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Abstract

Background and objective: S... D

Context and approach: F... S... O

Results: I... F... O... I

Conclusion and implications: E... D

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M... 3000, A-
F...

parenting, and some aim to raise self esteem among women experiencing adversity of various kinds (violence, poverty, depression). Few, if any, have aimed simply to provide companionship or friendship or to focus primarily on improving maternal outcomes. What is also notable is the dearth of postnatal support programs offered to new parents as couples. One recent exception aimed to address maternal fatigue and improve maternal mental health (anxiety and depression) via a universal psycho-educational intervention delivered to couples by experienced maternal and child health nurses, with a focus on improving the quality of the intimate partner relationship after birth and enhancing infant management [7].

Labour and birth have also been the focus of support interventions for mothers. Here childbirth education

educational and informational benefits of the support provided are less emphasised by women, despite the clear focus on these aspects in most social support interventions. Feeling isolated and alone are common experiences for women in the early months of motherhood, so it is unsurprising that women value the offer of reassurance and companionship so highly.

We have been involved in two randomised trials of pragmatic public health intervention strategies involving the offer of social support to recent mothers. In both studies social support was conceptualised and implemented, not in terms of information or education for women, but rather as befriending and companionship. The primary aim of both interventions was to improve maternal wellbeing, both emotional and physical, rather

importance of mothers looking after their own health and wellbeing. Local mothers were consulted, both through steering committees, specially organised meetings with mothers, and via small local surveys. Ideas were tried out; some gained traction, while others did not. A variety of small-scale, largely informal befriending opportunities emerged. Connecting mothers so they could enjoy something together (an activity, time, relaxation) was a common strategy, and included identifying and ‘naming’ mother-friendly places where women could meet (eg cafes, community venues), setting up activities for mothers (eg pram walking times, Mothers’ Day lunches), and making connections between mothers through a facilitator (eg the maternal and child health nurse).

So befriending in PRISM developed as a range of strategies, rather than being a single program. Invariably, lots of ideas were discussed by local Steering Committees. Some were implemented and maintained. Lots of sharing of ideas between areas occurred, particularly as a result of contact between the CDOs. Befriending initiatives were facilitated by a whole range of people and organisations, including: PRISM community development officers, maternal and child health nurses, staff in community houses, libraries, community health services and local businesses such as cafes, cinemas and leisure centres. See Box 1 for a more detailed account of the range of befriending opportunities that developed.

By midway into the second year of PRISM implementation, befriending had become highly valued by community stakeholders as a key element of the project. The findings of a Communities’ Feedback Survey sent to steering committees, mothers, primary care and community agencies in each area, demonstrated that 90% of stakeholders thought that provision of ‘increased opportunities for mothers to meet and do things they enjoy with other mothers’ had been achieved in their area, and over 80% of mothers and maternal and child health nurses surveyed thought it was important that such befriending opportunities for mothers be maintained.

Feedback from women taking part in befriending activities also indicated that they valued these opportunities to meet other mothers:

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mentors in antenatal clinics [26]. We sought women

about the nature of non-judgemental, lay support assisted the practice of empathy among mentors. Discussion of boundaries and the distinction between mentoring and the role of health and other professionals in referred women’s lives also focused mentors’ attention on the importance of their lay support role. Professional involvement may be a double-edged sword for women experiencing intimate partner violence because of the implications of mandatory assessments of the safety of their children. Several women in the mentor group were survivors of violence themselves and well understood that women’s fear of professional surveillance for child abuse often limits their willingness to disclose partner violence and seek support from health professionals or social workers.

Of the 90 women recruited into the intervention arm, 86 responded to the supplementary survey about mentoring. Included in the feedback women provided was this illustration:

I thought I...

Managing closure

Preparation for mentoring for a specified time period (up to one year in MOSAIC) had to be made explicit at the beginning of the mentoring relationship. MOSAIC was a research project and not an ongoing service and the option of up to a year of mentoring was made clear to participants in the informed consent process when women were recruited in the intervention arm of the trial. At the eight month review both mentor and woman were reminded that the exit period was approaching. The woman’s connections in her community were explored, her unmet needs were discussed and goals set for the next four months. The coordinator made additional efforts to talk to the mentor over the final three months to facilitate a satisfactory process of closure. Mentors were encouraged to move from a weekly meeting to once a fortnight to ease the farewell. If mentors wished to continue the friendship and some did, it was made clear that they were able to do so, but outside the MOSAIC program and its funding support. In feedback to the study, captured in mentored women’s evaluation surveys, 65/76 (86%) said they thought the

time was ‘about right’. Vietnamese women were among those more likely to prefer a longer period of support.

While the outcomes for both intimate partner abuse and depression were in the hypothesised positive directions, the study could only establish qualified support for the value of mentoring in reducing experiences of violence and enhancing maternal wellbeing, due in large part to the under-powering mentioned above [33]. Box 3 provides a brief summary and references for the key features and findings of MOSAIC.

Women’s feedback emphasised the importance of the non-judgemental and empathic aspect of the mentor role. Seventy-nine per cent said they most valued having someone who always encouraged them, and that they could talk about anything that bothered them (78%). Women said that what they had most gained was that they felt better about themselves (61%), less isolated (56%), and a better parent (56%). Eighty-two per cent said that they would definitely recommend mentoring to others.

‘I...

Discussion

The majority of perinatal support programs aim to improve... health and developmental outcomes, with maternal outcomes, such as improved confidence and self efficacy seen largely as mediating improvements in child health, rather than ends in themselves. In contrast the primary aim in both PRISM and MOSAIC was to improve... health and wellbeing. This focus on maternal issues informed our choices about how to provide support (lay rather than health professional support) and also our choices of outcome measures (maternal experiences of violence, depression, and overall maternal health and wellbeing). In this, our trials have more in common with some of the labour support interventions and the peer support postnatal interventions described earlier.

Based on feedback from our earlier research [35] and from women participating in PRISM and MOSAIC, we are conscious that fear about the judgements of health professionals often holds women back from disclosing depression and intimate partner violence. The perhaps inevitable tension between factors that compromise maternal health, and the impact that this has on child health and development, presents women with a dilemma. Do they disclose issues such as depression and intimate partner violence, and risk judgements about their capacity to provide appropriate care for their children, or is it safer not to disclose these issues, and endeavour to manage them without support?

PRISM and MOSAIC took different approaches to offering women social support. PRISM was a universal strategy to provide all recent mothers with increased opportunities to meet and make friends after the birth of a baby. MOSAIC developed a pool of local women to



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