Conclusion

- Health decision making in pregnancy should be viewed within the context of women's wider social and environmental circumstances, alongside their motivation.
- Consistent information, and reasons for changes to guidelines should be provided to pregnant women by health professionals. It is unclear how women's own networks can be supported to provide evidence-based advice; it is important to identify strategies.
- In order to reduce health inequalities, interventions which facilitate healthy pregnancies should be developed as a matter of urgency. These must be co-developed with women who are on low incomes, to ensure that interventions do not perpetuate health inequalities.

We gratefully acknowledge funding from the Wellcome Trust and College of Biomedical and Life Sciences at Cardiff University

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Research Briefing
December 2016

Exploring Health and Wellbeing in Pregnancy for Women living on a low income in Wales

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In order to build on the existing evidence base regarding health and health inequalities in pregnancy, we undertook participatory qualitative research with pregnant women living on low incomes in deprived areas.

Summary

Background

- Abstaining from alcohol and tobacco during pregnancy has benefits for infant health. Women from poorer backgrounds are more likely to drink alcohol and smoke during pregnancy.

Research design

- We worked alongside pregnant women from deprived areas using participatory qualitative interviews.
- The findings were mapped onto the **COM-B** model (Michie et al. 2011), which describes barriers and facilitators to health behaviours in relation to **C**apability, **O**pportunity and **M**otivation.

Findings

- Women faced barriers to healthy pregnancy behaviours in relation to **C**apability and **O**pportunity, including knowledge of healthy pregnancy guidelines and their social environment
- Women generally had high **M**otivation to engage in healthy behaviours for their baby's benefit.
- When women received inconsistent or confusing advice or were unable to follow the advice, they reported their behaviour was "good enough".

Conclusion

- There is an urgent need for interventions that facilitate healthy pregnancies. These should be co-designed with women from deprived areas to avoid compounding health inequalities.

Version 1, 07.12.16

Background

During pregnancy, a range of lifestyle factors, including smoking and alcohol consumption, have been linked to poor outcomes for the infant. Women from lower socio-economic groups are more likely to engage in behaviours that are harmful to infant health in pregnancy. Current healthy pregnancy interventions have low uptake and high drop out.

Research design

Data production

Ten pregnant women who lived in deprived areas of south Wales and claimed benefits took part in the research; nine of these took part in two interviews. The interviews used a creative participatory approach (Mannay, 2016), with participants creating timelines, collages and sandscapes (see picture) to lead the discussion, with a focus on health and wellbeing.

Data analysis

Interviews were coded for broad themes and analysed in two ways. First, to understand the barriers and facilitators to healthy behaviours in pregnancy using the COM-B (Capability, Opportunity & Motivation = Behaviour) Model (Michie et al., 2011; 2014). Second, data were analysed within a psychosocial framework.

Detailed Findings

Diet, alcohol and smoking: barriers and facilitators to healthy behaviour

Capability: Knowledge of healthy maternal diet and alcohol consumption was moderate. Conflicting or confusing advice was reportedly given by some health professionals.

Opportunity: Smoking and alcohol use were normalised, and it was difficult to socialise without taking part. Women who smoked or drank alcohol tended to do so in private, not public spaces. Some partners encouraged women to quit smoking.

Motivation: Nausea and sickness were central in many decisions around diet and facilitated abstinence from alcohol. Women reported that not smoking or drinking alcohol would be best for baby. Addiction to nicotine was challenging for some women.

Behaviour: Most women reported that they did not smoke and only moderately consumed alcohol. Participants found it difficult to eat within healthy pregnancy guidelines.

Pregnancy is not an illness

Some women suffered quite profoundly with nausea, sickness and tiredness, but they felt strongly that their pregnancy was not an illness. Rather, their symptoms were an inconvenience which impacted upon their family life. Rest and relaxation was understood as a luxury most could ill afford because of the demands of looking after their other children. In addition to modifying their diet, “Getting on with it” was the means by which they managed symptoms during pregnancy. Health issues aside, the women felt they were capable of the majority of activities they did before pregnancy, which largely focused around domestic tasks and child care.

Public spaces, surveillance, and judgement

Women were aware of a ‘public gaze’ and surveillance of their pregnant bodies and behaviour. This was experienced as intrusive, inappropriate and unwanted. Women stated that they strongly reserved the right to make their own decisions around the appropriateness of their health behaviours, social life and day to day activities. However, an awareness of the potential judgements of others meant that some behaviours, such as smoking and drinking alcohol were reserved for the home, rather than public.

Good enough mothering: “I haven’t killed them yet!”

The women felt they received inconsistent or contradictory health advice from professionals, particularly regarding new guidance to avoid alcohol completely, which resulted in confusion and frustration. To overcome this, women tried to follow their instincts, do what their own mothers did or used social media to engage in discussions in order to receive clarification and support from their peers.