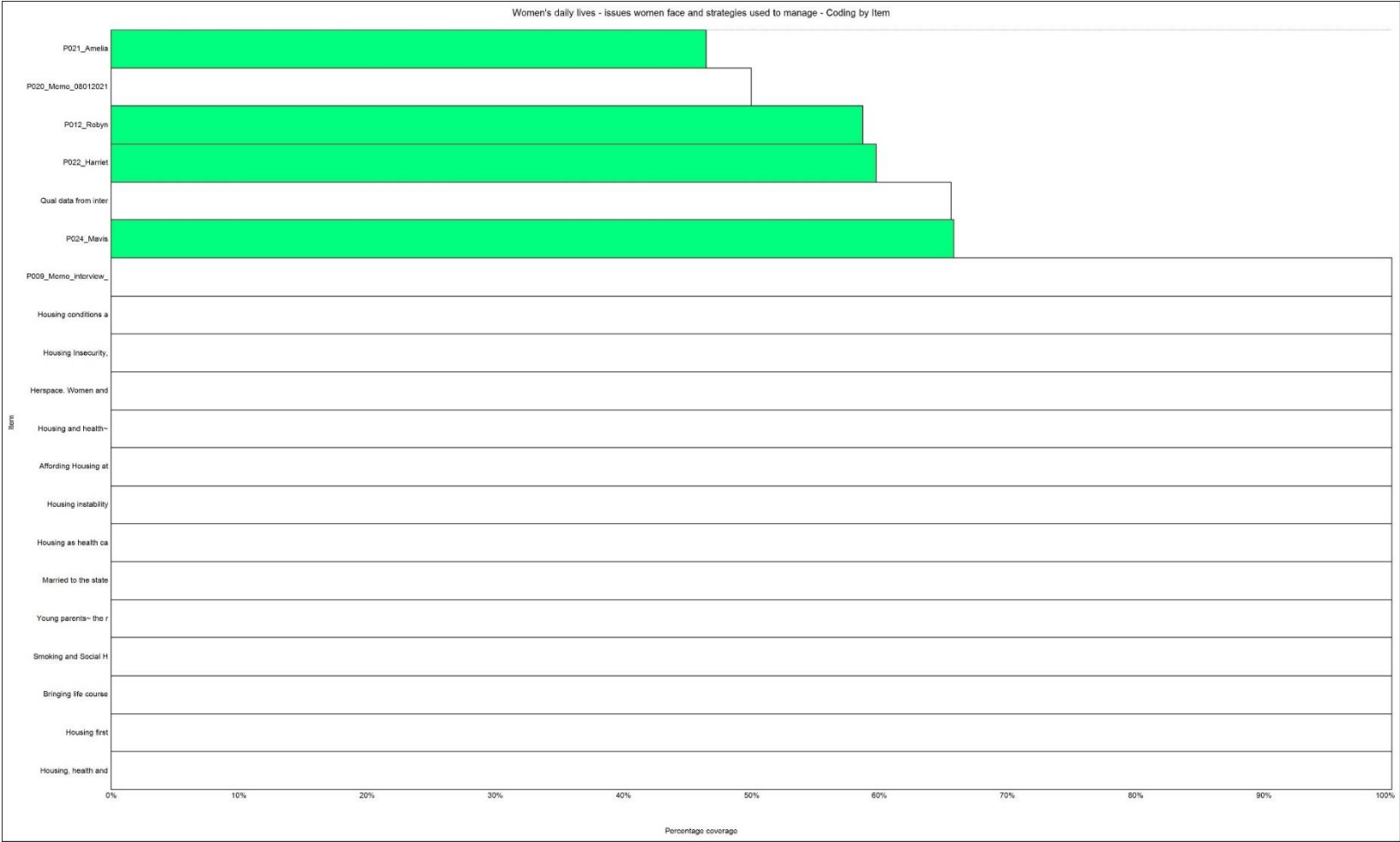
Sentiment behind the language women used to discuss the impact of their daily lives
hierarchy of sentiment coding in figure.

Women's relationship with themselves, strategies they employ to overcome issues they face				
Being a mother, relationship with self, pregnancy, and mo...	Impact of cultural and religious beliefs	Intuition		Time and space away f...
		Getting on with things - sucking it up		Longing and desire for...
	Not feeling seen or heard, denying own inner ...	Strategies and interventions women employ...		Sexual heal...
				Setting ...

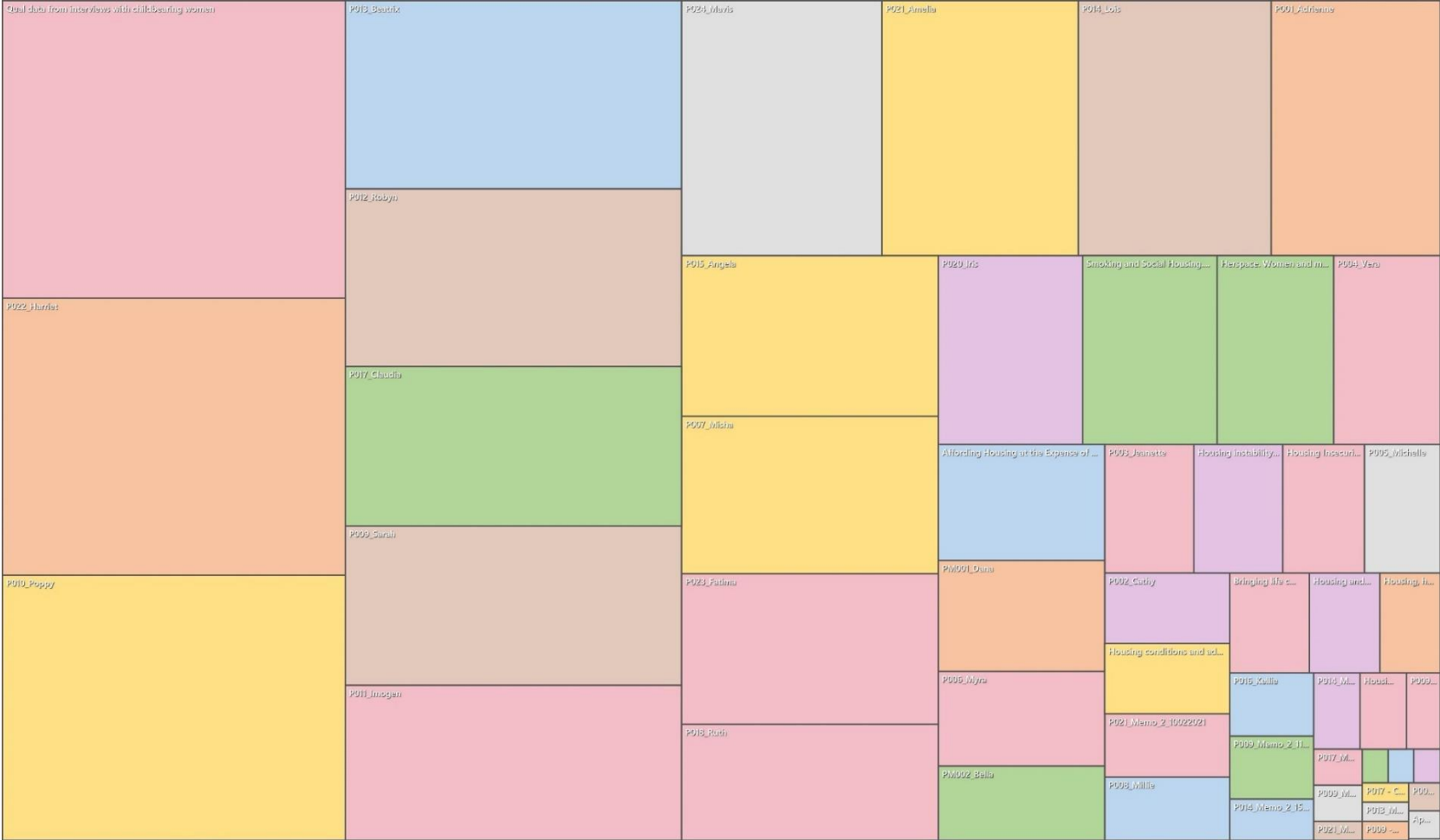
Different hierarchy charts to explore where the data is coming from within the above code/node.

Hierarchy by code, hierarchy by file (as below) to discern where the data is coming from within this main category and who is contributing the most to the discussion etc.

Coding by file type



Coding by files using a different type of hierarchy chart



I also used this visualisation to take a deep dive into the 'women's daily lives' code to ascertain relativity to where the codes fit within the wider discussion. Within the hierarchy chart I can click on summary tab and export the raw data into .xls file and then manipulate it further in either Excel or Visio as NVivo only provides a few colour options

Childbearing women - 04122022

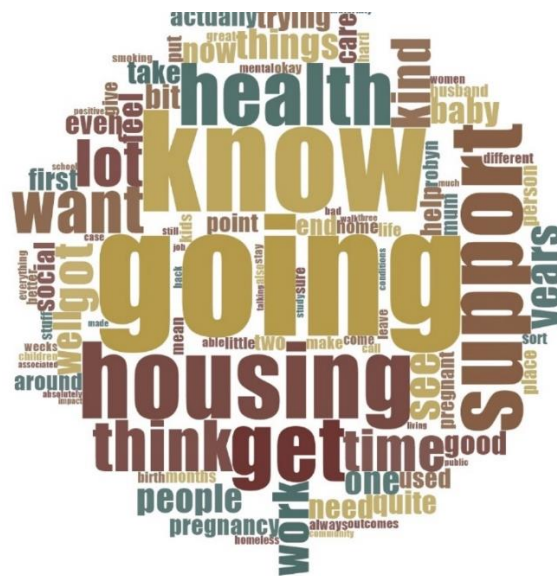
know	get	things	feel	lot	got	one	bit					
	support	midwife	need	home	care	quite	good	pregnancy	people			
		first	put	always	point	around	different	happened	absolutely			
going		kind	work	take	talk	pregnant	felt	someone	make	two		
think	time	now	day	little	team	everything	adrienne	went	positive	able	sure	
	even	weeks	sort	tell	hospital	mind	something	stuff	probably	used		
	want	actually	phone	come	nice	also	still	better	much	came		
well	see	okay	trying	way	birth	midwives	yes	back	check	labour	done	
			help	end	anything	appointm	husband	mum	lois	maybe	normal	thank
									robyn	case	difficult	
									right	three	fatima	

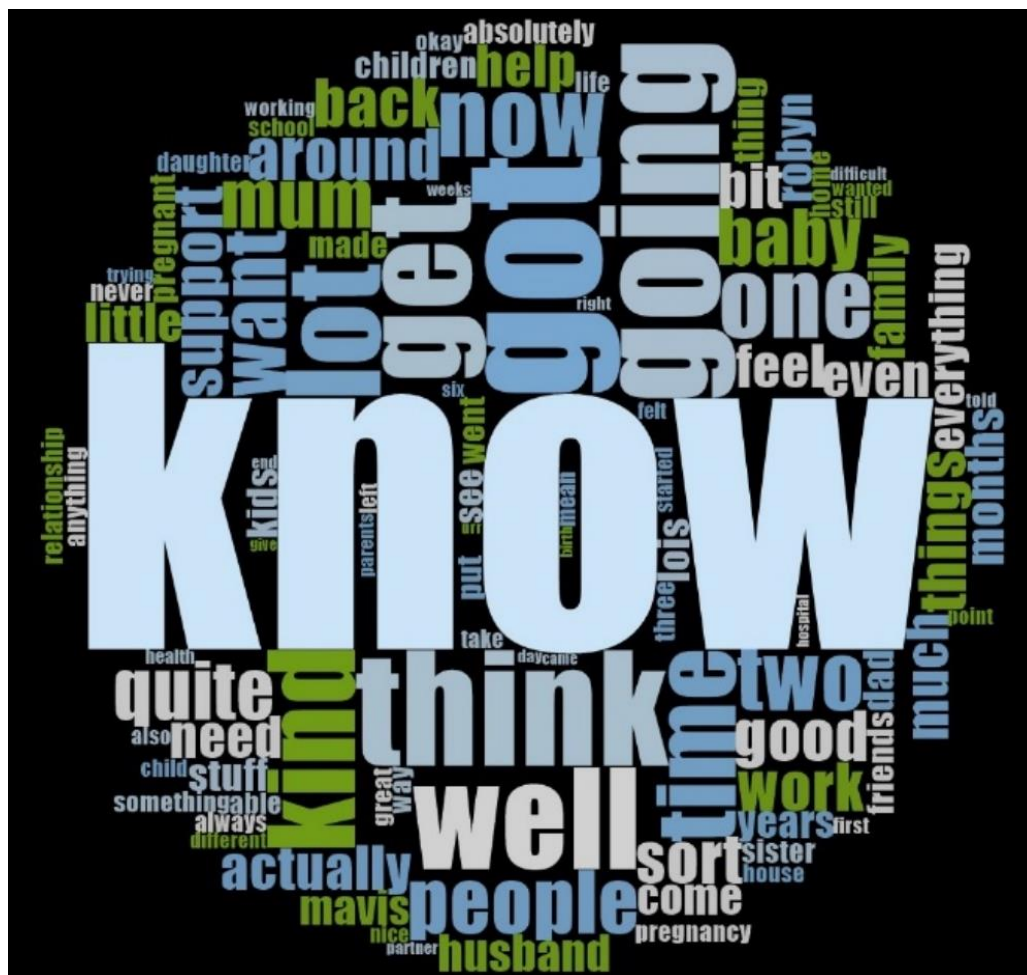
Word frequency queries

Use Word Frequency queries to list the most frequently occurring words or concepts in your files.

You could use a Word Frequency query to:

- Identify possible themes, particularly in the early stages of a project.
- Analyse the most frequently used words in a particular demographic. For example, analyse the most common words used by farmers when discussing climate change. You could do a coding query to gather all content coded at climate change and at 'case' nodes with the attribute farmer—then select the result node as the criteria for the Word Frequency query.
- Look for exact words or broaden your search to find the most frequently occurring concepts. For example, if you look for the most frequent words in a dataset survey, you might find that water, health, and harmful are the most frequently occurring words. However, if you group similar words together, you might find that the concept of pollution (including pollutants, pollution, polluted, and pollutes) occurs most frequently.
- Word cloud - of the words within the category – 'women's daily lives. If you select 'tag cloud' you can edit and export the word cloud.





Project Maps

Project maps are a graphic representation of the different items in your project. Create a project map to explore and present the connections in your data.

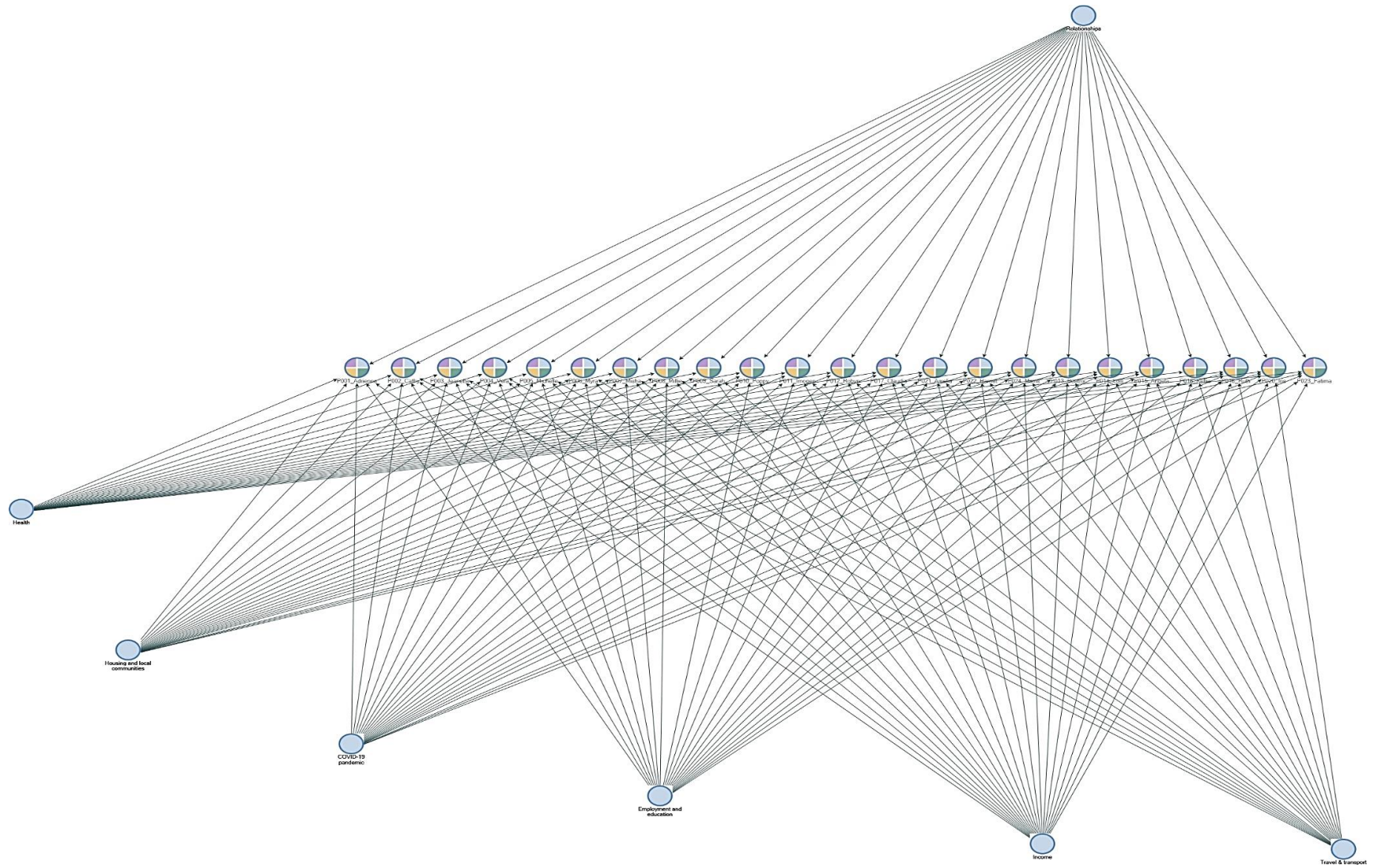
Project maps are made of shapes that represent the different items in your project and connectors which show links between items. You need some project data before you can create a project map.

To get started with a project map, you need to frame a question you want to ask of your project data. For example, how have these files been coded? Which cases are assigned to this classification? What are the attributes defined for this classification? Then, add the project items that are central to your question to the canvas to build up a visual representation of your enquiry. Add other, associated items to the canvas to help illustrate the answer.

You can use project maps to:

- Explore and organize data.
- Develop ideas, build theory, and make decisions.
- Identify emerging patterns, theories, and explanations.
- Visually represent the links between project items.
- Provide a record of stages in a project.

This project map below depicts what women discussed in their interviews coded to 'women's daily lives and the hierarchy of the topics, as you can see 'relationships' is the main topic, then health, COVID-19 and so on.



Explore Diagram

- Explore diagrams focus on a single project item, showing all the items connected to that item. The diagram is dynamic, allowing you to step forward and back through your project data to explore the connections between items.
- An explore diagram starts with a selected project item in focus. All its connected items are displayed around it.
- The power of this diagram is that it is dynamic. You can select any of the connected files, nodes or cases and refocus the diagram on that project item, generating a new diagram showing all its connected items.
- Your history of interacting with the diagram is remembered—letting you step forward and back through your project data exploring the connections between items.
- The diagrams below examine the codes 'women's daily lives AND 'relationships' and depicts what parent code, cases, files, and memos all discuss relationships.
- I can use this sort of diagram to build my participant profile

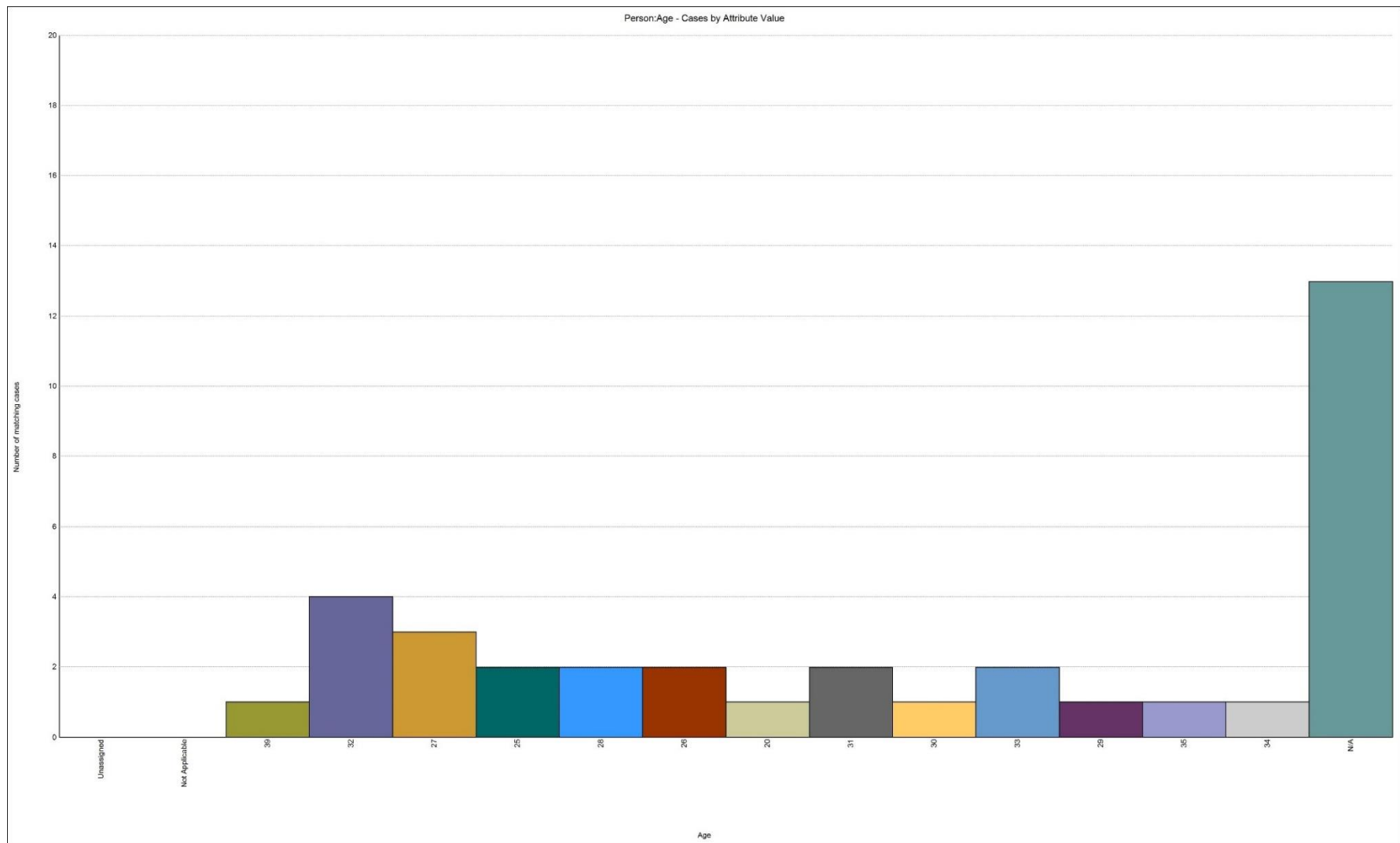


Charts

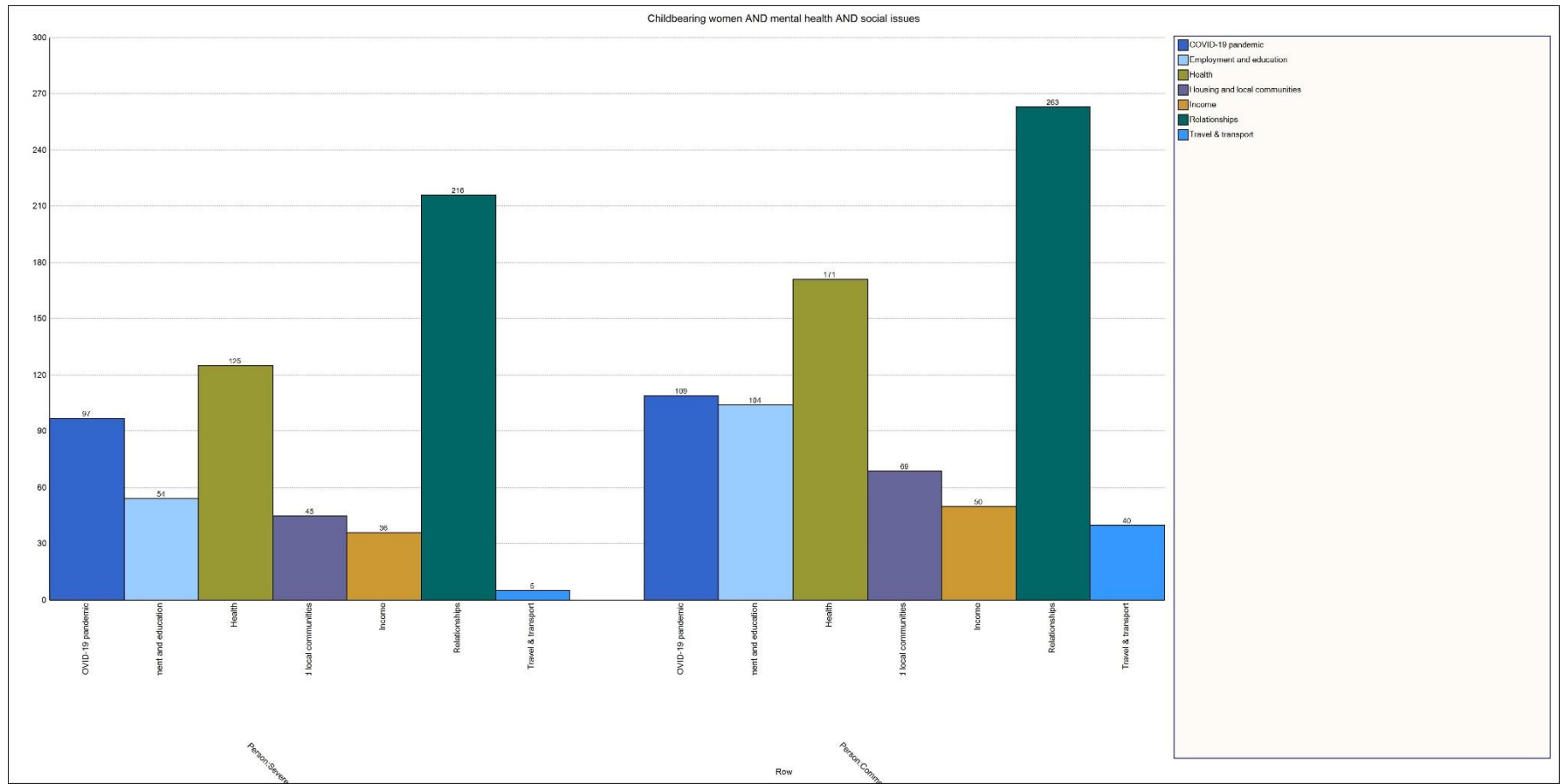
You can use charts to present or explore the coding in your project. Charts can help you answer questions—for example, what are the dominant themes in this interview transcript? or how is coding spread across the different demographic groups in my project?

The Chart tab displays the visual representation of your data. You can use charts to visualise your coding, files, and cases.

I used charts to explore the age distribution of perinatal women who talked about their daily lives. Women who are 32 are overrepresented. Visualisation of category > attribute value > age > distribution of participants discussion by age. Then I went into my case classifications and selected age > visualisation > chart cases by attribute value > this demonstrates spread of people's ages across the study and. In my case there were x4 32-year-olds and they also made up the most of my sample and they also had the most to say and contribute to the discussion on their daily lives and the issues impacting them during the data collection period. These participants are overrepresented in the category or are patterns in the data that I did not create. I am allowing the data to do the talking, representing their world view and not mine.

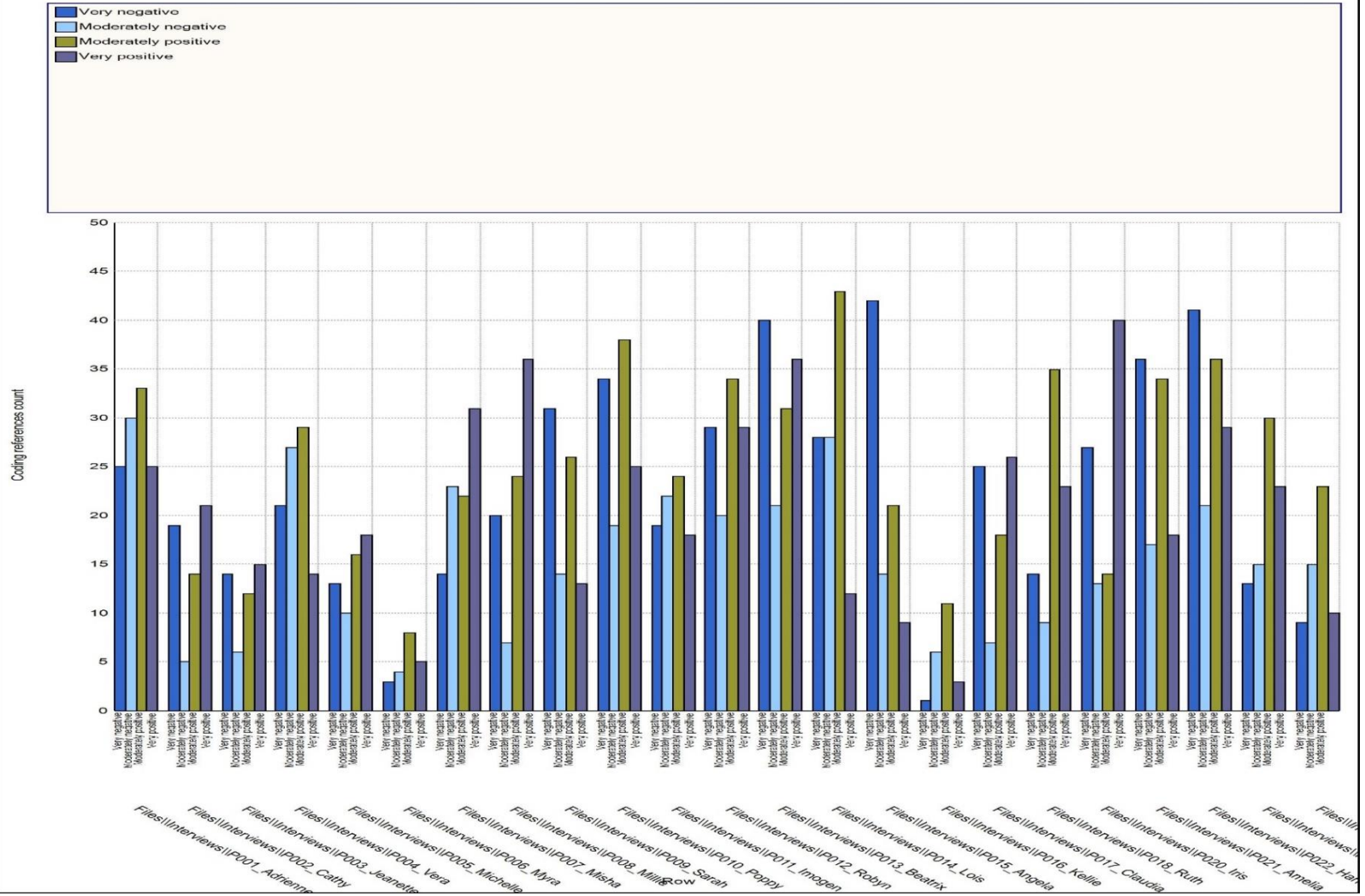


I also used charts to take a deep dive into the spread/association of coding within the code 'women's daily lives' AND how women with 'common' OR 'severe' mental health conditions discussed issues within this code. This was interesting and insightful as both groups discussed relationships, health, and COVID-19 the most > this now requires my critical analysis to explore the relationship/connections between these findings and the theoretical/selective coding which immerses from my analysis of the context/conditions > inter/actions/consequences of these codes:



I also looked at the relativity of auto coded sentiment coding in each interview with perinatal women:

Auto Code Childbearing Women Sentiment Results 04-12-2022 15.13



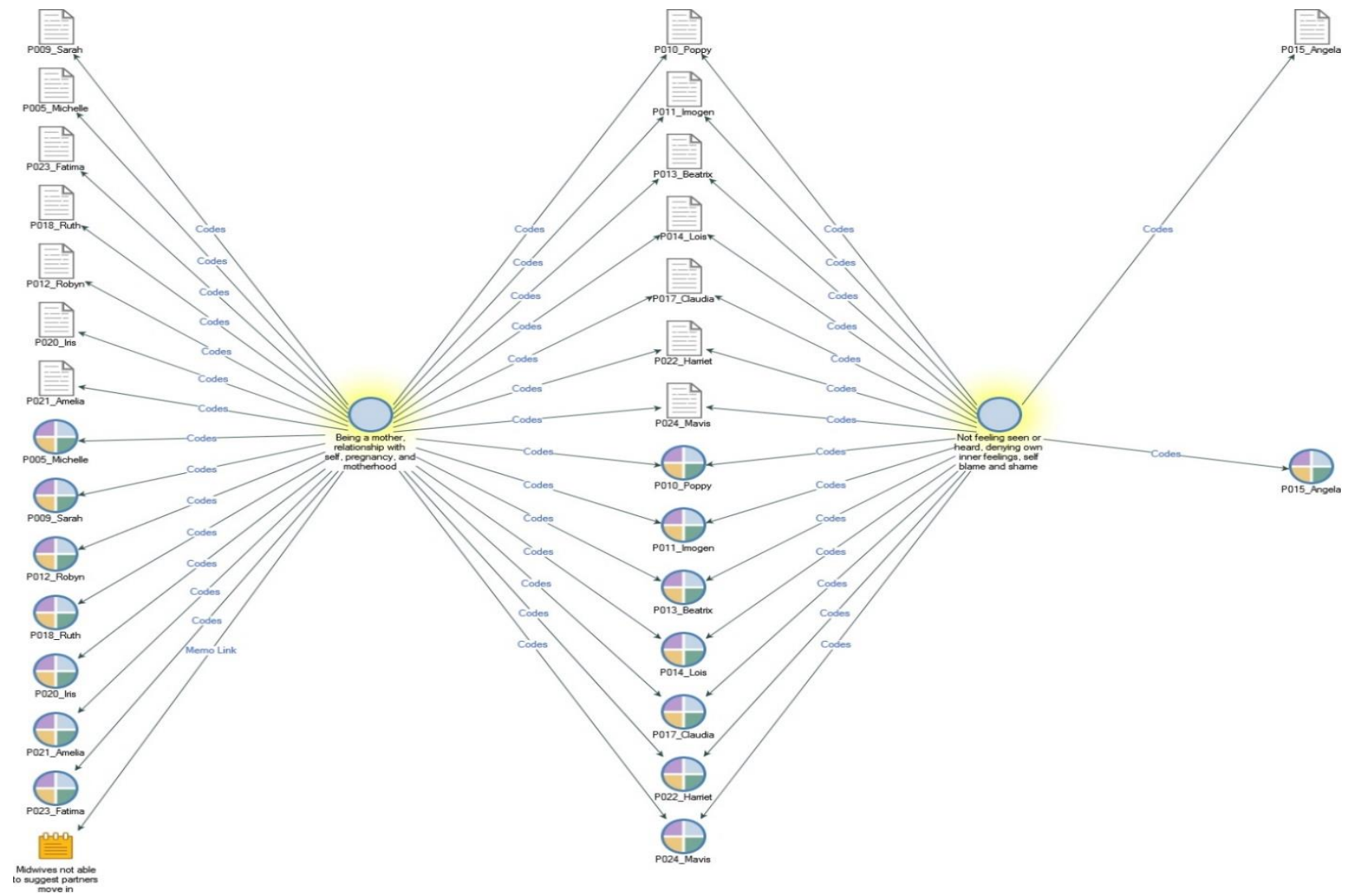
Comparison diagrams

Comparison diagrams can show you what two items have in common and where they differ. You can generate a comparison diagram to compare two of the same type of project items—for example, files, nodes, or cases—to see their similarities and differences.

Comparing two properties of a category > select two codes within the category > select compare and then I will be able to discern where people have talked about two categories and/or have not. Where people discuss both they will be situated/connected in the middle with examples of cases to either side, those that are uniquely concerned with either concept or there is not a known relationship will be situated to either side at this point.

By using visualisations, I found things I did not know in the data or would have found difficult to ascertain through manual analysis alone. It removes the drudgery and time required to attempt to make these associations on your own.

Below, I choose to compare > women's relationship with themselves > AND > not feeling seen or heard:



Project maps

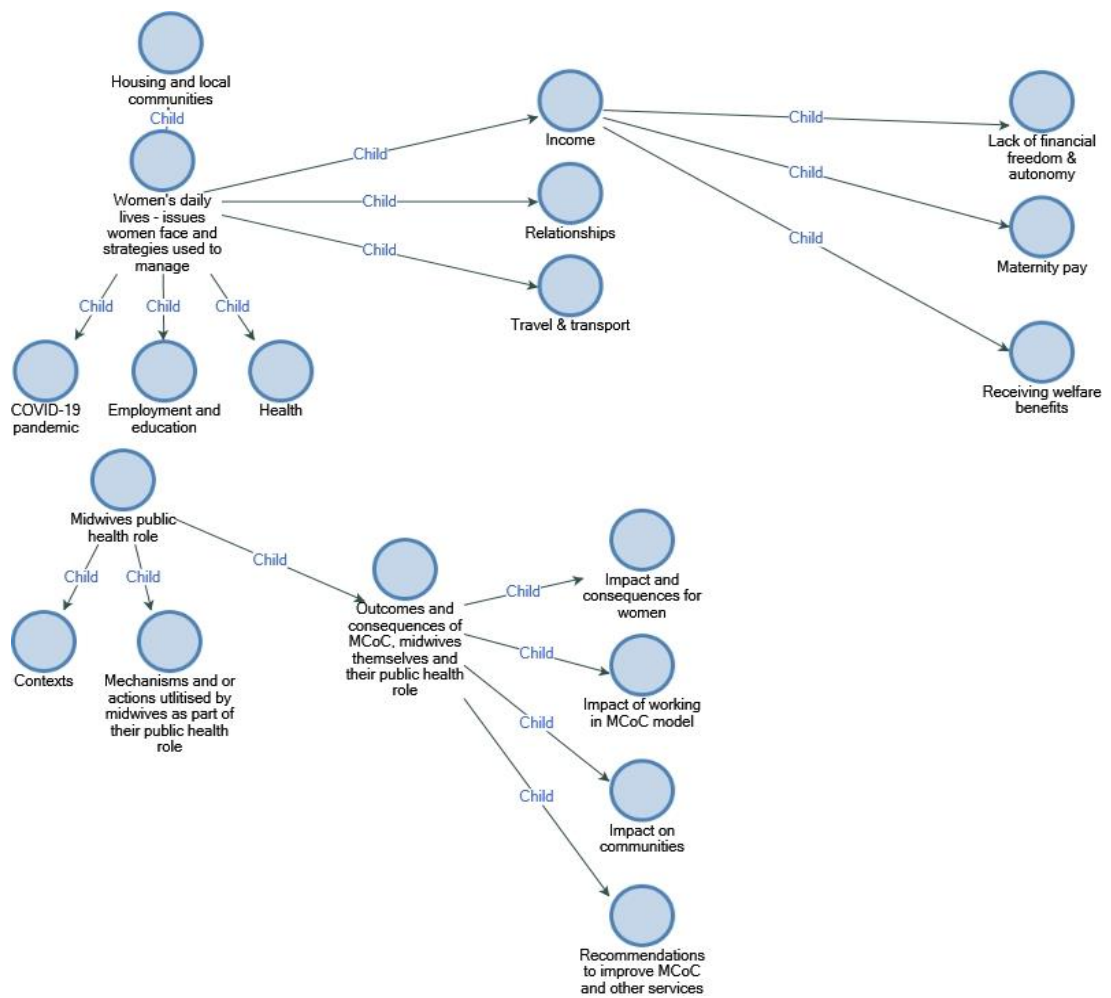
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- Develop ideas, build theory, and make decisions.
- Identify emerging patterns, theories, and explanations.
- Visually represent the links between project items.
- Provide a record of stages in a project.

Exploring the concepts/code – women's daily lives AND midwives' public health role:



11.5 Appendix 5. Email from NHS Digital

Email exchange to NHS Digital on lack of SDoH data in electronic health records in maternity

Personal communication with NHS Digital about SNOMED clinical coding in digital Maternity Information Systems

Email sent to staff at NHS Digital on 01/02/2022

Hello,

I'm a Clinical Academic Midwife from University Hospital _____ and I'm currently writing up my PhD research.

My research is examining the public health role of caseloading midwives working in areas of high deprivation using qualitative methods. It struck me how much the collection, processing, and reporting of structured data was an area of concern for the midwives and members of the public I interviewed during the COVID-19 pandemic. The perception from participants was that coding of clinical interventions and coding of interventions to address the wider determinants of health performed in midwifery continuity of carer models was poor and that this prevented teams from being able to evidence their impact on immediate, short- and long-term health outcomes other than mode of birth, smoking status etc.

I've had a look at maternity SNOMED coding that feeds into MSDS data on the dashboards, and I wondered if you could help me confirm what data standards and collections are captured by SNOMED coding? I'd hate to make any assumptions and welcome any information you are able to provide.

Really looking forward to hearing from you. I also contacted the SNOMED implementation team but they kindly highlighted that they focus on supporting organisations to implement SNOMED and so pointed me in your direction.

Best wishes,

Charlotte Clayton

Response from Population Health, Clinical Audit and Specialist Care, NHS Digital received on 22/02/2022

Hi Charlotte,

Apologies for such a delay in a response. We've now received the following information from our dataset development team which I hope helps:

The Maternity Services Data Set (MSDS) v2.0 introduced the ability to submit SNOMED CT codes within the data set. This is in line with the separate SNOMED CT Information Standard, which dictates the implementation of SNOMED across the NHS.

Within MSDS, we allow SNOMED CT codes to be submitted representing procedures, observations, findings, scored assessments, diagnoses, situations (for family history), and social and personal circumstances.

For MSDS, we have purposely not stipulated which SNOMED CT codes should be used for submission purposes. This is because the data set is for secondary uses purposes, and we would not want to restrict the local recording of codes for patient care purposes. However, we have published some guidance which specifies certain codes that can be used in submissions:

SNOMED CT mapping guidance, designed to help providers to adopt MSDS v2.0 when it first replaced MSDS v1.5. Saving Babies' Lives Care Bundle (SBLCB) v2.0 Technical Glossary, which

sets out the data items, values and (where relevant) SNOMED CT terms and codes that can be included in MSDS v2.0 submissions to support SBLCB compliance and reporting.

Ideally, SNOMED CT should be included within clinical systems to enable both the local recording of clinical data, and its subsequent submission in MSDS. This would reduce the need for local mapping of clinical data to the data set specification, enabling data to be collected once but used often. However, the various maternity systems in use by Trusts are at different levels of advancement when it comes to SNOMED CT usage.

The Digital Maternity Record Standard was created at a similar time to MSDS v2.0, and the idea was that the standard would incorporate SNOMED CT codes to capture data for patient care purposes as opposed to just reporting through the data set. We anticipated pointing to the record standard and these SNOMED CT codes within MSDS guidance once system suppliers had adopted the record standard. However, unfortunately the adoption of this standard is currently on hold, though an updated version is potentially planned.

Finally, further information about our approach to capturing SNOMED CT codes in MSDS v2.0 is also available in the data set User Guidance (pages 10-12).

Hopefully, these are all potentially relevant to what you are looking for.

Best wishes,

[name removed] Higher Information Analyst

Memo written on 23/02/2022

11.6 Appendix 6. Health and Wellbeing Board minutes



Meeting - Health and
Wellbeing Board Sout

11.7 References

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