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Frederiksen, Marianne Stistrup

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BY
MARIANNE STISTRUP FREDERIKSEN

DISSERTATION SUBMITTED 2021

AALBORG UNIVERSITY
DENMARK

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Marianne Stistrup Frederiksen

AALBORG UNIVERSITY
DENMARK

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Main supervisor: Associate Professsor Charlotte Overgaard
Aalborg University

Co- PhD supervisor: Professor Virginia Schmied
School of Nursing and Midwifery
Western Sydney University, Australia

PhD committee: Associate Professor Helle Haslund Thomsen (chair)
Aalborg University

Professor Jane Sandall
King’s College London

Professor Megan Aston
Dalhousie University

PhD Series: Faculty of Medicine, Aalborg University

Department: Department of Health Science and Technology

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CV

Marianne Stistrup Frederiksen holds a BSc in Anthropology and Ethnography from Aarhus University (2013) and a MSc in Social Anthropology from the University of Copenhagen (2016). Her journey from anthropology and into the field of women's health began during her master's degree where she spent five months in the Philippines conducting fieldwork on women's experiences with family planning. During later employments in Danish Non-Governmental Organizations, Marianne worked with women's rights and gender-based violence, as well on a project focusing on the well-being of women during the transition to motherhood. Overall, these experiences sparked an interest in the field with a particular interest in improving the conditions for women, children and families in vulnerable positions.

She was appointed as a PhD fellow in the Women's, Child & Family Research team, Public Health and Epidemiology Group at the Department of Health Science and Technology at Aalborg University ultimo 2017. The study was co-funded by Aalborg Municipality. Marianne has throughout the project period communicated her research broadly to a range of stakeholders, including health visitors and midwives, in numerous workshops and meetings, and through this contributed to quality development of cross-disciplinary maternity services.

From October 2019 to February 2020, Marianne was affiliated as a Visiting PhD Fellow at the School of Nursing and Midwifery at Western Sydney University, Australia. Marianne joined the Mother, Infant and Family Research Group led by Professor Virginia Schmied and Professor Hannah Dahlen. During her stay, Marianne was under supervision of Professor Virginia Schmied and an ongoing collaboration was established.

As part of her 3-year appointment as a PhD fellow, Marianne has spent six months full time teaching and supervising students enrolled in the BSc program in Medicine and MSc program in Public Health at Aalborg University on topics including public health theory, realist evaluation, qualitative methods, basic epidemiology, systematic literature search, quality appraisal, academic writing and problem-based projects in public health.

ENGLISH SUMMARY

Background

Significant inequalities are seen in a wide range of psychosocial vulnerability factors that may negatively impact maternal and perinatal birth outcomes, as well as the short and long-term health and well-being of the child and family. International guidelines recommend early identification of psychosocial vulnerability to ensure referral to tailored and needs-based maternity care services; however, although intended as supportive, existing research documents challenges in this line of work as parents often report negative experiences, including fear and stigmatization, during encounters with services and providers. Following recent policy changes in the North Denmark Region, these challenges were also given voice to by the health visitation services in Aalborg Municipality, who presented a strong wish to learn about parents' experiences with and perspectives on the services they delivered. To understand the factors contributing to successful parent-professional encounters and high-quality care as well as to avoid potential negative consequences, in-depth knowledge is therefore needed to understand how needs-based maternity services are perceived and experienced by both parents during pregnancy and the postnatal period.

Objective

The overall objective of this PhD-project is to develop new, in-depth knowledge about the care experiences of Danish parents in vulnerable positions during pregnancy and the postnatal period in order to contribute to the development of care practices and the organization of maternity care services for this group.

The overall objective is operationalized into the following research aims that are addressed in three scientific papers, which addresses:

1. what parents in vulnerable positions fear, how and why they experience fear, and how this shapes their childbearing experience and engagement with maternity care services through pregnancy and the postnatal period.
2. key elements of supportive encounters by exploring how parents in vulnerable positions experience their relationship and encounters with professionals during pregnancy and the postnatal period.
3. the role of continuity of care in creating a coherent care journey for parents in a vulnerable position during pregnancy and the postnatal period.

Methodology

Informed by hermeneutics, the study is designed as an ethnographic field study. Fieldwork was conducted in Aalborg Municipality from April 2018 to September 2019. Through a purposive recruitment strategy, 26 women and 13 men were recruited, who received supportive services during pregnancy and/or after the birth, due to past or current mental health issues, limited social support, past substance abuse, young age, adverse childhood experiences and/or traumatic experiences and abuse. 50 interviews were carried out with parents, and 51 parent-professional encounters were observed. The material was subjected to a thematic analysis to address the study's overall objective, and the findings reported in three scientific papers .

Findings

Parents in vulnerable positions can experience fear in relation to their mental health, their parenting role and encounters and engagement with and providers. The way they experience encounters with professionals is thus important in terms of whether they feel safe, included and respected. If parents feel afraid, excluded and judged, this contribute to further fear and stigma. Their experiences also have to be seen in light of whether they experience coherent care over time. Continuity of carer, flow of information between services and providers as well as ensuring services that matches parents' needs is necessary to avoid fragmented care experiences as this leaves parents feeling frustrated and unsafe due to their needs for support not adequately met.

Implications for practice

To avoid producing fear and stigma and to establish trusting relationships, professionals need good relational skills to approach parents in an empathetic and non-judgmental way. Through clear communication and transparency, professionals can support parents by explaining the purpose of services and be reflexive about their own role. Further qualifications may be required to ensure professionals feel equipped to undertake this line of work. Policies that support all forms of continuity are recommended to ensure relational continuity, handover of information between services and providers and easy access to various evidence-based services, including support for parents facing perinatal mental health problems.

Conclusion

Parents' care experiences are impacted by a number of contextual factors, including the social context of their lived experiences, the relationships they form with professionals, processes of stigmatization, the felt tension between support and surveillance as well as the practice of needs-based maternity services. By giving voice to a group of parents, the study contributes with in-depth knowledge on their care experiences, which can contribute to the development of care practices and the organization of services for these families.

DANSK RESUME

Baggrund

Der ses en stor ulighed i psykosociale sårbarhedsfaktorer som øger risiko for negative fødselsudfald såvel som øget dødelighed og sygelighed, samt trivslen og sundheden hos barnet og familien på både kortere og længere sigt. Internationale retningslinjer anbefaler derfor tidlig opsporing af psykosociale sårbarhedsfaktorer med henblik på henvisning til en tværfaglig og behovsrettet indsats i løbet af graviditeten og/efter fødslen. På trods af at formålet er at støtte forældre i sårbare positioner, peger den eksisterende forskningslitteratur på en række udfordringer i dette arbejde, da forældre ofte kan opleve frygt og stigmatisering i mødet med tilbud og fagpersoner. I lyset af ændrede retningslinjer i Nordjylland, Danmark, fremsatte sundhedsplejen i Aalborg Kommune derfor et ønske om at blive kogere på forældrenes egne oplevelser og perspektiver på den behovsrettede indsats, de tilbyder. For at undgå negative oplevelser og konsekvenser mangler der dybdegående viden om, hvordan behovsrettede tilbud opleves af begge forældre, da dette kan bidrage til at forstå de faktorer, der understøtter et godt samarbejde mellem familierne og fagpersoner samt sikre gode forløb.

Formål

Det overordnede formål med denne afhandling er at udvikle dybdegående viden om, hvordan forældre i sårbare positioner oplever at modtage særligt tilrettelagte tilbud og behovsundersøgelser i løbet af graviditeten og efter fødslen med henblik på at kunne bidrage til udvikling af praksis og organisering af svangreomsorgen og behovssundhedsplejen for disse forældre og familier.

Det overordnede formål er adresseret igennem følgende specifikke mål og formidlet i form af 3 videnskabelige artikler, som undersøger:

1. Oplevelsen af frygt hos forældre i sårbare positioner, hvordan dette har betydning for deres oplevelser med graviditet og forældreskab, samt hvordan frygten påvirker deres oplevelser med at modtage støttende tilbud

2. Centrale nøgleelementer i møder som opleves støttende af forældre i sårbare positioner samt deres generelle oplevelse af mødet med og relationen til fagpersoner

3. Betydningen af kontinuitet og hvilken rolle dette spiller i forhold til et sammenhængende patientforløb for forældre i sårbare positioner

Metodologi

Denne afhandling er placeret indenfor et hermeneutisk videnskabsteoretisk ståsted og designet som et etnografisk feltstudie. Dataindsamlingen blev gennemført i Aalborg Kommune fra april 2018 til september 2019. Ved brug af en formålsbestemt rekrutteringsstrategi blev 26 kvinder og 13 mænd inkluderet i studiet. De modtog støttende tilbud under graviditeten og/eller efter fødslen på grund af nuværende eller tidligere mentale udfordringer og psykisk sygdom, ung alder, manglende social støtte, tidligere misbrug af stoffer og alkohol, svære oplevelser i opvæksten eller andre traumatiske oplevelser som vold og overgreb. Der blev gennemført 50 interviews med forældre samt 51 feltobservationer af deres møde med fagpersoner. Data blev analyseret ved hjælp af en tematisk analysestrategi med afsæt i studiets overordnede formål, og resultaterne blev formidlet i tre videnskabelige artikler.

Resultater

Forældre i sårbare positioner kan opleve frygt relateret til deres mentale helbred, forældrerollen samt mødet med fagpersoner og deltagelse i understøttende tilbud. Den måde de oplever at blive mødt på af fagpersoner er derfor vigtig i forhold til, hvorvidt de føler sig trygge, inkluderede og respekterede. Hvis forældre derimod føler sig utrygge, ekskluderede og stigmatiserede, kan det bidrage til øget frygt og stigma. Forældrenes oplevelser skal derudover ses i lyset af, om de oplever sammenhæng i deres forløb over tid. For at undgå fragmenterede forløb, som efterlader forældre utrygge og frustrerede, er kontinuitet i fagpersoner, kontinuitet i information samt kontinuitet i tilbud centrale elementer for om forældre oplever sammenhængene forløb.

Anbefalinger til praksis

For at undgå negative konsekvenser, såsom frygt og stigma, er det centralt at fagpersoner møder forældre på en empatisk og ikke-dømmende måde, da dette er med til at danne tillidsfulde relationer. Igennem åben kommunikation og gennemsigtighed kan fagpersoner forklare tilbuddenes formål og være reflekterede omkring egen rolle. Opkvalificering kan være nødvendig for at understøtte fagpersoners kompetencer. Alle former for kontinuitet bør understøttes, således at forældre oplever sammenhængende forløb. Dette kræver hurtig og let adgang til en række evidens-baserede indsatser, heriblandt støtte til forældre med mentale helbredsudfordringer.

Konklusion

Hvordan forældre i sårbare positioner oplever at modtage svangreomsorgens tilbud skal ses i lyset af en række kontekstafhængige faktorer, såsom deres egne sociale kontekst og levede erfaringer, deres relationer til fagpersoner, stigmatisering, modsætningen mellem støtte og overvågning samt den behovsrettede organisering af svangreomsorgens. Ved at give stemme til en gruppe af forældre bidrager dette studie med dybdegående viden om deres oplevelser, som kan bidrage til at udvikle organisering af fremtidig indsatser.

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Charlotte Overgaard, my supervisor, for all of your support and hard work over the last couple of years and for providing me with the opportunity to conduct this line of work in a field of research that is so very important to both of us. Your caring and constructive guidance have ensured that I never felt completely alone in the conduction of this project, and for this I am immensely thankful.

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Ulla Nordtorp, former head of the health visiting program in Aalborg Municipality, for cooperation on the initial establishment of the project. *Susanne Henriksen*, current head of the health visiting program, for the subsequent excellent collaboration and ongoing support and interest in the project. I also want to thank the rest of my advisory group for your collaboration and constructive feedback on the project, including *Denise Bakholm, Dorthe Taudal Jensen* and *Trine Troldborg*. A special thanks to Dorthe and Trine for your support in facilitating contact to the health visitors in the municipality.

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The health visitors and midwives in Aalborg Municipality for your interest and support in this project. I am particularly thankful for your invaluable contribution in the recruitment of participants, as well as allowing my presence during home visits, consultations and staff meetings over the last couple of years.

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Health visitors and midwives supported recruitment of participants by informing women and parents about the study and inviting them to speak to the researcher. This contribution from the field of practice is addressed in the discussion.

As also stated in the three papers, funders and other stakeholders had no role in the overall research design, analysis and interpretation of data, preparation of the manuscript or the decision to submit the manuscript for publication (Frederiksen et al., 2021b, 2021c, 2021a).

LISTS OF PAPERS

Paper 1 (Frederiksen et al., 2021b)

Frederiksen, M. S., Schmied, V., & Overgaard, C. (2021).
Living With Fear : Experiences of Danish Parents in Vulnerable Positions During Pregnancy and in the Postnatal Period. *Qualitative Health Research*, *31*(3), 564 –577. https://doi.org/10.1177/1049732320978206

Paper 2 (Frederiksen et al., 2021c)

Frederiksen, M. S., Schmied, V., & Overgaard, C. (2021).
Supportive encounters during pregnancy and the postnatal period: An ethnographic study of care experiences of parents in a vulnerable position. *Journal of Clinical Nursing*, *30*(15–16), 2386–2398. https://doi.org/10.1111/jocn.15778

Paper 3 (Frederiksen et al., 2021a)

Frederiksen, M. S., Schmied, V., & Overgaard, C. (2021).
Creating coherent care journeys during pregnancy and the postnatal period: An ethnographic study of the role of continuity of care for Danish parents in a vulnerable position. Manuscript submitted to *Women and Birth*, August 2021.

Journal information

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- Impact factor: 3.277 (Indexed by Web of Science).
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- Impact factor: 3.036 (Indexed by Web of Science)
- Danish Bibliometric Research Indicator ("BFI") list: 2 point

Women and Birth
- Impact factor: 3.172 (Indexed by Web of Science)
- Danish Bibliometric Research Indicator ("BFI") list: 1 point

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CHAPTER 1. INTRODUCTION

In this chapter, I will present the study's rationale and background, including an overview of existing studies, identification of knowledge gap and the overall objective of the study.

1.1. PSYCHOSOCIAL VULNERABILITY DURING PREGNANCY AND EARLY PARENTHOOD

Over the last decades maternal and child health have improved significantly in high-income countries, including Denmark, but this benefit is not equally distributed (De Graaf et al., 2013; The Danish Health Authority, 2013, 2020). Significant inequalities are seen in a wide range of psychosocial vulnerability factors that may negatively impact maternal and perinatal birth outcomes, as well as the short and long-term health and well-being of the child and family (Daoud et al., 2015; Harron et al., 2021; Rod et al., 2020). As highlighted by the World Health Organization (WHO) and others, inequality in health starts at conception and sometimes even before (Marmot et al., 2010; The Commission on Social Determinants of Health, 2008).

There is no universal definition of psychosocial vulnerability factors, but they include a wide range of co-existing and interrelated stressors related to the woman and her partner's overall socioeconomic position, living condition, age, ethnicity, and mental health problems (Bilsteen et al., 2018; Harron et al., 2021; Johansen et al., 2020; Philpott et al., 2019). Also limited access to social support and social networks, single-status parenthood and non-supportive or conflictual relationships to partners are important factors (Chhabra et al., 2020; Howard et al., 2013; Hutchens & Kearney, 2020; Norhayati et al., 2015; O'Hara & Wisner, 2014; Racine et al., 2020; Schmied et al., 2013; Wee et al., 2011), as well as a history of self-harm, substance misuse or exposure to domestic or other forms of violence, abuse or trauma (Biaggi et al., 2016; Dahlen et al., 2018; Hutchens & Kearney, 2020; Kothari et al., 2016)

A recent national, Danish report on social inequity in health has established that maternal educational level is associated with adverse maternal and perinatal outcomes, and that social inequity in maternal and child health remains a pressing issue in Denmark (The Danish Health Authority, 2020), despite the country's status as a high income country with a high level of social security. This finding is in line with a strong body of international evidence showing that pregnant women with low educational level/low social position often face multiple stressors, including material deprivation, poverty and/or live in disadvantaged neighborhoods and are at greater risk of low birthweight and pre-term birth, as well as infant morbidity and mortality, including stillbirth and early child mortality (Bilsteen et al., 2018; Daoud et al., 2015; De Graaf et al., 2013; Harron et al., 2021).

In contrary to some other high-income countries such as Australia (Austin et al., 2017; The Australian Department of Health, 2018), the current Danish national guidelines for maternity care services issued in 2013 have limited focus on perinatal mental health[1] (The Danish Health Authority, 2013). A recent review in World Psychiatry however highlights perinatal mental health disorders as the most common complication of childbearing as well as their significant contribution to maternal mortality and adverse child outcomes (Howard & Khalifeh, 2020).

Postnatal depression is the most common perinatal mental health disorder, but prevalence rates vary greatly across and within countries (Howard & Khalifeh, 2020; Jomeen et al., 2017; Kim & Swain, 2007; Madsen & Juhl, 2007). Postnatal depression has been found to negatively impact on mother-infant-bonding with mothers experiencing difficulties in their relationship and caring for their child and is associated with negative consequences on the development, behavior and overall health of the infant (Slomian et al., 2019). Also, paternal postnatal depression has an effect of on their children's early behavioral and emotional development that was long overlooked (Gentile & Fusco, 2017; Kim & Swain, 2007). Furthermore, suicide is a major cause of death in the perinatal period in many high-income countries, and suicide risk are linked to moderate to severe mental illness, particularly severe depression (Howard & Khalifeh, 2020; Slomian et al., 2019).

Although mental health problems occur in all groups in society, this is also an example of how social and psychological vulnerability are often linked. Studies have demonstrated that parents in a socioeconomic low position, including low income and a low level of education, are at increased risk of perinatal mental health problems (Chhabra et al., 2020; Howard et al., 2014; Norhayati et al., 2015; Philpott et al., 2019). Also, parents in a low socio-economic position often experience multiple and chronic stressors, including issues with housing, unemployment and financial problems, and increased psychological distress that can also increase the risk of adverse maternal and perinatal outcomes (Kramer et al., 2000). Furthermore, low social support as well as marital conflicts and dissatisfaction are other factors that have been associated with perinatal mental health problems in both parents (Chhabra

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[1] Perinatal mental health problems are psychiatric disorders occurring during pregnancy and/or the first year following birth, including depression, anxiety, stress, obsessive-compulsive disorders, postpartum psychosis and post-traumatic stress disorder; conditions that differ in intensity and severity (Jomeen et al., 2017; O'Hara & Wisner, 2014).

et al., 2020; Howard et al., 2014; Hutchens & Kearney, 2020; Norhayati et al., 2015; Philpott et al., 2019; Racine et al., 2020; Schmied et al., 2013; Wee et al., 2011), which further illustrates the link between social and psychological challenges.

Moreover, parents with existing psychological vulnerability or a history of mental health problems are at significantly greater risk of experiencing setback or new onsets as well as developing perinatal mental health problems (Biaggi et al., 2016; Chhabra et al., 2020; Glasser & Lerner-Geva, 2019; Howard & Khalifeh, 2020; Johansen et al., 2020; Norhayati et al., 2015). In Denmark, a new forthcoming register-based study estimates that 11% of pregnant women are affected by mental health problems (Heuckendorff et al., 2021). Consequently, a large number of women may thus be vulnerable to developing perinatal mental health problems during pregnancy and/or after the birth. As maternal postnatal depression has been identified as a significant risk factor for the development of perinatal mental health problems in fathers (Kim & Swain, 2007; Philpott et al., 2019; Wee et al., 2011), this further illustrates the potential negative impact on the entire family.

Overall, existing research documents that a range of co-existing and interrelated risk factors are associated with adverse health outcomes with both short- and long-term consequences for the pregnant woman, her partner and child. Often these risk factors are present within the family, thus influencing and potentially exacerbating each other, which underlines the importance of applying a family perspective on psychosocial vulnerability. To support the well-being of pregnant women, their children, and families, prevent adverse health outcomes and tackle social inequality in health, early interventions and targeted maternity services during the ante – and postnatal period have been highlighted as a central public health strategy (Marmot et al., 2010).

1.2. THE CONCEPT OF VULNERABILITY

To describe parent in vulnerable positions at risk of adverse health outcomes, multiple terms and concepts such as disadvantage (Ebert et al., 2014; McLeish & Redshaw, 2019), marginalization (Balaam & Thomson, 2018; Downe et al., 2009), socioeconomical deprivation or low income (Landy et al., 2012; Origlia et al., 2017), high-priority (Browne et al., 2010; Moules et al., 2010) and at-risk or risk factors (Jack et al., 2005; Rayment-Jones et al., 2019) are used in the comprehensive international literature that form the basis for both the choice of key concepts and the positioning of this research in the field of studies of women and/or parents with psychosocial vulnerability. This diversity reflects different research traditions and out of respect for the authors, some of these terms will therefore appear in the study when referring to specific studies.

However, for the purpose of this study vulnerability was chosen to designate that a wide range of psychosocial risk factors as illustrated in the previous section are associated with adverse outcomes and is thus not limited to for example socioeconomic position. The concept of vulnerability was chosen and employed to conceptualize "*life conditions or situations, which potentially can place an individual at risk of adverse health outcome due to the existence of diverse and interrelated risk factors"* (Frederiksen et al., 2021b, p. 564).

The concept of vulnerability is often used to classify and identify individuals or groups in need of support due to social, health or economic problems (Virokannas et al., 2018) but it is also a debated concept that can carry different meaning depending on the context (Brown, 2011; Brown et al., 2017; Spiers, 2000; Virokannas et al., 2018).

In the field of health visiting, Appleton found that vulnerability is viewed as an interaction of medical, psychological, social and cultural factors, in addition to internal and external stressors that either mitigate or heighten vulnerability (Appleton, 1994a). In recent studies, vulnerability is similarly defined as factors that makes a pregnant woman vulnerable to adverse health outcomes due to risks, stressors or threats (Briscoe et al., 2016; Colciago et al., 2020; de Groot et al., 2019; Scheele et al., 2020). As this perspective including both stressors and resources was in line with the field of practice in Denmark and approach taken by the Danish Health Authority and maternity care services (The Danish Health Authority, 2013, 2017; The North Denmark Region, 2017), I found the concept of vulnerability appropriate for use in this study.

While the concept of vulnerability is widely used in empirical studies in the field of maternity care (Balaam & Thomson, 2018; Barlow et al., 2005; Guterman et al., 2018; Hogg et al., 2013; Kirkpatrick et al., 2007; Paton et al., 2013; Pedersen et al., 2021; Thomson et al., 2013), and especially among the very few Danish studies that has been published (Brygger Venø et al., 2021; Jakobsen & Overgaard, 2018; Klode et al., 2020), few of these studies offer in-depth reflections on the concept and its limitations. In a 2016 concept analysis of women's vulnerability during pregnancy, birth and the postnatal period, Briscoe, Lavender and McGowan argued that vulnerability is a complex phenomenon that is poorly understood (Briscoe et al., 2016). They argue for viewing vulnerability as a dynamic state instead of a fixed or innate state-of-being:

> *"(...) the journey of becoming vulnerable is in constant flux and rests on a course of events that become interlinked, creating complexity for the woman and those who provide maternity care"* (Briscoe et al., 2016, p. 2331)

Consequently, barriers and reparative conditions can influence the impact of risk factors. Stigma and limited access to health care can contribute to increased vulnerability, whereas trusting relationship to professionals, being included in the planning of the care, raised self-esteem or social support, can mitigate vulnerability (Briscoe et al., 2016). For the purpose of this study, risk factors are thus placed within a social context as the level of vulnerability changes in response to the quality of the delivered services, protective factors and events occurring over time.

However, framing vulnerability within a risk discourse has been criticized as it potentially stigmatizes mothers identified as in need of targeted services (King, 2018). Although targeting vulnerable groups in health care interventions aims at preventing adverse health outcomes, Brown also argues that it can be stigmatizing:

> *"Although not the only way to view vulnerability, we must recognize the deficit-orientated nature of the term and its link with stigma. We also need to know more about how services users and receivers of policies aimed at 'protecting the vulnerable' view being labelled in this way. This is essential if policies aimed at 'the vulnerable' are to have legitimacy in the eyes of those whom they are meant to help"* (Brown, 2011, p. 319)

Moreover, focusing on risk factors can lead to assumptions about what vulnerability looks like at the risk of overlooking women, who may also be in need of additional support (King, 2018). Consequently, King argues for the importance of *"(...) recognizing vulnerability as an inherent human experience whereby all mothers, irrespective of class or circumstance, should be able to ask for and receive the support they require to care for their babies"* (King, 2018, p. 14).

To incorporate both risk factors and the experience of vulnerability, Spiers proposes understanding vulnerability from both an *etic* and an *emic* viewpoint (Spiers, 2000) concepts originating in anthropology to describe the researcher's categories and an informant's point of view (Maddens, 2010). The etic perspective includes an external identification of individuals at risk of adverse health outcomes as found in public health interventions (Spiers, 2000), whereas the emic perspective includes the individual's own experience:

> *"From an emic perspective, vulnerability is based on the experience of exposure to harm through challenges to one's integrity. This perspective places vulnerability in a psycho-social-cultural context. An advantage of viewing vulnerability as challenges experienced by the*

> *person is that it avoids regarding vulnerability as an inevitable consequence of the person's gender, socio-economic status, race, marital status, health status or occupation”* (Spiers, 2000, p. 718)

Following this, for the purpose of this study, I include both the etic and the emic perspective on vulnerability (Spiers, 2000), as this offers a temporal and contextual understanding of vulnerability as not only determined by risk factors but also depending on the particular socio-cultural context. Overall, the conceptualization of vulnerability chosen for this study calls for experience-near research to understand the care experiences of parents in vulnerable positions. Moreover, to avoid potential stigma participant are referred to as ‘parents in vulnerable positions’ rather than ‘vulnerable parents’.

1.3. EARLY INTERVENTIONS AND NEEDS-BASED MATERNITY CARE SERVICES

As part of reviewing evidence-based interventions to reduce health inequalities, the landmark report *Fair Society, Healthy Lives* suggested that investment in prevention and early interventions should have the highest priority recommendation, including ante – and postnatal interventions that aim at reducing adverse health outcomes by addressing risk factors and maximizing protective factors or personal resilience (Marmot et al., 2010). In line with this, international guidelines recommend early identification during the antenatal period and subsequent referral to tailored and specialized maternity care services based on the individual needs of the family (Austin, 2014; Austin et al., 2017; NICE, 2010; The Australian Department of Health, 2018).

However, studies have indicated potential challenges in the identification of vulnerability. In 2004, Appleton and Cowley found that health visitors worried that structured screening tools miss out on important cues (Appleton & Cowley, 2004). More recently, Aston et al (2014) found that public health nurses experienced that a screening tool focusing on risk factors did not identify everybody in need of additional support (Aston et al., 2014). In an Australian context, Schmied et al report that although midwives felt comfortable undertaking a depression and psychosocial screening and overall found this beneficial to women, midwives did not always agree with the overall risk assessment (Schmied et al., 2020). Consequently, to gain a holistic view on the woman’s and family’s situation, midwives and health visitors instead relied on their professional judgement to identify families in need of additional services and determine appropriate level of care (Appleton & Cowley, 2004; Aston et al., 2014; Schmied et al., 2020).

Moreover, psychosocial assessment is not always experienced as comfortable by women themselves (Forder et al., 2020; Mule et al., 2021; Rollans et al., 2013). Women can feel unprepared when asked sensitive questions, which is particularly distressing for women with past traumatic experiences (Rollans et al., 2013). Also, when screened for perinatal depression and anxiety, women are not always honest, which is particularly prevalent among women with the highest need for support (Forder et al., 2020). Non-disclosure of information has been linked to limited trust in the professional and fear of repercussions and negative response of others (Forder et al., 2020; Mule et al., 2021).

Once psychosocial vulnerability has been identified, enrolment in early interventions and targeted maternity are highly recommended (Harron et al., 2021); however, few interventions tailored to pregnant women in vulnerable positions have been thoroughly evaluated. Back in 2011, a high-quality systematic review by Hollowell et al concluded that the evidence-base for the effectiveness of targeted antenatal care programs to reduce infant mortality and preterm birth in socially disadvantaged pregnant women was insufficient (Hollowell et al., 2011). A decade later, a newly published Danish review came to the same conclusion as the number of studies in robust research design to determine the effect of interventions to reduce preterm birth among women with psychosocial vulnerabilities remains limited (Pedersen et al., 2021). Interventions consisting of group-based antenatal meetings and continuity of carer proved most promising (Pedersen et al., 2021). Similar positive outcomes have been reported elsewhere (Kemp et al., 2011), including a 3-year follow up on an RCT study of a sustained home visiting program designed to support mothers experiencing adversities, which found positive effects on maternal mental health (Goldfeld et al., 2021) as well as the home environment and parenting practices (Goldfeld et al., 2019).

Studies on home visiting programs targeting fathers in vulnerable position is even more scarce and not adequately designed to reach firm conclusion on effects (Guterman et al., 2018; McGinnis et al., 2019; Raouna et al., 2021). A British program targeting at-risk parents did however indicate a positive effect on program participation and improvement of parental mental health and parental-child relationship for both mothers and fathers in a prospective, observational study (Raouna et al., 2021) and thus provide support for involvement of fathers in home visiting services.

Moreover, continuity of care has also been proposed as a way of improving maternity care services for in pregnant women in vulnerable positions (D'haenens et al., 2020). A Cochrane review based on randomized controlled trials (RCT) identified that midwifery models of continuity of care has a positive effect on perinatal outcomes, including preterm births, fetal loss and neonatal deaths (Sandall et al., 2016). The study focused on low-risk women but urged future research to explore the effect of continuity of care for socially disadvantaged women. A growing body of evidence from studies in observational and thus weaker research designs however indicates a positive effect on perinatal outcomes among infants born to women living in disadvantaged communities and facing multiple risk factors (Homer et al., 2017; Rayment-Jones et al., 2015, 2021). In the United Kingdom, a midwifery continuity of care model has been found to contribute to women at risk of pre-term birth having more positive care experiences compared to standard care (Turienzo et al., 2021), and even though no significant effect on perinatal outcome was found, the model was reported feasible to implement (Turienzo et al., 2020). However, more research is still needed on the effect of continuity of care for parents in vulnerable positions as well as how parents themselves experience receiving this type of care in terms of their overall experiences.

1.4. THE DANISH CONTEXT

Mirroring international policies, targeted interventions during pregnancy and early childhood has been a central political strategy in Denmark. As part of the finance act in 2018, the Danish Government launched the *1000-days program – a better start in life* with funds allocated to families in vulnerable positions, including strengthening of the health visitation program and early childhood education (The Danish Ministry of Children and Social Affairs, 2018). Also, funds were allocated to develop interventions to support vulnerable, pregnant women and their partners to prevent social inequality in health (The Danish Health Authority, 2017)

The Danish maternity care sector offers universal services to all pregnant women and families, free of charge, provided on a shared care basis by the women's general practitioner(s), midwives and health visitors[2]. The national guidelines for maternity care service outlines that care should be offered in four levels, as illustrated in table 1, to ensure that women and families are offered services that match their level of social, medical or physical risk factors and resources. Allocation to service levels are flexible and can be changed in response to the family's needs (The Danish Health Authority, 2013).

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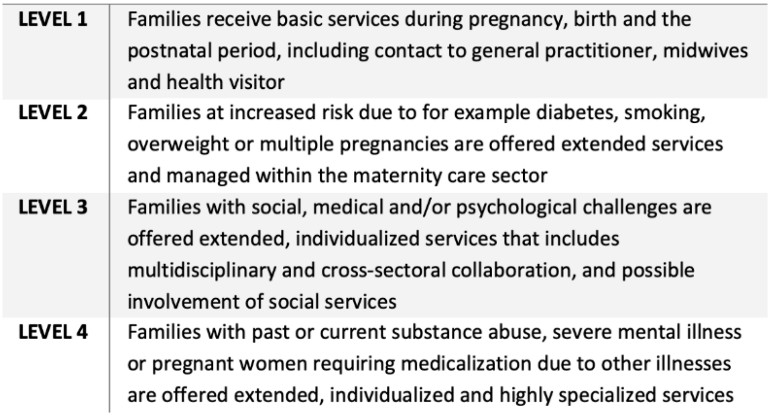
[2] The health visitors are specialist community public health nurses, who provide support and advice for parents as well as promote and assess child health, growth and development the first year of a child's life (The Danish Health Authority, 2013). They are employed in the municipality and primary health care sector.



LEVEL 1	Families receive basic services during pregnancy, birth and the postnatal period, including contact to general practitioner, midwives and health visitor
LEVEL 2	Families at increased risk due to for example diabetes, smoking, overweight or multiple pregnancies are offered extended services and managed within the maternity care sector
LEVEL 3	Families with social, medical and/or psychological challenges are offered extended, individualized services that includes multidisciplinary and cross-sectoral collaboration, and possible involvement of social services
LEVEL 4	Families with past or current substance abuse, severe mental illness or pregnant women requiring medicalization due to other illnesses are offered extended, individualized and highly specialized services

Table 1: Differentiation of maternity care services in Denmark (level 1-4)

Pregnant women and partners are allocated to care-group 3 and 4, when they face social, medical and/or psychological challenges, which differ in complexity and severity. This include varying degrees of mental illness, limited social support, young age, adverse childhood experiences, previous substance abuse, trauma, sexual abuse, domestic violence, poverty and/or housing problems (The Danish Health Authority, 2013). While Level 3 services are primarily community based, level 4 services are specialized and primarily hospital-based services, although both levels of care includes cross-sectional and multidisciplinary collaboration. In practice, the organization of care and tailored services offered differ highly between municipalities and hospitals (The Danish Health Authority, 2018).

In Aalborg Municipality, in which this study takes place, a dialogue based routine psychosocial risk assessment is undertaken as part of the first midwifery consultation for all women. This is part of a new guidance developed jointly by the North Denmark Health Authority and eleven municipalities in the region to reduce social inequality in health, ensure early identification of vulnerabilities and improve cross-sectoral and multidisciplinary intervention and create coherent care pathways for all pregnant women and partners in vulnerable positions (The North Denmark Region, 2017). Psychosocial risk assessment was implemented in Aalborg Municipality in 2017 and is performed by use of a screening tool based on open-ended questions that explores both the pregnant woman and her partner's social situation and upbringing, earlier childbearing experiences as well as a range of issues related to the transition to parenthood. If vulnerability factors are identified, the woman/couple is offered level-3 services with flexible boundaries to level 2 and 4 (The North Denmark Region, 2017). An overview of services will be presented in chapter 2 to describe the study setting in further detail.

1.5. THE DEVELOPMENT OF AND RATIONALE FOR THIS STUDY

The idea for this study was developed in a collaboration between the Research Team for Women's, Child and Family Health, The Department of Health Science and Technology, Aalborg University and the health visitation services in Aalborg Municipality as part of a mutual interest in improvement of care for parents in vulnerable positions. This study focusses on the delivery of level 3 services during pregnancy and the first year after birth to women and families living in Aalborg Municipality.

The increased national focus on early interventions as well as the development of the new regional guidelines for cross-sectional and multidisciplinary collaboration in 2017 gave rise to many questions and uncertainties, especially from those working front-line with the families. Studies have found that needs assessment and support of parents in vulnerable positions is a well-known but also challenging task for health visitors (Appleton, 1994; Appleton, 1996; Browne et al., 2010; King, 2016). The health visitors – and later it appeared also the midwives, who work closely together to support the families – presented a strong wish to learn about parents' experiences with and perspectives on the services they delivered. Insights they hoped would bring critical reflections on their own care and an increased understanding of the factors contributing to successful parent-professional encounters and high-quality care. Before turning to the research objective of this study, I will present a brief overview of existing research exploring the care experiences of parents in vulnerable positions to place this study within the international scientific literature.

Even though women in vulnerable positions can benefit from additional support, earlier survey studies found that pregnant women with low educational level, non-marital status, and/or ethnic minority more commonly have late or reduced uptake with antenatal services as well as have negative experiences with receiving care, including poor communication with professionals (Feijen-de Jong et al., 2012; Lindquist et al., 2015; Raleigh et al., 2010). A qualitative study also reported that pregnant women facing vulnerability experience limited access to services and feel that their needs for support are not adequately met (Thomson et al., 2013). Inequalities in health care access and engagement thus remains a pressing issues, which underlines the need to understand how to improve services for this group of parents.

This need is further supported by systematic reviews of studies on user perspectives, which provide solid documentation that women in vulnerable positions often face discrimination, racism and stigmatization that have a profound negative impact on their experiences of accessing and engaging with maternity care services (Downe et al., 2009; Origlia et al., 2017; Rayment-Jones et al., 2019). Discrimination is often based on women’s ethnicity, young age, low income or single-parent status (Origlia et al., 2017), and women often report encountering prejudiced and paternalistic care (Rayment-Jones et al., 2019). These negative experiences can make it difficult for women to be honest with professionals out of fear of being discriminated or stigmatized yet again, and consequently, they may delay or avoid engaging with health care services altogether (Origlia et al., 2017).

Similar negative experiences have also been reported in earlier qualitative studies on women’s experiences with receiving sustained home visiting programs in Australia (Paton et al., 2013), the United Kingdom (Barlow et al., 2005; Kirkpatrick et al., 2007) and Canada (Jack et al., 2005; Landy et al., 2012), which illustrates that service engagement is not necessarily easy. In Denmark, only a single and small study of care experiences of mothers in vulnerable positions has been undertaken; however, in line with the international research, this study found that an supportive intervention had potential unintended negative consequences as some women felt stigmatized and judged as unfit mothers, felt ambivalent about participation and experienced self-doubt about their parenting abilities (Jakobsen & Overgaard, 2018).

To overcome these challenges and ensure that parents in vulnerable position have positive care experiences, and that their health needs are subsequently addressed, a recurring thread in the existing qualitative studies concerns the importance of establishing of trusting relationships to professionals (Balaam & Thomson, 2018; Jack et al., 2005; Jakobsen & Overgaard, 2018; Kirkpatrick et al., 2007; McLeish & Redshaw, 2019). Also, in their recent review, Rayment-Jones et al identified that the quality of the relationship influence whether or not women have positive care experiences with maternity care services and perceive these as helpful and supportive (Rayment-Jones et al., 2019).

However, the establishment of trusting relationships can be difficult considering that parents may have limited trust in professionals, for example due to adverse childhood experiences, trauma and abuse (Paton et al., 2013; Rayment-Jones et al., 2019), and thus these relationships can take time to develop. To support this, continuity has been reported as essential, as demonstrated by Landy et al (2012), who found that for young, low-income mothers, a continuous relationship to a known public health nurse was key to a positive experience of an intensive home visitation program (Landy et al., 2012). Similarly, for fathers in vulnerable positions, one study found that developing a meaningful relationship to the public health nurse over time was important; however, many fathers were also reluctant and distrusting to engage with the service, did not participate or felt that they were not being involved during visits (Ferguson & Gates, 2015).

One perspective on these challenges and the negative experiences outlined in the existing literature concerns the unequal parent-provider relationship and the tension between support and surveillance (Marcellus, 2005; Peckover & Aston, 2018). As argued by Marcellus, surveillance is integral to the work of public health nurses, who monitor and assess the health and development of children. Although framed as care and support, surveillance is basically technique of power and a routine component of public health nursing (Marcellus, 2005).

This perspective has further been illustrated by Peckover in her seminal work on mothers exposed to intimate partner violence. She argues that the relationship these women have with the health visitor is ambivalent, as the health visitor is placed in a double position due to both practicing support and surveillance (Peckover, 2002, 2003). That the unequal parent-provider relationship can potential impact on care experiences has also been illustrated in other empirical studies. Due to their disadvantaged position, Ebert et al for example found that during birth women felt left out of the decision-making process and would refrain from speaking their mind and adhere to the midwife's advice (Ebert et al., 2014). More recently, McLeish and Redshaw demonstrated that pregnant women with multiple disadvantages feel undermined by professionals and feel powerless with little opportunity to voice their wishes and exercise choice regarding their care (McLeish & Redshaw, 2019).

Based on the current literature there is thus evidence that multiple challenges exist, which is important to consider in light of recent policy changes and the strong focus on identification of vulnerability and subsequent referral to needs-based and targeted services as reflected in organization of the Danish maternity care sector (The Danish Health Authority, 2013, 2018; The North Denmark Region, 2017). Overall, the existing studies document significant challenges for the service engagement of parents in vulnerable positions as well as the ambivalent and mixed emotions they may experience during encounters with professionals, including feelings of stigmatization, self-doubt, fear and powerlessness. Although targeted services for these families are strongly intended to be supportive, this thus illustrates that they are not always experienced as supportive by the service users and can have potential negative implications for their overall care experiences. Considering this, more knowledge is needed to understand how and why these experiences occur to avoid infusing further fear, stigma and other unintended consequences.

Furthermore, although the parent-professional relationship is identified as highly important, what appears from the literature is that this relationship is fragile and experienced as ambivalent by parents themselves as it can also be the site of conflicts and mistrust due to the tension between support and surveillance. Little is known about the different components that goes into the establishment of trusting relationships, how this can be achieved in practice, and how and why it is experienced as significant for parents in vulnerable positions. In-depth knowledge that explores parents' relationships with professionals over time is thus needed to further our understanding of when mutual understanding and/or conflicts occur during these encounters.

One limitation of the existing research is moreover that it primarily includes the perspectives of the woman. As fathers are also at risk of facing psychological and/social challenges, this calls for a research design that explicitly seek to include both parents' perspectives. This is also reflected in the wish from Aalborg Municipality to be better equipped to understand the needs of both parents in vulnerable positions. To ensure that parents have their needs for support addressed and are included in the planning of their care, it is overall important to include their experiences to inform interventions and policies. To address this knowledge gap, the study will contribute with in-depth knowledge on parents' care experiences during pregnancy and the postnatal period.

1.6. OVERALL OBJECTIVE AND RESEARCH AIM

The overall objective of this study is to develop new, in-depth knowledge about the care experiences of Danish parents in vulnerable positions during pregnancy and the postnatal period in order to contribute to the development of care practices and the organization of maternity care services for this group.

The overall objective is operationalized into the following research aims that are addressed in three separate papers:

1. To explore what parents in vulnerable positions fear, how and why they experience fear, and how this shapes their childbearing experience and engagement with maternity care services through pregnancy and the postnatal period.

2. To identify key elements of supportive encounters by exploring how parents in vulnerable positions experience their relationship and encounters with professionals during pregnancy and the postnatal period.

3. To explore the role of continuity of care in creating a coherent care journey for parents in a vulnerable position during pregnancy and the postnatal period.

CHAPTER 2. METHODOLOGY

In this chapter, I present the study's methodology to demonstrate how the knowledge has been produced, the theoretical underpinning of the chosen methods as well as subsequent implications for the collection, analysis and interpretation of data (Lau & Traulsen, 2017).

2.1. PHILOSOPHICAL UNDERPINNINGS

To achieve in-depth knowledge on the care experiences of parents in vulnerable positions, I draw on a hermeneutical perspective as outlined by Hans-Georg Gadamer (Gadamer, 2013). In light of the overall research objective, I found this approach suitable as the scientific contribution of hermeneutic research is to enrich our understanding of social phenomenon through an exploration of human experiences and interpretation in particulars contexts as argued by Kristiansen (2020):

> *"Its central domain is human beings ascribing meaning to phenomena in a specific time and a particular social and spatial context. One of the key starting points is therefore that people experience the world in a certain context, which colors and influences the way they perceive and understand it"* (Kristiansen, 2020, p. 138)

Although Gadamer critically expands on phenomenology by highlighting the role of interpretation, he is influenced by a phenomenological philosophy of science, and particularly the phenomenological understanding of the subject's place in the world (Gadamer, 2013). According to Gadamer, any understanding of the world takes place through the experiencing subject, and consequently, rather than viewing the subject's pre-dispositions as a barrier or potential bias, the knowing subject becomes a productive factor (Gadamer, 2013). Within a hermeneutical philosophy, the nature of reality is therefore not objective but constructed as multiple realities exist across time and space (Kristiansen, 2020). Due to the fluid nature of reality, knowledge about the world will always be partial as it is conditioned by one's position, and as historically situated subjects, individuals are caught up in structures beyond our own comprehension, which means that understanding is always influenced by its historical context (Gadamer, 2013). Thus, Gadamer breaks from the ideal of objectivity as knowledge is always tied to the subject creating it, and the context in which it is produced (Gadamer, 2013).

Following this, Gadamer argues that understanding is reached by moving between wholes and parts in what he terms the hermeneutical circle, whereby the subject's horizon continually expands and shift as new understanding is acquired through an open and dialectical relationship with the phenomenon under study (Gadamer, 2013). To put yourself in the other's situation and expand your own horizon by striving to understanding theirs, allows for the merging of horizons to occur, which contribute to new understanding (Dahlager & Fredslund, 2008; Michrina & Richards, 1996).

Gadamer's hermeneutics is thus suitable in qualitative research to gain understanding of human experiences, which is reached gradually in dialogical encounters with research participants as well as produced texts, such as interview transcripts and field notes (Vandermause & Fleming, 2011). In these encounters, the role of listening, sensitivity and openness are key within a hermeneutical research practice to be able to explore and understand human experiences (Moules et al., 2015; Vandermause & Fleming, 2011). By adopting the hermeneutical perspective, I am thus able to generate in-depth knowledge on how parents in vulnerable positions experience, interpret and create meaning out pregnancy and early parenthood and the maternity care services and providers, they engage with during this period. In the following, I will unfold how the hermeneutical perspective influenced the research design, data collection and analysis, and along with that the assumptions that has shaped how I approached the field of study and the subsequent knowledge claims on the basis hereof.

2.2. THEORETICAL ORIENTATIONS

The study is theoretically informed by an anthropological approach to the study of health, illness and medicine, which provides a framework for studying the care experiences of parents in vulnerable positions during pregnancy and the postnatal period. Medical anthropology focus on how medical knowledge and practices as well as patient experiences are influenced by and constructed in cultural, political and historical contexts that differ across time and place (Lock, 2001; Prentice, 2010). Consequently, I consider concepts such as vulnerability and the practice of needs-based maternity constructed in the sense that they are tied to a specific time and place and given meaning in a particular social context.

Anthropologist and medical doctor Arthur Kleinman played a central role in this line of work, particularly in the development of an interpretive approach in medical anthropology (Good, 1994). Influenced by phenomenological and hermeneutical thinking, Kleinman was concerned with the lived experience of illness and health as people always create meaning out of and interpret bodily symptoms and illness experiences in a social context (Kleinman, 1980, 1988). Kleinman similarly viewed health care systems and medical practices as socially and culturally constructed, and he argued for the importance of dismantling the normative perspective of health professionals by applying a cross-cultural perspective (Kleinman, 1980). He also argued for the significance of taking the patient perspective seriously:

> *"The illness experience includes categorizing and explaining, in common-sense ways accessible to all lay persons in the social group, the forms of distress caused by those pathophysiological processes. And when we speak of illness, we must include the patient's judgements about how best to cope with the distress and with the practical problems in daily living it creates."* (Kleinman, 1988, p. 4)

Following this, to support parents in vulnerable positions during pregnancy and the postpartum period, their own experiences and perspectives on their situation must be included into clinical practice. According to Kleinman, this is imperative as the patient's experience often differs from a biomedical understanding of disease (Kleinman et al., 1978). Thus, during patient-provider encounters, diverse explanatory models are at play due to differences in knowledge and value systems, which influence the way we talk about and understand the body, symptoms and treatment. Failure of considering the psychosocial aspects of the patient's experience can disrupt the relationship between providers and patients and lead to conflicts, poor communication and potential cause patients harms and lead to their health needs not being properly addressed (Kleinman, 1988). This underlines the importance of generating in-depth knowledge on the care experiences of parents in vulnerable positions.

2.3. ETHNOGRAPHIC RESEARCH DESIGN

The study was designed as a long-term ethnographic study, where knowledge is acquired through immersion in a specific context through the use of participant observation and interviews (Atkinson, 2015; Hammersley & Atkinson, 2007; O'Reilly, 2004; Tjørnhøj-Thomsen & Whyte, 2008). The strength of this approach is that it assist in examining social practices and experiences 'in situ' (Atkinson, 2015) and follow individuals over a longer period of time to understand the particular trajectories of their experiences (Castenada & Holmes, 2014).

For the purpose of this study, ethnographic research design was chosen to encapsulate the complexities of parents' experiences. By conducting long-term fieldwork, I was able to explore how parent-professional encounters took place in practice, how trust was developed and maintained, and how the parents responded to and experienced the services they were offered over time. Thus, the design allowed for encapsulating the upredictability and temporality of the field (Miller, 2015; Shirani & Henwood, 2011), which I found necessary as parents' level of vulnerability and support needs could change in response to unpredictable life events.

When adopting a hermeneutical perspective, I understand ethnography as a highly interpretive practice. In ethnographic fieldwork, the researcher engages with the social world under study and is 'thrown' into on-going social processes of which to make sense through interpretation (Kleinman & Kleinman, 1996). The researcher is therefore highly involved as knowledge is created in the relationship that is formed to participants in the field (Hastrup, 2004). This mirrors Gadamer's statement of the knowing subject being an integral part of the hermeneutical circle through which understanding is reached (Gadamer, 2013). Moreover, in line with the hermeneutical perspective understanding cannot be reached at once but through dialectical encounters (Moules et al., 2015; Vandermause & Fleming, 2011). By adopting the long-term ethnographic research design, I was thus able to engage in a continuous and dialogical relationship with the field and the participating families, where understanding was reached gradually as the fieldwork progressed.

2.4. STUDY SETTING

The study was undertaken in Aalborg Municipality from April 2018 to September 2019. The municipality includes the 4th largest city in Denmark, Aalborg, which is the capital of the North Denmark Region, but also minor towns and rural areas with a total number of 217.094 inhabitants in 2020.

Aalborg University Hospital, a tertiary level hospital with a highly specialized obstetric unit and a neonatal intensive care unit, is located in Aalborg. The hospital also offers a home birth service (approximately 2% homebirths, mostly women at low obstetric risk). In Denmark, midwives provide care independently for women with low risk pregnancies and births; however, they care for all women with risk factors in collaboration with an obstetrician.

In Aalborg, antenatal services are provided by midwives employed at Aalborg University Hospital but delivered from two midwifery community clinics. The women/couple will often see the same or a small number of midwives during pregnancy, but not organized as a caseload midwifery service. Some pregnant women, who are identified with psychosocial vulnerability factors are referred to a specialized midwife in the community clinic for antenatal care if available.

Parental education classes are in Aalborg Municipality offered to all first-time parents jointly by midwives and health visitors during pregnancy and after the birth. Specialized parental education classes targeting parents in vulnerable positions are also organized, which compared to the standard class are organized in smaller groups and involve a visit to the Obstetric Unit at Aalborg University. Parents in vulnerable positions can choose to participate in either class but can also combine them.

After birth, multiparous women with uncomplicated births are discharged less than 24 hours postpartum. Primiparous women and women with complicated births are offered postpartum care in the hospital. After discharge from hospital, the role of midwives is limited, and postnatal care is mainly provided by health visitors.

In Aalborg Municipality, the home visitation program is organized and administered in four divisions. Each division has their own clinic, where consultations and parental classes take place. During weekdays, all four clinics have open telephone hours between 8-9 am. The standard program includes five home visits and/or consultations, when the infant is 1-2 weeks old, 2-4 weeks old, 2 months, 4-6 months and 8-10 months. During the 2-months visits, all parents are offered a screening for postpartum depression. In Aalborg Municipality, the Edinburgh Postnatal Depression Scale and Gotland Male Depression Scale is combined (Cox et al., 1987; Madsen & Juhl, 2007; Smith-Nielsen et al., 2018).

Beyond the standard care, one or two pregnancy visits can be offered to families in case of special needs. After the birth, need-based care is practiced, where the health visitor adjusts the number and timing of visits based on a professional judgement and refer to additional services if a need for support arise. The services available in the study setting, and which were the services that parents in the current study were engaged, is illustrated in table 2. No parents used all of these services but often a combination of these at different time periods depending on their need for support.

In Denmark, all citizens are obliged to notify social services with concerns about the well-being of children, but professionals are placed in a stricter mandatory reporting position and frequently need to make a notification to social services to ensure relevant support is offered or for child safeguarding purposes (The Danish Health Authority, 2013). The authority to place a child into care lies with the social services (The Danish Ministry of Social Affairs and the Interior, 2019).

Service	***Description***
Municipal	
Health Visitor	*1-2 visits during pregnancy and/or 5 or more visits after the birth depending on the family's need*
Social Services	*A variety of services for child safeguarding purposes, e.g. investigation of parenting competencies or additional support in the home*
Interdisciplinary Team	*Ante – and postnatal home visits offered by a two-person support team (health visitor, social worker, child nurse educator and/or psychologist)*
Municipal/regional	
Team Meeting	*Joint antenatal meeting with midwife and health visitor to make a support plan and referral to services and strengthen cross-sectional collaboration*
Birth preparation and Parenting Class	*Specialized group-based classes organized jointly by midwives and health visitors at the community midwifery clinic or a local health visiting clinic*
Regional level	
Midwife	*Women with known vulnerability factors are referred to a specialized midwife by general practitioner. Women identified with vulnerability factors in early pregnancy often continue receiving care from their originally assigned, non-specialized midwife*
Obstetrician	*Only in case of medical or obstetric issues*
General Practitioner	*Routine care as well as referral to e.g. psychologist*
Informal, social Café	*Open, group-based, weekly intervention offered by specialised midwives. Focus on networking, support and capacity building through information and training (e.g. baby massage)*
Mental Health Services	*Requires referral from general practitioner but acute admission to the psychiatric ward is also possible*
Psychologist	*Access to publicly funded psychologists requires referral from general practitioner.*
Family Outpatient Unit	*Delivered by a team (midwife, psychologist, pediatricians, obstetrician, and social work coordinator) highly specialized in e.g. substance misuse and severe mental disorders (Level 4 service)*
Non-Governmental Organisation	
Mødrehjælpen (Mother's Aid)	*Long-term, group-based, weekly intervention for vulnerable mothers delivered by a midwife, health visitor and social worker during pregnancy and after the birth*

Table 2: Services in Aalborg Municipality

2.5. RECRUITMENT STRATEGY

As the overall objective of this study was to obtain in-depth understanding of the care experiences of parents in vulnerable positions, a purposive recruitment strategy to include information-rich cases was chosen (Bernard, 2006; Maxwell, 2005; Patton, 2002). This included women/couple who were experiencing receiving targeted maternity care services during pregnancy and/or the postnatal period. This allowed for me to understand their current perspectives and to follow them over time to the degree possible.

Moreover, inclusion criteria were that the woman/couple: 1) were pregnant or had recently given birth, 2) spoke Danish, 3) Resided in Aalborg Municipality, 4) received level 3-services in pregnancy and/or the postnatal period due to psychosocial vulnerability factors/complex care needs. As women/couples who do not speak Danish are offered different services, they were not included in the study.

As the study had a broad focus on targeted services for women and couples during pregnancy and after birth, the guiding principle of maximum variation was employed as part of the purposive recruitment strategy to achieve variation among the participants (Onwuegbuzie & Leech, 2007; Patton, 2002).

The concept of information power guided the number of participants recruited for the study based on whether the sample size hold enough information to address the aim (Malterud et al., 2016). Following the broad research aim and maximum variation strategy, the sample size had to be large enough to hold information power (Malterud et al., 2016). As the research design includes participant observation and interviews with participants over time, the sample size had to accommodate this. Following these considerations, at least 25 women/couples were pre-estimated to be the ideal number of participants, allowing the sample to be large enough to hold information power, whilst enabling for collecting in-depth data with each woman/couple.

As documented in prior studies, recruiting participants in vulnerable situations for research can be difficult (Ellard-Gray et al., 2015; Horowitz et al., 2002; Mirick, 2016; Nordentoft & Kappel, 2011). As described in the papers (Frederiksen et al., 2021b, 2021c, 2021a), multiple methods were used to contact potential participants, and the strategies continually adjusted along the way.

My access to the field was approved by the head of the health visitation services, Aalborg Municipality and the head of midwifery, Aalborg University Hospital, who facilitated contact to health visitors and midwives, who were encouraged to invite participants into the study. If a family was interested, I contacted them by SMS or over the phone. I was also invited into midwifery and health visiting consultations or home visits, with the permission from parents, as well as antenatal classes and a weekly drop-in café at the midwifery community center. This enabled me to invite parents, where they could see me and ask questions about the project. Invitations were also distributed online and in clinics, but with limited response (Frederiksen et al., 2021b, 2021c, 2021a).

Due to these multiple methods, it is impossible to give an exact number of invited women/couples. It is however likely that most of the potential participants turned down participation. In 16 known cases, I had made initial contact but the women or her partner was not recruited. Some explained that they were busy, found it distressing whilst being pregnant and/or caring for a new baby, or that they did not identify with the target group of the study (Frederiksen et al., 2021b, 2021c, 2021a)

Despite these challenges, the strategies proved successful as 26 families were recruited, including 26 women and 13 men, who will be described in further detail in chapter 3.

2.6. PARTICIPANT OBSERVATION

To gain in-depth understanding of the service-provision context and parent-professional encounters, I conducted participant observation. In ethnography, this includes participating in the social life under study by observing activities, listening to conversations and engaging in informal conversations with participants (Maddens, 2010; Spradley, 1980; Tjørnhøj-Thomsen & Whyte, 2008).

Initially, I observed health visitors and midwives to understand their practices. I spent 9 days with health visitors (mainly home visits to families but also two parenting classes) and 5 days with midwives (mainly antenatal consultations at the clinic). I visited key stakeholders, including a nongovernmental organization and the Family Outpatient Unit at Aalborg University Hospital and Obstetric Unit at Aalborg University Hospital. Also, I was present at the main antenatal midwifery clinic once a week, where parental classes and the social drop-in café for parents were held, which altogether furthered my understanding of the field of study. Moreover, it enabled me to establish relationships to the health visitors and midwives, who as trust was developed over time invited me into diverse arenas to meet their clients, and participant observation thus became integral to the recruitment process.

After recruitment, if the parents agreed to it, I would observe various services. In this way, it became possible to study their care journeys over a longer period of time. A total of 51 encounters were observed with 21 of the participating women/couples. This ranged from none to six observation per family unit. The variation was due to the participants' preferences and different opportunities for observations of care encounters. The majority of observations was conducted during ante – and postnatal visits and consultations with the health visitor (n=44), but also included antenatal team meetings with the health visitor and midwife (n=3), antenatal consultations with the midwife (n=2), home visit by a social support worker (=1) and home visit by the transdisciplinary team (n=1).

My role during participant observation depended on the context. In some situations, I was mainly passive, whereas I at other times was participating more actively. During visits I signalled active listening through body language and facial expression to indicate that I was present and responsive to what parents were telling even though not verbally responding. When possible, I engaged in informal interviews, which is central to participant observation (Bernard, 2006) as this allowed to ask questions arising from the social situation. This was mainly done before and after observations of service encounters and formal interviews.

During visits, field notes were not written down; however, I brought a note pad to make jottings immediately after, which were later constructed into field notes. I also noted dates for the next visit with the family, questions to follow up on and preliminary analytical ideas. Field notes are thus not seen as describing an objective reality but rather viewed a social constructs reflecting the researcher's position from which the world is observed and interpreted (Emerson et al., 2011). This reflects the hermeneutical position that knowledge is contingent on the subject's position in and orientation towards the world (Gadamer, 2013). Thus, I understand the process of participant observation and taking field notes as highly interpretive practices.

Importantly, by participating in and being familiar with the services and professionals that parents engaged with, I was able to ask meaningful questions that were related to their care experiences. Asking meaningful questions is highly contingent on gaining knowledge of the social world under study, as argued by Hastrup:

> *"To establish a true relationship the parties must be present in the same space; in fieldwork this has to be theirs – if there is any pint to participation. The general point is that living a particular social field implies a merging of action and awareness. This merging is the basis for the self-evidence of 'local' knowledge – also in everyday life –*

> *and a prerequisite of any skill or practical competence, including the skill of posing meaningful questions"* (Hastrup, 2004, p. 466).

By being part of the field that were relevant for parents' care experiences during pregnancy and the postnatal period, I was able to ask questions that arose from and were related to their social context. Conducting participating observation alongside interviews thus played a central role in generating in-depth knowledge on their care experiences. Overall, my 1 ½ year of field work contributed to a deeper understanding of the field of study, including the organization of maternity services, the health care providers involved in this care, the parents using the services as well as became a shared point of reference in interviews with parents. Also, it allowed for the establishment of relationships to participants over time, which contributed to the collection of in-depth data. In this way, observations played a central role in the production of the knowledge, on which this study is based.

2.7. INTERVIEWS

To gain insight into and understand the care experiences of parents during pregnancy and after the birth, I carried out semi-structured interviews, which are useful to generate in-depth knowledge on human experiences, intentions and perspectives, and understand how people interpret and create meaning out of these experiences (Christensen et al., 2008). In ethnography, interviews are characterized by being conversational and bears similarities to a dialogue, but with the explicit aim to collect data for research (Maddens, 2010; Spradley, 2016).

Methodological and ethical challenges arise, when members from the same family participate in research, and both individual and dyad interviews can be conducted (Bjørnholt & Farstad, 2014; Mellor et al., 2013; Valentine, 1999; Zarhin, 2018). Whereas individual interviews allow for personal experiences to be expressed, they can also create discomfort or conflicts out of fear what the partner is disclosing; however, conflicts can also occur during dyad interviews (Valentine, 1999; Zarhin, 2018). Maintaining confidentiality in the representation of data from individual interviews with members of the same family can also be difficult, whereas dyad interviews eliminate challenges of confidentially as both are present in the situation (Bjørnholt & Farstad, 2014; Mellor et al., 2013). The strength of dyad interviews is that it enable that couples can support each other in the telling of a shared narrative, but the risk is that one person may dominate the interview, leaving out the partner's voice (Zarhin, 2018).

Following these considerations, I chose to combine both types of interviews and leave it up to parents to decide what they preferred to ensure that participation was on their terms. Moreover, as interviewing participants multiple times encapsulate how experiences change in contrast to a one-time interview (Miller, 2015; Shirani & Henwood, 2011), all participants who received target maternity care services over a longer period of time were invited to participate in follow-up interviews.

Overall, 50 interviews were conducted, lasting between 32 and 107 minutes. They were tape-recorded and transcribed ad verbatim in Danish. Participants chose the time and place, mostly in their own home. Most fathers participated in dyad, whereas mothers opted for individual as well as dyad interviews. The number and timing of dyad and individual interviews is described in Table 3:

	ANTENATAL	**POSTNATAL**
INDIVIDUAL	11	26
DYAD	4	9

Table 3: Number and timing of dyad and individual interviews

Some parents decided that they only wanted to participate in a single interview. Practical issues also influenced this, for example if follow-up interviews were cancelled due to illness, if the family moved, or the research period came to an end. 16 mothers and 1 father were followed over time, whereas 10 mothers and 12 fathers only participated in a single interview. However, half of the parents, who only participated in one formal interview, also allowed me to participate in field visits. An overview of the number of interviews with each participant is presented in table 4.

	Female	**Male**
One interview	**10**	**12**
During pregnancy	3	3
After the birth	7	9
Two interviews	**9**	**0**
One during pregnancy and one after the birth	8	0
Two after the birth	1	0
Three interviews	**7**	**1**
One during pregnancy and two after the birth	6	1
Three after the birth	1	0

Table 4: Number of interviews conducted

To explore parents' experiences, a thematic interview guide was constructed (Bernard, 2006), including topics on parents' experiences with the services they received, their relationship and interactions with health care providers and their experiences with pregnancy and parenthood. Ethnographic interviewing techniques was employed using open-ended and explorative questions (Spradley, 2016) as exemplified in Table 5.

Experience	**Example**	**Directive questions**	**Reflexive**
Do you want to tell me about happened when you found out that you were pregnant?	You say that you often feel judged, and it sounds like it often happens. Do you have an example where you felt judged?	Last time I saw you, things were a bit hectic, what was going on? How are you now?	To me it sounds like that the relationship to professionals is important to you. How would you characterize a good relationship?
Can you describe what happened during the first midwifery consultation?	When you say that you like your health visitor, what is it that she does that makes you feel like that? Do you have an example where you felt supported? Do you have an example where you felt the opposite (contrasting examples)?	The last time I was here, I noticed you got a bit upset when the health visitor mentioned this service, she could refer you to. What went through your mind at that point?	You say this thing about not wanting to be placed in a box or type casted. Can you elaborate on what you think is in this box you're talking about?
How did you feel about being notified to social services?	Do you have examples of some of the services and providers you are in contact with?	The last time I was here, you and the health visitor talked about this new service that you wanted to participated in. I remember from the first time we spoke that you had initially turned it down. What made you change your mind?	Based on what you're saying, it sounds like you found it easy being honest with her. Why do you think that you feel that way?

Table 5: Examples of ethnographic interview questions

Descriptive questions, such as experience and example questions, are useful to start the interview (Spradley, 2016). Inviting parents to talk about how they *experienced* particular situations typically prompted long answers. To further an understanding of their experiences, *example questions* were useful (Spradley, 2016). Furthermore, *directive questions* were used (Spradley, 2016) to follow up on previous interviews or visits. Lastly, *reflexive questions* were helpful to engage in a reflexive dialogue with parents (Moules et al., 2015), which invited parents to elaborate on their answers, thus contributing to a deeper understanding of their experiences.

Although a thematic interview guide was constructed, the style, content and structure of each interview differed as parents' responses facilitated unforeseen questions. As participating in services with parents allowed me to ask questions that were closely related to what they were going through at the moment, I adjusted interviews accordingly. Also, during interviews, infants or older children were often present, who needed to be tended to. This necessitated a high degree of improvisation, where I had to keep the conservation going, although in a more informal way, but also had to steer it back on track to explore the themes outlined in the interview guide.

The interviews were thus non-standardized, which is in line with a hermeneutical philosophy of science (Patterson & Williams, 2002), as interviews always develop in unanticipated and surprising ways in response to the social situation that is unfolding, which resembles the dialogical nature of reaching understanding in hermeneutics (Michrina & Richards, 1996). As the aim of the interview within a hermeneutical paradigm is not to confirm but to gain insight into the other's perspective and experiences, this requires openness and sensible listening on the part of the researcher (Moules et al., 2015). Consequently, flexibility is necessary to reach new understanding (Dahlager & Fredslund, 2008; Vandermause & Fleming, 2011)

2.8. DATA ANALYSIS

In ethnographic research, data collection, analysis and writing are interrelated in an iterative process, including a dialectical interplay between theory and the empirical material (Atkinson, 2015; Emerson et al., 2011; Hammersley & Atkinson, 2007; O'Reilly, 2004). Pure data is however not derived directly from the empirical world as research cannot be done without prior knowledge or analytical ideas, and therefore the researcher does not conduct fieldwork with an empty mind but rather with an open mind (Atkinson, 2015; Emerson et al., 2011). This reflects Gadamer's' notion of pre-understandings being necessary for the production of knowledge in the first place (Gadamer, 2013).

The process of writing things down, and then writing them up, is central in ethnographic analysis to fix social life, experiences and practices in textual form (Atkinson, 2015; Geertz, 1973). I transcribed 50 tape-recorded interviews and constructed 51 field notes of parent-professional encounters. Data were managed in NVivo 12 software (QSR International Pty Ltd, 2020) and organized for each woman/couple. As it is important to know the data through repeated and detailed readings (Hammersley & Atkinson, 2007), I transcribed the interviews myself and read the interviews and field note to gain familiarization. Also, I mapped each woman/couple's care pathway on paper to visualize the services, they received, and to gain an overview over initial themes that characterized their care experiences.

The principles of thematic analysis were used to identify and interpret patterns across the data set (Braun & Clarke, 2006). I assigned initial codes based on its significance to understand the care experiences of parents in vulnerable positions. The codes were sorted into initial themes, which I reorganized after reading the extracts under each theme. Figure 1 illustrates the initial codes.

Within an interpretive framework, themes are not residing in the empirical data but actively constructed by the researcher through interpretation (Braun & Clarke, 2006). Due to the broad, overall research objective and large data set I was able to construct a range of analytical themes. I selected the most significant and well-substantiated for further development and refinement (Braun & Clarke, 2006).

In hermeneutics, analysis does not end with the identification of themes, but involves a high level of interpretation (Moules et al., 2015), which I did by continuously making interferences within the empirical material, for example by comparing data across cases or to existing research and theories. Also, by placing the data within the context of the participants' social conditions and the particular time and space in which these experiences unfolded, it was possible to further interpret the meaning and significance of the care experiences of parents in vulnerable positions. Thus, interpretation takes place through an ongoing dialogue between the research and the text, which is central in the hermeneutical circle to reach understanding (Dahlager & Fredslund, 2008).

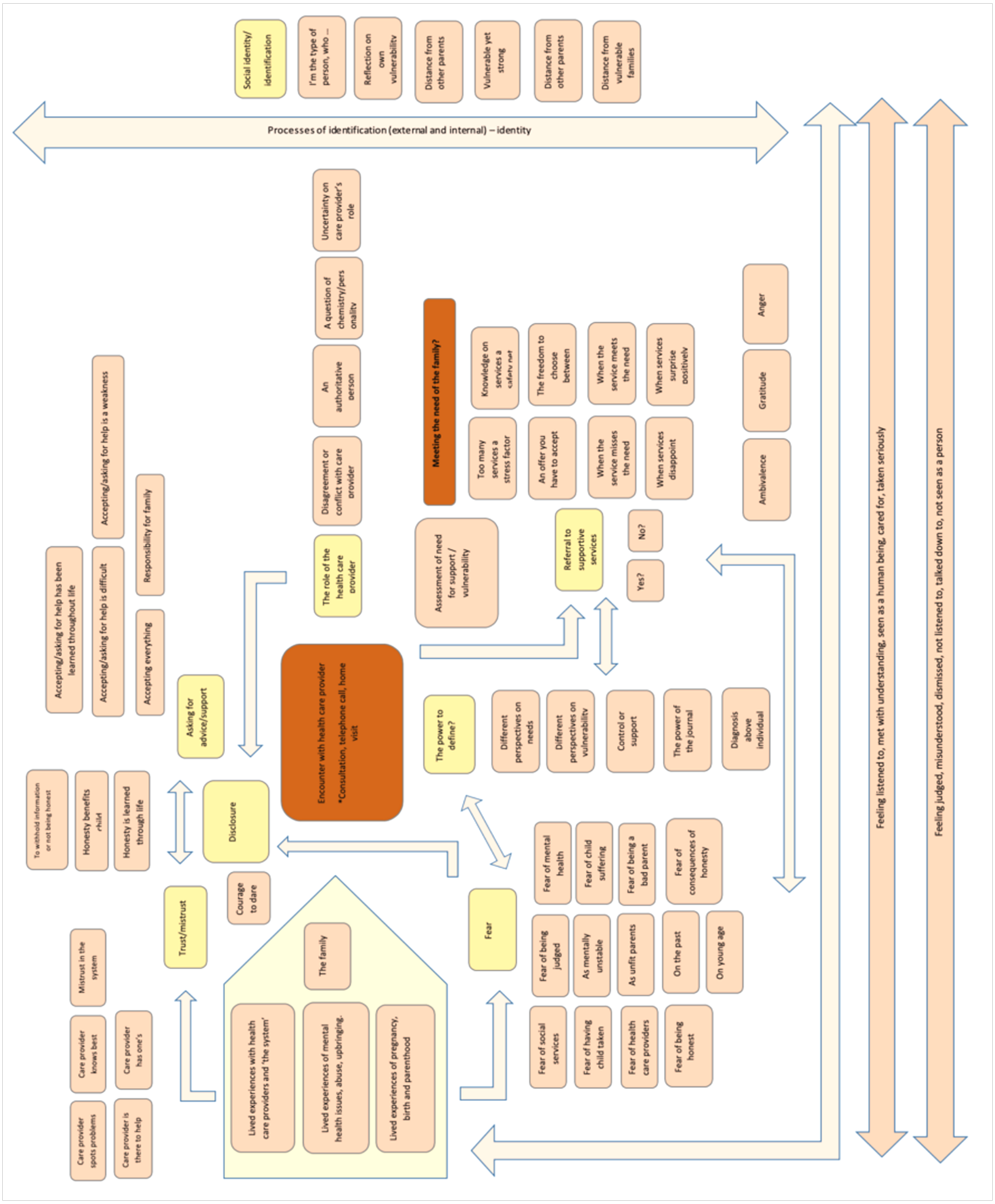


Figure 1: Mapping of initial codes

At first parents' experiences with fear stood out, which based on the existing literature was not surprising; however, the magnitude of these experiences and the highly diverse ways fear were experienced called for further analysis. Furthermore, multiple codes had been assigned to the empirical material to form a major theme surrounding the parent-professional relationship. Although this was related to the experience of fear, I decided to present a separate in-depth analysis to identify the key elements of supportive encounters as this was found significant for parents' overall care experiences. However, initial themes had also been constructed in relation to what took place after parent-professional encounters and parents' referral pathways. By placing this in the existing body of literature, the major theme of continuity of care was constructed.

Figure 2 gives an overview of the major constructed themes. The findings presented in the three papers (Frederiksen et al., 2021a, 2021b, 2021c) should thus be read in the light of one another as they are part of the same analytical process and ethnographic study as they address the overall objective of generating in-depth knowledge on the care experiences of parents in vulnerable positions.

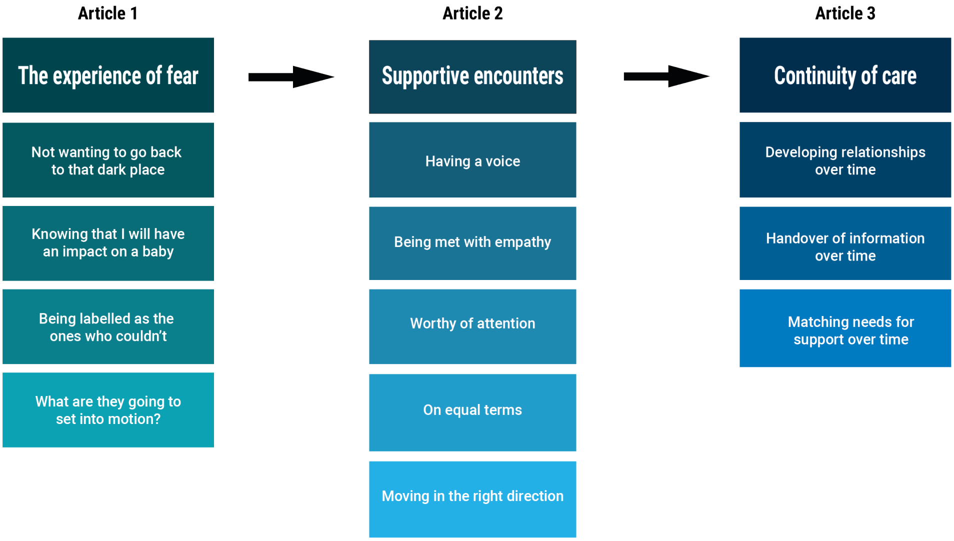


Figure 2: Overview of the themes presented in the three papers

2.9. ETHICAL CONSIDERATIONS

According to Danish legislation, qualitative research studies are based solely on informed participant consent. Unless a qualitative study is linked to a study or trial involving liveborn human individuals or biological material, it is not among the type of studies that can be submitted for ethical approval by the scientific committee (The National Committe on Health Research Ethics, 2018).

The research was conducted following the Danish legislation (The National Committe on Health Research Ethics, 2018), the Helsinki Declaration (The World Medical Association, 2013) and the Danish Code of Conduct for Research Integrity (The Danish Ministry of Higher Education and Science, 2014), concerning informed consent, confidentiality and management of data.

Parents received verbal and written information as basis for being able to give informed consent for participation. Prior to obtaining informed consent, we discussed the information material and content of the form. I emphasized that participation would not have any implications for the services that they received now or in the future, and that no information would be shared with the professionals involved in their care. Also, we discussed the degree that participants wanted to participate, for example number of interviews and possible activities to observe, as well as the possibility to withdraw from the study at any time until data was published. Talking through the information material allowed for me to explain the meaning and implications of participation and enabled that parents could ask questions before signing.

Data were handled in agreement with the General Data Protection Regulation legislation (Otto, 2018). The study is listed with the Danish Data Protection Agency (Record No. 2019-899/10-0020). Data were stored in an encrypted file drive, which was only accessible by me.

Principles of confidentiality and anonymity were followed. Conducting qualitative research over a longer period of time allows for encapsulating the temporality of lived experiences (Shirani & Henwood, 2011); however, the anonymization of richly detailed narratives can be difficult without losing the particular richness and narrative of the case (Taylor, 2015). To protect parents' confidentiality, pseudonyms were used, and only information that was significant to understand their experiences were included in the analysis. Following the guidelines regarding the non-use of pseudonyms in the journal *Qualitative Health Research* (Morse & Coulehan, 2015), pseudonyms were not used in paper 1 (Frederiksen et al., 2021b).

Additionally, ethical considerations applies to the overall objective of the study, as it confronts the double issues of a sensitive topic and participants in vulnerable positions (Marsh et al., 2017). To obtain data for qualitative research it is central to invite them to share their experiences, which can be sensitive due to the potentially stressful situation they can be in (Dickson-Swift et al., 2007).

As interviews can open up for traumatic experiences (Horowitz et al., 2002) and produce potential painful reflections on the participant's life condition (Newton, 2017), I found it vital to avoid causing further harm to the participants. On the other hand, I found that participants should not be assumed that they are too vulnerable to contribute as excluding vulnerable participants from research is paternalistic (Alexander, 2010). Importantly, research participation can create a space for participants to make sense of their experiences and in this way feel heard (Newton, 2017) as well as allow participants to have a voice by contributing with expert knowledge based on their own lived experiences (Nordentoft & Kappel, 2011). Also, positive experiences have been reported as participation can be felt as positive and supportive despite vulnerability (Alexander et al., 2018). Whereas these ethical considerations cannot be fully anticipated beforehand, it calls for a situational ethics, where reflexivity regarding potential implications for participants is required throughout the entire research process (Birch & Miller, 2000; Maddens, 2010).

2.10. POSITION IN THE FIELD

With a background in anthropology, I approached the field of study influenced by a particular ethnographic gaze and sensibility (Atkinson, 2015; Emerson et al., 2011) and theoretical orientation (Kleinman, 1980, 1988). From the perspective of Gadamer, one's position conditions how understanding is achieved (Gadamer, 2013).

The ethnographic research design and the theoretical orientation to medical anthropology provides a framework through which I was able to explore the experiences of parents in vulnerable positions. As an experienced fieldworker previously doing research in the field of parents' experiences with family life and reproductive health, I employed my earlier experiences to navigate a challenging field consisting of a sensitive research topic, participants in vulnerable positions, and inter-disciplinary collaboration with health visitors and midwives.

To participants, I introduced myself as an anthropologist or a scholar from Aalborg University conducting research on interventions for parents in vulnerable positions during pregnancy and after the birth. By emphasizing this, I positioned myself outside of the health care system and the professionals that parents were in contact with, such as midwives, health visitors or social workers. This was intended to signal that I was not involved with the care they received. It was highlighted that I was interested in hearing their stories, and that their personal experiences were central for the research project and would contribute to create knowledge that would be invaluable to quality improvement of services intended to provide support and care for parents and families.

During encounters with midwives and health visitors, I similarly positioned myself as an anthropologist with limited knowledge about the maternity care sector. This allowed me to take an apprentice position with curiosity towards their field of work, their practices, and experiences with working with families in vulnerable positions. As I was working in an inter-disciplinary and cross-sectoral setting, the fact that I was positioned in a non-medical profession helped navigating this field.

CHAPTER 3. FINDINGS

In this chapter, I will present a brief summary of key findings from the three papers (Frederiksen et al., 2021a, 2021b, 2021c). This is followed by an integrated analysis that present five major themes identified across the findings. These transverse themes serve to address the overall research question and contribute with new interpretations that can deepen our understanding of the care experiences of parents in vulnerable positions during pregnancy and the postnatal period. At first, I will however provide a description of the participating families, whose experiences form the backbone of the study's findings.

3.1. PARTICIPATING FAMILIES

Altogether, 26 women accepted the invitation to participate in the study. Out of these women, six women were alone in the parenting role with no or very little contact to their child's father. The remaining 20 women were either married or living with their partner, who all identified as male and the father of the child. Of these 20 fathers, 13 chose to participate in the study.

Of the 26 participating mothers, seven were in regular employment when not taking maternity leave. Seven were still studying, including one pursuing high school education, and six pursuing a medium or long cycle higher education. The twelve remaining mothers received public benefits due to unemployment or sick leave.

The mothers' highest level of education obtained differed. Some had obtained a bachelor's or master's degree at the university (n = 5), whereas others had medium-cycle higher education (n = 6) or occupational or short-term higher education (n = 6). One group of mothers had secondary (n = 5) or high school (n = 4) as their highest completed level of education.

Most of the 13 participating fathers were in regular employment (n = 8), whereas a few were still studying (n =3). Two did not have regular employment.

Some fathers had obtained a bachelor or master's degree at the university (n = 3), some had medium-cycle higher education (n = 3) and some occupational or short-term higher education (n = 2). One had secondary school as their highest completed level of education (n = 1), whereas the educational background of four fathers were unknown (n = 4).

17 out of the 26 families lived in rented apartments or houses, whereas 6 (all couples) were house owners. The living situation of three families were unknown. The families

lived in various geographical areas of Aalborg Municipality with different levels of deprivation. The majority resided in the city, while others lived in one of the minor towns or rural areas of the municipality. Only very few ethnic minorities were recruited in the study, except four participants, who had been grown up outside of Denmark, or whose parents had been immigrants. All participants spoke Danish.

Table 6 describes the participants with pseudonym and main vulnerability factors. To protect the privacy of the participants, only limited details are given. Therefore, the couples are also separated in the table to further protect the anonymity of participants, particularly those mothers who participated in both individual and dyad interviews.

All vulnerability factors are self-reported by the participant.

The term mental health issues cover both minor and major incidents located in the past or present, including symptoms of emotional distress, stress, anxiety and depression, as well as diagnosed anxiety and mood disorders, severe postnatal depression, obsessive-compulsive disorder, attention deficit hyperactivity disorder, personality disorders, bipolar disorder, schizotypal disorders, and disorders on the autistic spectrum.

The term adverse childhood experience covers e.g. experiences of loss, psychological, psychical or sexual abuse, parental mental and somatic illness, parental substance misuse before the age of eighteen, in some cases leading to long or short-term placement out of home.

Past substance use covers only past misuse and/or abuse of alcohol and/or drugs. No participant shared information about domestic violence. In this context, young age is defined as the mother and/or father being below 23 years old as this makes them eligible for additional support.

Name	***Main vulnerability factor(s)***
Mothers	
Amalie	Mental health issues.
Anna	Mental health issues.
Annette	Mental health issues. Adverse childhood experiences.
Britt	Mental health issues. Adverse childhood experiences.
Camilla	Young age. Adverse childhood experiences.
Carla	Mental health issues. Single parent. Adverse childhood experiences.
Caroline	Mental health issues. Adverse childhood experiences.
Christina	Mental health issues. Single parent. Adverse childhood experiences. Past substance use.
Emma	Single parent. Young age. Adverse childhood experiences.
Emily	Mental health issues.
Esther	Mental health issues.
Freya	Mental health issues.
Heidi	Mental health issues. Adverse childhood experiences.
Helene	Mental health issues. Adverse childhood experiences.
Irene	Mental health issues. Adverse childhood experiences.
Isabella	Mental health issues. Adverse childhood experiences. Past substance use.
Karina	Mental health issues. Single parent.
Laura	Mental health issues.
Line	Mental health issues (partner)

Mia	Mental health issues. Young age.
Natalie	Mental health issues. Adverse childhood experiences.
Sabrina	Mental health issues. Single parent. Adverse childhood experiences.
Sarah	Mental health issues.
Simone	Mental health issues.
Sophie	Mental health issues. Adverse childhood experiences.
Tina	Mental health issues. Single parent. Adverse childhood experiences. Past substance use.
Fathers	
Andreas	Mental health issues (partner).
Carl	Mental health issues (partner).
Christopher	Mental health issues (partner).
Martin	Mental health issues (partner).
Noah	Past substance use. Adverse childhood experiences.
Oliver	Mental health issues (partner).
Peter	Mental health issues (partner).
Sebastian	Past substance use. Adverse childhood experiences. Young age.
Simon	Mental health issues. Mental health issues (partner)
William	Mental health issues (partner).
Casper	Mental health issues (partner).
Stephen	Mental health issues. Adverse childhood experiences.

Table 6: The names and main vulnerability factor(s) of participants

3.2. FINDINGS OF PAPER 1: THE EXPERIENCE OF FEAR

Experiences of fear were identified as a significant aspect of the general experiences of care and childbearing for parents in vulnerable positions. Paper 1 documents the multiple, ambiguous, and interrelated ways many parents were found to experience fear (Frederiksen et al., 2021b). Four themes were constructed as illustrated in figure 3:

Figure 3: The experience of fear (Frederiksen et al., 2021b, p. 568)

Parents' past or current experiences with mental illness and embodied knowledge of suffering from mental illness could give rise to an immense fear of having to cope with this or go through this again whilst being pregnant or tending to a newborn baby. For especially women with increased risk of developing postnatal depression, fear of going back to "that dark place" could be a motivation for reaching out for help (Frederiksen et al., 2021b). Also, the challenges some parents were facing could trigger fear related to parental role. For example, mental illness and adverse childhood experiences often led to worries and insecurities about having a negative impact on the baby or not being a good parent. Overall, psychosocial vulnerabilities generated insecurities regarding their role as a parents and a fear at failing at this, potentially causing their children harm (Frederiksen et al., 2021b).

While this type of fear was related to feelings of guilt and shame, parents also feared that professionals would pass judgment on them due to for example mental disorders, young age, and actions or adverse experiences in their past, and consequently, judge them as unfit for parenthood. This fear was often shaped by previous negative experiences, where they had felt stigmatized by professionals or in social situations with other people. Anticipation and expectation of negative responses left parents uncertain about how much information to disclose to professionals as they feared their response to their life stories (Frederiksen et al., 2021b).

Related to this, parents in vulnerable positions generally experienced fear of consequences from services and providers. The ultimate consequence and worst-case scenario included involvement with social services and losing custody of their children. Consequently, some parents were afraid to interact with professionals and of being honest. For some, this was related to uncertainty about the professional's role. This fear has to be seen in the light of the parent-provider relationship, and that surveillance is also an integral part of offering support, which makes help-seeking an ambivalent experience (Frederiksen et al., 2021b).

Overall, paper 1 contributes with in-depth insights in the complex and contextualized forms of fears that parents in vulnerable positions may experience. In contrast to the existing research, the findings document that fear cannot be perceived only as a barrier to be overcome by professionals. Fear is a central aspect of the childbearing and care experiences for parents in vulnerable positions. Understanding fear as arising in social situations illustrates that the experience of fear is both shaped by their particular life trajectory and their encounters with the maternity care sector. The intersection of these experiences can lead to painful and difficult experiences that influence engagement with services and providers in different ways (Frederiksen et al., 2021b).

3.3. FINDINGS OF PAPER 2: SUPPORTIVE PARENT-PROFESSIONAL ENCOUNTERS

In paper 2, key elements of supportive encounters are identified on basis of the parents' experiences of their relationship and encounters with professionals during pregnancy and the postnatal period (Frederiksen et al., 2021c). As illustrated in figure 4, five central elements of parents' experiences of their encounters with professionals as supportive – or the opposite – was identified.

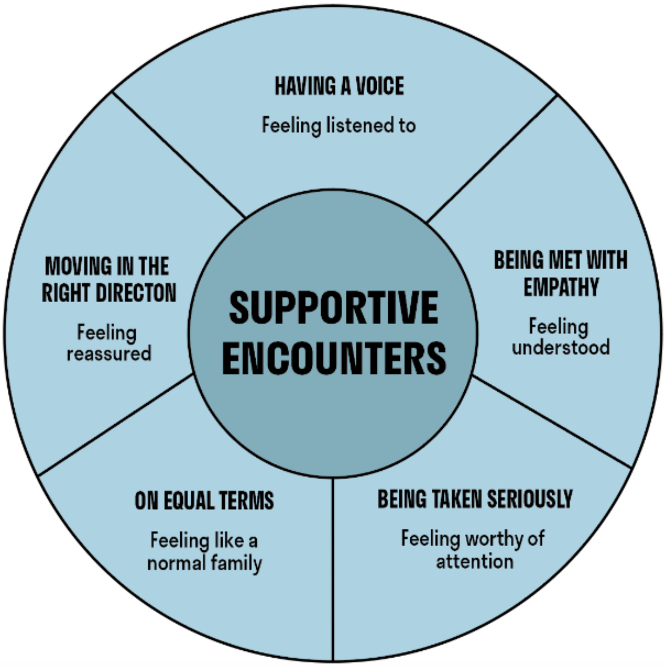


Figure 4: Supportive encounters (Frederiksen et al., 2021c, p. 2391).

Feeling that they had a voice and was listened to was found to form a significant basis for parents in vulnerable positions to perceive their encounters with professionals as supportive. The parents highly valued being invited to tell their stories and share their perspectives on their situation. When the professionals listened actively and invested time in the dialogue with parents, this was experienced as expressions of interest and respect. Also, active listening indicated to parents that their perspectives would be considered in the planning of their care (Frederiksen et al., 2021c).

Feeling understood was another important aspect of encounters that were perceived as supportive by parents. When professionals responded with empathy to the parents' life stories or situation, they felt acknowledged and thus less flawed or wrong – feelings that were closely linked to the stigma and self-stigma that often came with mental health problems and social disadvantage. Moreover, it mattered greatly to parents, when they felt that their concerns and requests regarding their care were taken seriously, and appropriate actions taken. This contributed to parents feeling that they were worthy of attention. Conversely, feeling dismissed or disregarded by professionals prompted painful experiences of powerlessness and sometimes frustration over not feeling their requests and needs for support was met adequately (Frederiksen et al., 2021c).

Inherent to the experience of encounters as being supportive was also the feeling of being treated as equals and with respect and spoken to “as normal people” (Frederiksen et al., 2021c). This occurred when professionals did not pass moral judgement or signs of thinking less of them due to their past or current vulnerabilities. Contrarily, feeling judged or spoken to in a condensing manner prompted feelings of otherness and stigma and often reaffirming prior negative experiences with professionals (Frederiksen et al., 2021c).

Lastly, it was important for parents to feel reassured, and that they were moving in the right direction. Many parents felt insecure in their parenting role, and some had concerns over service engagement. To feel acknowledgement of their effort and confirmation that their baby was thriving and met developmental milestones, significantly relieved parental burdens of stress and fear (Frederiksen et al., 2021c).

Overall, encountering the supportive care practices described above was paramount for parents to have positive care experiences. Supportive care was often not expected by the parents due to earlier negative interactions with professionals but allowed them to feel included, respected, and safe and positively impacted their engagement with services and care providers (Frederiksen et al., 2021c).

While the identified care practices may be seen as basics of good care in general, for parents in vulnerable positions it appears paramount that care providers have the competences and necessary time to listen to them, attend to their stories, and take their concerns and requests for support serious in a non-judgmental and open way. Understanding the significance of how parents are approached during care encounters are central to the ability of professionals to meet their often complex care needs and avoid causing harm (Frederiksen et al., 2021c).

3.4. FINDINGS OF PAPER 3: CONTINUITY OF CARE

Parents in vulnerable positions often receive multiple, interdisciplinary, and cross-sectoral services. In paper 3 the focus is on the role of continuity in creating coherent care journeys (Frederiksen et al., 2021a). Figure 5 illustrates the three overall themes generated in the analysis.

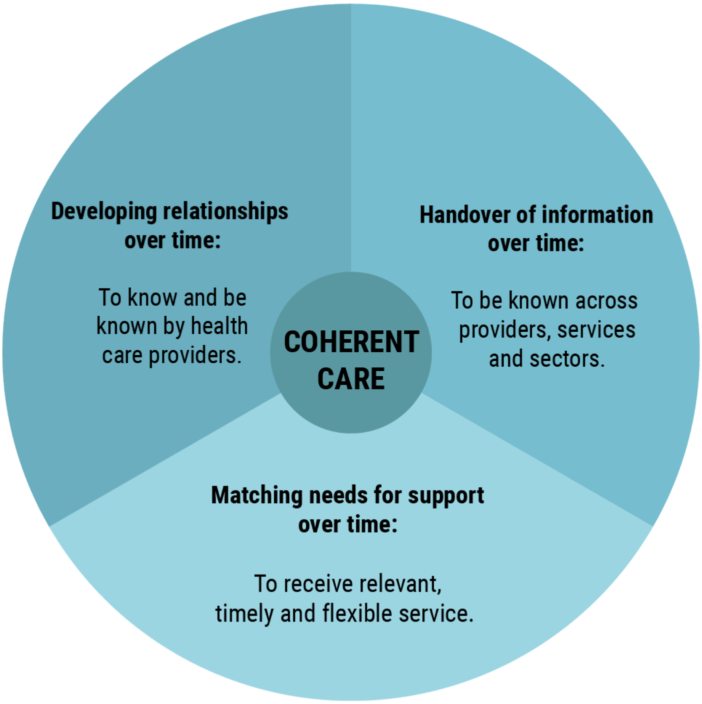


Figure 5: The role of continuity for coherent care journeys (Frederiksen et al., 2021a, p. 34).

Relational continuity and continuity of carer (Haggerty et al., 2003), allowed parents to develop trusting relationships over time to the professionals involved in the care. Parents valued that they knew and were known by professionals as this made them feel more comfortable in care encounters and in reaching out for support. Parents trusted that the known provider's in-depth knowledge of their individual challenges and care needs would improve their ability to support them or detect problems or need for support at an early state. Being assigned known providers also allowed the parents to feel safe and not constantly under reassessment and eased their access to care in case challenges arose (Frederiksen et al., 2021a).

Informational continuity (Haggerty et al., 2003), including relevant handover of information, contributed to parents feeling known across services, providers, and sectors, which gave them a sense of security. This was particularly important as they often moved in and out of services and made contact with numerous care providers in different sectors. Adequate information flows meant that parents did not have to retell their stories and allowed them to feel safe and to have their individual needs met even when in transition between services. This did however require information to be shared and acted upon by providers; when this did not happen, parents felt lost, forgotten, and insecure, as they did not know whether their special care needs were acknowledged. Handover of information between care providers and health care sectors did however also leave some parents feeling exposed or vulnerable as they worried about the consequences or found it difficult to trust unknown professionals (Frederiksen et al., 2021a).

Management continuity (Haggerty et al., 2003) was also important as the parents' needs for support and tailored services had to match over time for their care pathway to be experienced as coherent. The care needs of parents in vulnerable positions were highly variable and contingent on their individual situation and the changeable challenges they were facing. The parents thus depended on being referred to and able to access service that were experienced as relevant and matching their expectations and need for support. Many parents experienced easy access to care and that they were offered helpful support and services matching their needs, but fragmentation easily occurred in cases of waiting lists or unavailability of needed services in their local community. This left parents feeling frustrated and unsafe. Thus, referral pathways that were easy to navigate, for both parents and professionals, were found to be essential. Furthermore, parents would sometimes need professional support in accessing and navigating services (Frederiksen et al., 2021a).

Overall, continuity of care in all its forms was found to play a significant role in creating coherent care journeys for parents in vulnerable positions. Although relational continuity was highly valued, the need for continuity was found to expand beyond knowing and being known by the same carer. To meet the complex care needs of these parents, appropriate information flow and collaboration between providers in addition to the availability of accessible services that matches the parents need for support is crucial. When all types of continuity are in place, parents' care experiences are improved as the quality and relevance of services are increased. Also, continuity of carer can potentially support appropriate transfer of knowledge and ensure that parents are referred to relevant services; however, this requires good coordination and knowledge of referral pathways (Frederiksen et al., 2021a).

3.5. INTEGRATED FINDINGS

In the following, I will present five major themes, which illustrate key factors that have an impact on the care experiences of parents in vulnerable positions during pregnancy and the postnatal period. These major themes transverse the individual findings presented in the three papers and thus contribute with a new interpretation that contribute to address the overall research objective of the study. These five theme are presented in Figure 6.

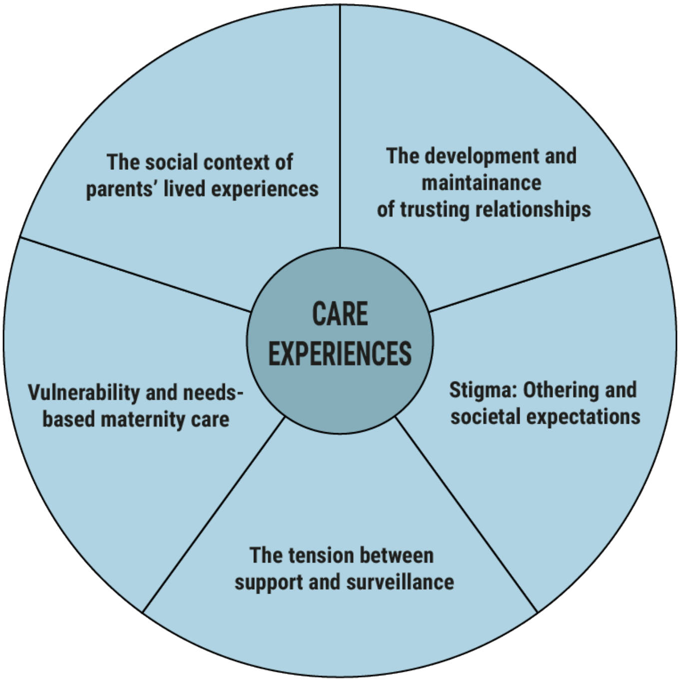


Figure 6: Integrated findings

The social context of parents' lived experiences

Overall, the care experiences of parents in vulnerable positions were found to be highly influenced by their individual life trajectories. Parents' past experiences, their current situation but also their orientation towards the future appeared to shape their experiences and anticipation of pregnancy and early parenthood as well as maternity services and care providers, as also demonstrated in paper 1 and 2 (Frederiksen et al., 2021b, 2021c).

By allowing the voices of parents in vulnerable positions to be heard, experiences of vulnerability were unfolded. The parents' lived experience of vulnerability included painful and burdening experiences of mental health problems, stigmatization, marginalization, lack of social support, exposure to violence, abuse, or other traumas; experiences that had been and often continued to be a source of suffering. Overall, psychosocial vulnerability was experienced in highly different ways and prompted a need for individualized care, that was sensitive to their individual life stories and social situation. Understanding and acknowledgement of the parents' lived experiences as embodied knowledge that they carried with them into both pregnancy and parenthood as well as care encounters was important for care providers to meet these parents' complex care needs.

For most parents included in this study, exposure to psychosocial vulnerability factors was longstanding, often leading to years of experiences with the health care system or social services, as well as experiences with seeking out and receiving care and treatment. The quality of these prior experiences impacted their care experiences during pregnancy and early parenthood, and how they felt about engaging with services and professionals.

Many parents felt that the "system" or professionals had neglected them, let them down or in other ways failed to help in difficult situations during their childhood or later in life. They often recounted feeling judged, unsupported, or stigmatized during encounters with professionals (Frederiksen et al., 2021b, 2021c). Such negative experiences left parents with little faith in the ability or willingness of professionals to help them and a general lack of trust in professionals. Other parents however recounted positive experiences of past encounters with professionals, who they felt had their best interest at heart and were somebody they could count on. This type of positive past experiences shaped parents' initial expectations and anticipation of services.

To fully understand the care experiences of parents in vulnerable positions and meet their complex need for support, it is necessary to consider these parents' life trajectories as an important social context for their encounters with maternity care providers.

Developing and maintaining trusting relationships

Another major finding in this study relates to the development and maintenance of trusting relationships between parents and the professionals involved in their care. As described above, parents' lived experiences with vulnerability and previos experiences with service engagement shaped their anticipation and initial level of trust in professionals. The perceived quality of the relationships that parents formed to professionals therefore had a strong impact on their overall care experiences and were in many ways a prerequisite for establishing trust, which was found to be central for parents to feel safe to be honest and reach out for as well as accept support.

These trusting relationships between parents and professionals were developed and maintained through repeated positive interactions. During parent-professionals encounters, parents paid close attention to the approach taken by the professionals, and how they responded to their situation and needs, as illustrated in paper 2 (Frederiksen et al., 2021c). Moreover, us unfolded in paper 3, during parent-professionals encounters parents highly valued relational continuity as this was another element that contributed to positive care experiences (Frederiksen et al., 2021a).

By combining these elements, repeated positive interactions with known professionals contributed to parents feeling safe and supported; conversely, repeated non-supportive interactions with known professionals could also add to existing feelings of mistrust and reinforce parents' negative expectations of services and providers. Continuity of carer did therefore in itself not guarantee that a trusting relationship was established as some parents also reported feeling excluded, judged or not listened to by a known carer. Consequently, it is neither supportive practices nor relational continuity in itself that has an impact on parents' care experiences, but rather a combination where they positively reinforce one another.

Moreover, the parent-provider relationships were inherently fragile and also a site of ambivalence, as the way that parents experienced their relationship to professionals could easily change over time. As argued in paper 1, the experience of fear was highly temporal as that it arose from and in response to social situations, including encounters with professionals (Frederiksen et al., 2021b). Similarly, the experience of trust was found to be contingent on how parents' care pathways unfolded over time and was in this sense not static. Some parents thus experienced that even though a relationship had been established, this could later change if they for example experienced discontinuity, encountered non-supportive practices or experienced that their needs were not addressed by the professionals. On the other hand, at first some parents felt unhinged and apprehensive during encounters with professionals, but over time experienced that the professional was capable of making them feel safe, included and respected, and were highly qualified to address their needs for support, which contributing to parents placing more faith in the professional and the maternty care sector as a whole.

Stigma: Othering and societal expectations

Based on the findings, the care experiences of parents in vulnerable positions were also influenced by stigmatization. The process of identifying psychosocial vulnerabilities and assessing needs and service tailoring were in many ways perceived as embedded in wider societal norms and values related to pregnancy and parenthood.

Many parents shared accounts of feeling stigmatized or judged due to young age, mental illness and/or past substance abuse and felt that their professionals, but also other people had preconceived ideas about them and changed their attitude towards them accordingly. Due to these experiences, parents therefore anticipated negative responses when disclosing their vulnerabilities to professionals (Frederiksen et al., 2021b). At times, parents did not agree with the professional's assessment of their situation and often felt that too much emphasis was placed on their past or current challenges, while strengths and resources were overlooked. The feeling of stigma could be alleviated if parents felt that professionals curiously and respectfully approached them as they would any other family. However, when parents felt that professionals held prejudices this exacerbated their feelings of being stigmatized and reinforced their negative expectations of professionals (Frederiksen et al., 2021c).

Processes of stigmatization were further at play as parents associated vulnerability with negative attributes and thus stigmatized and were prejudiced towards other parents (Frederiksen et al., 2021b). Overall, most parents did not wish to be seen as someone in need of support for managing parenthood and linked psychosocial vulnerabilities with low social position and marginalization, social categories that parents found it very hard to identify with. Targeted services addressing psychosocial vulnerabilities was generally perceived as suitable for highly disadvantaged parents, incapable of taking care of their children. The wish for professionals to see beyond the stigma attached to for example mental illness or young age was thus also rooted in parents' own notions about vulnerability and a way of differentiating themselves from a category of people they normally associated vulnerability with (Frederiksen et al., 2021b, 2021c).

Moreover, for some participants, stigmatization also had an impact on their experiences as they internalized the felt stigma, which contributed to painful feelings of self-doubt, particularly in relation to their new role as a parent (Frederiksen et al., 2021b). Feelings of self-doubt and low self-esteem were common, as seen when the parents talked about feeling 'wrong' or flawed or blamed themselves for shortcomings during pregnancy and the postnatal period. As demonstrated in paper 2, a common approach to address this from the professionals was to provide the parents with reassurance and acknowledgement for their efforts. Also, approaching parents with empathy and understanding, contributed to them feeling accepted and valued (Frederiksen et al., 2021c). This was further mediated by continuity of carer as this allowed professionals to know what parents felt worried or insecure about in their parenting role and in this way work with them to strenghten their belief in themselves and feel more confident.

The tension between support or surveillance

The findings showed that the parents' care experiences were closely related to the systemic context in which they were formed, including an unequal power relationship between parents and professionals. Although targeted services were offered with the primary purpose of supporting and helping parents, they also included elements of surveillance and control. This tension presented challenges in the parents' relations to professionals as they found it difficult to decipher the purpose of services and were worried about consequences. Consequently, service engagement was related to highly ambivalent feelings as many parents often wanted support whilst also being concerned about the implications of this. While both parents with and without child protection issues or prior experiences with the social services were included in this study, the tension between support and surveillance were by far limited to parents at-risk of losing custody of their children but were experienced across the recruited families.

Fear of losing custody was especially triggered when social workers were involved, as they were related with 'the system' and child welfare concerns; nonetheless, midwives and health visitor could also trigger this fear as unfolded in paper 1 (Frederiksen et al., 2021b). Due to uncertainty about their role, parents felt under surveillance and worried that their midwife or health visitor would notify social services with remarks on the baby's development, health, and well-being. The tension between support and surveillance was particularly felt when a health visitor carried out a home visit to a family before birth, if parents were referred to additional support, or in cases where a care provider made a notification to social services. The parents compared these situations with being tested or at an exam, where they had to prove or explain themselves. Engagement with services and care provider could thus be perceived as unnerving as parents did not want to be the subject of negative attention. This added to their prior feelings of fear and mistrust, which was further exacerbated when parents felt excluded from the process or was unsure about the purpose of services.

In general, clear communication from professionals and transparency made parents feel reassured as they did not have to read between the line or guess the professional's agenda (Frederiksen et al., 2021c). The tension between support and surveillance were softened when the purpose of services and the professional's role was explained, and the parents' concerns and fears were openly addressed. The constructing of trusting relationships through continuity and supportive care practices further played a central role in reaching this goal (Frederiksen et al., 2021a, 2021b, 2021c)

Vulnerability and needs-based maternity care services

The findings illustrate that parents' care experiences were influenced by the organization of the maternity care sector, the identification of vulnerability and provision of needs-based services. Many different forms of vulnerability were experienced by the parents in this study, and often unforeseen events or challenges would arise, thus prompting new needs for support over time, which illustrates the temporal aspects of vulnerability. This required a high level of service flexibility and far from all parents experienced coherent care, and that their care needs were adequately addressed (Frederiksen et al., 2021a).

Often professionals and parents were in alignment regarding their challenges and appropriate course of action, but in other cases they held different perspectives on the situation and hence the needs for support. Both mutual understanding as well as conflicts and disagreement could thus occur. For parents to find the services referred to meaningful, they needed to feel included in the decision-making process. As described in paper 2, this could be achieved when parents felt that professionals listened to them, understood their individual situation, and took their requests seriously. These care practices were thus paramount to avoid parents feeling insignificant or dismissed (Frederiksen et al., 2021c). Continuity of carer through in-depth knowledge of parents played an important role in tailoring care to the needs of the family as it allowed the professionals gaining insight in the family's situation, preferences and values. Continuity was also seen to improve the timeliness and relevance of referral to other services as the care providers were able to aid information sharing across services, once they recognized a need for support (Frederiksen et al., 2021a).

The findings also underline that the care experiences of parents in vulnerable positions are contingent on the availability and accessibility of services in the community. The variety, quality, and number of services available differ from municipality to municipality due to the decentralized organization of the maternity care sector. For some parents, although a trusting relationship was constructed through supportive practices and continuity of carer, their care journeys were fragmented as they were not referred to appropriate services. Consequently, their health needs are at risk of remaining unaddressed, which can also break parents' trust in the system being able to support them. To ensure that parents receive appropriate and high-quality care matching their health needs, easy referral pathways are important, and some parents may benefit from having a coordinating person that can help them accessing services (Frederiksen et al., 2021a).

CHAPTER 4. DISCUSSION

In this chapter, I discuss the five major themes based on the integrated findings from paper 1 (Frederiksen et al., 2021b), paper 2 (Frederiksen et al., 2021c) and paper 3 (Frederiksen et al., 2021a). I discuss these findings in light of the overall aim of this study and in the context of previous research. Furthermore, I reflect upon the study's methodology as well as its strengths and limitations.

4.1. DISCUSSION OF FINDINGS

4.1.1. THE SOCIAL CONTEXT OF PARENTS' LIVED EXPERIENCES

The parents' past experiences, their current situation and their orientation towards the future shaped their experiences and anticipation of pregnancy and early parenthood as well as maternity care services and providers (Frederiksen et al., 2021c, 2021b). Overall, their experiences were strongly influenced by their life trajectories. Following Kleinman (Kleinman, 1980, 1988) contextualizing care experiences in the light of service users' lived experiences illuminates how they interpret and make sense of their current situation and challenges and their rationales for engaging or disengaging with services and providers.

Furthermore, as argued in paper 1, rather than viewing fear as a barrier that makes parents choose not to engage with services, understanding what parents bring with them into their encounters is important to understand the experiential aspect of fear (Frederiksen et al., 2021b). In line with this perspective, Kleinman argues that looking at the lay experience through the lens of e.g. 'compliance' and 'denial', represents a biomedical perspective and normative judgment regarding patients' behaviour (Kleinman, 1980). Following this line of thinking, the study findings illustrate that parents' experiences of fear, trust and mistrust, disclosure and withholding of information as well as accepting and turning down services should not be seen as irrational practices nor as non-compliant and compliant behaviour. These are responses based on experiential knowledge and past experiences, which influence their care experiences and sense-making during pregnancy and the postnatal period.

To a certain degree this reflects the findings presented by Downe et al (2009), in their study on barriers of antenatal care, where they argue that service engagement is a complex process, where women make rational choices regarding their care based on their personal circumstances (2009):

> *"(...) marginalized women decide whether or not to access antenatal care through a process of ' weighing up and balancing out' personal issues and circumstances within their social context, and in the context of the care provision they anticipate and encounter"* (Downe et al., 2009, p. 526).

This corresponds with the findings presented in the current study as services engagement are experienced in highly diverse and at times ambivalent ways and influenced by multiple factors; however, the findings also expand on this by suggesting that we move beyond casting their care experiences in medical terms such as barriers to care but emphasise the importance of considering the social and cultural context, and how individuals make sense out of and interpret their experiences. Thus, an anthropological perspective on the care experiences of parents in vulnerable positions underlines the importance of gaining in-depth understanding of their social context and attending to their lived experiences with vulnerability. Understanding what parents in vulnerable positions are bringing with them into pregnancy and early parenthood and their encounters with the maternity care sector shed light on their overall care experiences.

4.1.2. DEVELOPING AND MAINTAINING TRUSTING RELATIONSHIPS

This study illustrated how the relationships that parents form with professionals have a strong impact on their care experiences during pregnancy and the postpartum period. This finding corresponds with existing studies that has similarly identified that the professional's approach is important in establishing a relationship with families in vulnerable positions as this facilitate trust and influence their overall experiences with receiving care (Balaam & Thomson, 2018; Harvey et al., 2015; Jack et al., 2005; Jakobsen & Overgaard, 2018; Kirkpatrick et al., 2007; McLeish & Redshaw, 2019; Paton et al., 2013; Rayment-Jones et al., 2019).

Based on interviews with women during pregnancy and the postnatal period, Lewis et al explored the development of trust in women-midwife relationships (Lewis et al., 2017). Although the women initially trusted the midwife based on their need for maternity care and positive expectations of the midwife's competencies, trust was not static but evolved in response to how women subsequently experienced the quality of the care delivered by the midwife. Women reported that continuity, respect and empathy were central to develop and sustain a trusting relationship (Lewis et al., 2017), thus resembling the findings in paper 2 (Frederiksen et al., 2021c) and paper 3 (Frederiksen et al., 2021a).

Although Lewis et al do not focus on women in vulnerable positions, they point our attention to how the establishment of trust is an inherently social process that takes place in repeated interactions between women and their midwives (Lewis et al., 2017). From this perspective, trust is contingent on how parents experience these encounters, and the care they receive over time. As demonstrated in the current study, parents' expectations to maternity services and their initial trust in professionals are contingent on previous positive, negative or ambivalent experiences with receiving care. As proposed by Dinç and Gastmans in their review of the concept of trust in the nursing literature (2012), placing trust in others is inherently a vulnerable process:

> "*Trust involves risk, because by trusting, individuals become dependent and vulnerable while expecting that the trustee will take care of the valued things entrusted to them. However, the person being trusted may not be fully committed to the relationship or have the necessary competencies"* (Dinç & Gastmans, 2012, p. 232).

As patients rely on professionals being able to support them and address their health needs, this entails uncertainty as it is never possible to anticipate whether this trust will be redeemed (Dinç & Gastmans, 2012). Consequently, the establishment and maintenance of trusting relationship can be viewed as particularly important for this group of families, but, in a sense, also more fragile and experienced as potentially dangerous, as unfolded in paper 1 (Frederiksen et al., 2021b). This perspective may further our understanding of the care perspectives of parents in vulnerable positions, and the ambivalence that can exist in relation to service engagement.

Following this line of thinking, the current study expands on the existing literature by not only cementing that the relationship is important, but also unpacking the key elements that are emphasized by parents as important for them to feel safe, included and respected during encounters with professionals. In other words, it contributes with knowledge on the practices necessary to develop – and maintain – trusting relationships over time. Although parents may initially place trust in professionals and/or the maternity care sector, this can easily be lost if they encounter fragmented care, if they experience that it is difficult to establish relationship to the professional involved in their care, or if they experience that their health needs are not addressed.

Additionally, considering the importance of trusting parents-professional relations for parents' overall care experiences, structural factors need to be in place to support that relationships are developed and sustained over time. King found that health visitors value being able to develop relationships as they perceive this as key to gain parents' trust; however, policy changes in the organization of services meant that they had less time to know the family, placing constraints on the relationship (King, 2016). Two recent reviews similarly found that for midwives to identify and discuss perinatal mental health problems with women, they find it necessary to develop a relationship over time. Lack of continuity and insufficient time were however reported as major barriers (Bayrampour et al., 2018; Viveiros & Darling, 2019). Moreover, poor coordination and communication between services and providers can disrupt the relationship and potential compromise the care provided for parents (Homer et al., 2009; Psaila et al., 2014; Schmied et al., 2010). Thus, structural factors also influence whether or not professionals are able to establish and maintain trusting relationship with implications for parents' care experiences, as demonstrated in this study.

4.1.3. STIGMA: OTHERING AND SOCIETAL EXPECTATIONS

Stigmatization was found to play a significant negative role in the care experiences of parents in vulnerable positions with influence on their service engagement. Stigma includes a devaluation of a person's status, when they are perceived to deviate from social norms and seen as competent or dangerous, where negative attributes are associated with a health condition, such as mental illness and addiction (Benoit et al., 2010). Consequently, stigma can prevent people from accessing health care services with potentially adverse health outcomes (Benoit et al., 2010). Moreover, according to Goffman, individuals navigate and control information that can place them in a stigmatized position, particularly if the information it not visible or known beforehand. This raises questions regarding what to disclose and to whom during social encounters to minimize the risk of being discriminated against (Goffman, 2009).

Following Goffman (Goffman, 2009), lay encounters with professionals always involve a dilemma between telling and withholding information, where the disclosure of potentially discrediting information about oneself entails a risk. Structural power is thus at play, as stigma, as argued by Link and Phelan, is not an individual attribute but socially produced in unequal relationships between those, who have these potential stigmatizing conditions, and those who do not (Link & Phelan, 2001). Thus, women's experiences of maternity care services cannot be separated from the unequal power relations that characterizes parent-professional encounters (Rayment-Jones et al., 2019). Parents' fear of being judged is therefore not likely to go away but can resurface or linger (Frederiksen et al., 2021b), as it is not possible for the parents to fully anticipate or predict how professionals will be responding, particularly as an unequal power relationship exist.

Similar findings have been reported in other studies. Mothers have reported feeling a stigma attached to being a young mother, being a single parent and/or living in poverty or disadvantages neighborhoods (Landy et al., 2009; McArthur & Winkworth, 2018). Also past or current substance abuse was reported as an important trigger of stigma as this is viewed as incompatible of motherhood (Harvey et al., 2015; Stengel, 2014; Stone, 2015). Moreover, perinatal mental health problems were associated with shame, self-blame and failure of being a good mother (Megnin-Viggars et al., 2015; Viveiros & Darling, 2019). Women and families in contact with the child protection services also experience stigma as this contrast societal norms regarding good parenthood (Tantawi-Basra & Pezaro, 2020). In line with the current study, these studies illustrate how psychosocial vulnerability factors can cause stigma, especially when conflicting with societal norms about parenthood. Also, stigma theory helps explain, why parents' engagement with services and care providers may be experienced as entailing a risk of being discriminated against due to the disclosure of potentially discrediting information.

Considering the centrality of stigma for parents' care experiences, stigma can also be conceptualized as an unintended negative consequence of maternity care services targeting parents in vulnerable positions. Although the notion of vulnerability is not always explicitly used by professionals during encounters with parents, the act of identifying needs and offering support on the basis hereof entails a differentiation of families following the standard care program and families in need of additional support (The Danish Health Authority, 2013; The North Denmark Region, 2017). As argued by Merton all social action can have intended as well as unintended consequences (Merton, 1936), and particularly public health interventions risk unintended negative psychosocial consequences, such as fear, stigma and social discrimination (Allen-Scott et al., 2014). However, by drawing on theoretical concepts, by comparing with similar interventions in other settings and by talking to stakeholders in the area that hold context-specific knowledge, potential negative consequences of interventions can be anticipated (Bonell et al., 2015). Thus, the study findings can inform future intervention development to consider stigma and its impact on care experiences and service engagement.

4.1.4. THE TENSION BETWEEN SUPPORT OR SURVEILLANCE

The study findings tie into an often-discussed theme in the research literature concerning the role of surveillance when caring for vulnerable, pregnant women and their partners, which can make it difficult to establish a trusting relationship between parents and professionals (Harvey et al., 2015; Marcellus, 2005; Peckover & Aston, 2018; Rayment-Jones et al., 2019). Working with pregnant women at-risk of having their children removed, midwives have reported that the dual role of advocacy and support as well as surveillance and reporting is challenging. As the midwife's responsibility is both for the health and well-being of the mother and her unborn child, conflicting interests can cause friction in the relationship to the pregnant woman and make it difficult to establish trust (Everitt et al., 2017). In a Danish context, Klode et al also reported that professionals working with pregnant women in vulnerable positions find the balance between care and control difficult, as they wanted to support the woman in her parenting role, whilst at the same time had to be aware of potential risks for her and her baby (Klode et al., 2020).

Similarly, the findings of this study show that the tension between support and surveillance can make it difficult for parents to disclose potential problems or reach out for support from professionals. Although intended as supportive, receiving targeted services can be associated with being under surveillance, which contribute to fear and insecurity (Jack et al., 2005; Jakobsen & Overgaard, 2018). As also discussed in paper 1 and 2, contextualizing parents' care experiences in the light of surveillance illustrates, why parents can find service engagement difficult as parents do worry about telling their story to professionals, prefer not being assigned a new professional or have reservations about information being shared between those involved in their case (Frederiksen et al., 2021b, 2021c). When service engagement is associated with some level of risk, parents feel exposed or vulnerable during encounters with professionals (Frederiksen et al., 2021b).

To address the tension between support and surveillance, transparency and clear communication can be a useful strategy; however, this necessitates that professionals are reflexive about their own role (Marcellus, 2005; Peckover & Aston, 2018). A similar argument has been put forward by Peckover and Aston (2018), as any relationship is imbued with power, and surveillance is an integral part of the work of health visitors and public health nurses, as well as other professionals:

> *"One of the key messages arising from our discussion is that practitioners, by better understanding how their role can be experienced by mothers, can thus become more aware of their own practices of surveillance. Often they present themselves as friendly and supportive and do not conceptualize their role in terms of surveillance or control."* (Peckover & Aston, 2018, p. e387).

Thus, although surveillance and the unequal power relationship cannot be eliminated, professionals can unintendedly induce fear and potential stigma if not reflexive about how their own role is perceived by parents and understand why and how their role can indeed be experienced as highly intimidating. This is particularly important considering the multiple ways that parents can experience fear and other negative feelings during encounters with professionals.

4.1.5. VULNERABILITY AND NEEDS-BASED MATERNITY CARE SERVICES

As this study highlights, the care experiences of parents in vulnerable position are influenced by the organization of the maternity care sector, including the identification of vulnerability and the practice of needs-based maternity services. This entails a differentiation into care-levels as exemplified in the Danish context (The Danish Health Authority, 2013), and ‘vulnerable families’ as a target group eligible of additional support is thus constructed. As the concept of vulnerability can be deficit-oriented and stigmatizing (Brown, 2011), professionals need to be attentive to the fact that being identified with psychosocial vulnerability and offered services beyond the standard care program can be an ambivalent experience for parents themselves.

Moreover, as demonstrated in this study, different perspectives on vulnerability exist, which present another challenge to ensure that the needs of the family are adequately met. A recent Danish study highlight that maternity care providers interpret vulnerability based on their professional background, which result in fluid, and at times, divergent perceptions regarding the assessment of vulnerability (Klode et al., 2020). Also, another new Danish study found that general practitioners distinguish between obvious vulnerability in pregnant women, for example psychiatric disorders or a history of childhood abuse, and intangible vulnerability related to e.g. poor mother-infant bonding or lack of self-care, where they felt they had to rely on ‘a gut feeling’. Consequently, they experienced that they in hindsight had either overemphasized or underestimated vulnerability in some situations (Brygger Venø et al., 2021).

This highlight that the assessment of vulnerability is open to interpretation with the possibility that value judgement influence the assessment and can vary among and within health professions with potential consequences for identification of support needs and referral to services. Furthermore, in line with this study, others have found that differences in perspectives may also exist between families and professionals (Barlow et al., 2005; Jakobsen & Overgaard, 2018). As health needs is identified and addressed in parent-professional encounters, as argued by Chalmers in her health visiting study back in 1993 (Chalmers, 1993), it can be viewed as a social process in which negotiation and interpretation takes place. Considering the discussed tension between support and surveillance, ensuring needs-based services can prove challenging as it raises a discussion regarding, who has the power to define and identify a family’s needs for support and subsequently ensure that this need is being addressed, which becomes further complicated by divergent – and potentially conflicting – perspectives both among professionals and between professionals and families.

To assist professionals in identifying vulnerability and offer needs-based maternity services, systematic screening tools are recommended, but as earlier described, midwives and health visitors find this challenging as it risks overlooking strengths and resources (Appleton & Cowley, 2004; Aston et al., 2014; Schmied et al., 2020). A contextual approach to vulnerability is thus needed, which is in line with the argument put forward by Colciago et al (2020):

> *"Given that vulnerability is highly context-specific, all healthcare professionals need to be able to determine the risks within the woman's context. A woman who lacks a health determinant could be well supported in her own environment as, vice versa, apparently healthy women may have environmental risk exposure."* (Colciago et al., 2020, p. 8).

Moreover, without disregarding the etic perspective on vulnerability as social and/or psychological challenges can present a risk to the health of the woman and her child, the emic perspective needs to be incorporated as well (Spiers, 2000). This can potentially avoid parents feeling left out of the decision-making process, which as highlighted in this study as well as the existing literature (Ebert et al., 2014; McLeish & Redshaw, 2019) is a recurring challenge reported by parents. Consequently, during the process of identifying vulnerability and referring to services, inclusion of parents' perspectives is important to ensure that the planning of care is in alignment with their experienced challenges and need for support.

As this study also illustrates, the practice of needs-based maternity care services necessitates easy referral pathways, and that services are available in the community to ensure that once a need for support has been identified, appropriate action is undertaken. As described in paper 3, failure at securing referral to appropriate service can lead to fragmented care experiences (Frederiksen et al., 2021a). For professionals, however, matching parents and services may prove challenging as it is contingent on the organization of services, the often highly diverse needs of parents in vulnerable positions and the professionals' qualifications, as reported in a recent Danish evaluation (The Danish Health Authority, 2018). To ensure that parents' health needs are addressed and hereby that their health and well-being is improved, the current study findings thus highlight the importance of providing appropriate, individualized and high-quality care for pregnant women and parents in vulnerable positions as this has a strong impact on their care experiences.

4.2. DISCUSSION OF METHODOLOGY

4.2.1. RESEARCH DESIGN AND METHODS

Research design

To generate in-depth knowledge on the care experiences of parents in vulnerable positions, I chose an ethnographic research design positioned in the hermeneutic paradigm. This allowed for the research process to be highly flexible and enabled me to adopt an open, curious and non-standardized approach to the collection of data (Moules et al., 2015; Patterson & Williams, 2002; Vandermause & Fleming, 2011).

This proved particularly useful to navigate a complex field of study, consisting of a range of different stakeholders as well as diverse settings, including clinical settings as well as the homes of participants. Midwives and health visitors typically had busy schedules with different periods of heavy workloads. Also, the participating parents were affected by psychosocial challenges in varying degrees, as well as had an everyday life with a newborn infant. This called for increased flexibility to adjust scheduled appointments accordingly. Even though this at times proved frustrating, applying the ethnographic research design offered me a possibility to accommodate the unpredictability of the field of study (Hammersley & Atkinson, 2007), which I as an experienced fieldworker did not find too difficult to adjust to.

One limitation of a hermeneutical perspective however is that it can be difficult to analyze structural factors. Gadamer has been criticized for not being able to challenge power relationship and ideology, and it has been argued that he has a conservative perspective on knowledge and tradition (Schmidt, 2006). During the course of the study I became more attuned to how societal and structural factors impacted on the experiences of parents in vulnerable positions, both in terms of the challenges they were facing, and the care they received. Through the application of a poststructuralist approach inspired by Michel Foucault, I would have been able to focus on power relations and the production of subjectivities (Villadsen, 2020).

However, in light of the overall research objective, the hermeneutical perspective did prove suitable to acquire in-depth knowledge on the care experiences of parents in vulnerable positions. Furthermore, from a hermeneutical perspective, interview data is not merely a reproduction of people's inner thoughts and feelings as the analytical endeavor lies in placing these subjective experiences in a wider context that moves beyond each individual case (Kristiansen, 2020). I was thus still able to interpret how parents' care experiences were conditioned by larger social processes by placing their experiences in a dialogue with the existing research and anthropological and sociological theory as well as the empirical context of targeted maternity care services in Denmark.

Data collection

As part of the ethnographic research design, interviews and observations were conducted simultaneously. Although not all participants were followed for a longer period of time, the longitudinal design enabled that I could spend prolonged time in the field. When parents invited me to follow them for a shorter or longer period and agreed to participate in observations and/or multiple interviews, this allowed me to gain in-depth understanding about their experiences. Although observational data does not give direct insight into parents' experiences but is more suitable to explore social practices (Maddens, 2010), it could be argued that the decision to use this method does not sit well with the study's overall focus on parents' experiences.

However, by conducting observations, I was able to observe parent-professional encounters as they took place in practice. By conducting interviews alongside I was able to explore parents' experiences prospectively and their immediate thoughts and reactions following these encounters. Also, it enabled me to ask questions that was directly related to what I had observed as well as follow up on any developments in the care they received. Overall, the combination of interviews and observations furthered my understanding of the field and allowed me to contextualize the interviews as well as contextualize the observations based on what I was discussing with parents during interviews. Thus, it was a useful method to generate in-depth knowledge on parents' experiences during pregnancy and the postnatal period.

Analytical strategy

Thematic analysis was chosen as an analytical strategy; however, this decision also presented some challenges. One limitation concerns the difficulties with including temporality in the presentation of data in contrast to narrative and biographical perspectives (Braun & Clarke, 2006). In this study, the temporal aspects of parents' experiences were difficult to contain when assigning codes to the empirical data, for example when multiple observations and interviews had taken place. To mitigate this, different strategies were pursued. First of all, larger bits of data were coded to remain contextual information (Braun & Clarke, 2006). Secondly, parents' care pathways were mapped to be able to contextualize extracts in the light of their broader trajectory. In hindsight, a narrative approach would have contributed with novel insights on how parents make sense out of their experiences over time.

The thematic analysis overall did prove useful as it enabled me to identify similarities and differences across a large data set with a heterogenous group of parents. Although it can be difficult to identify central themes if the included cases are too diverse, this is the strength of the maximum variation strategy by identifying common patterns across variation (Patton, 2002), which also proved highly useful to identify significant themes that were shared among the participating parents despite their differences.

4.2.2. RECRUITMENT STRATEGY

A strength of this study relates to the diversity of families that were recruited as they differed highly in their life situations, age, marital status, parity, educational level, socio-economic position and vulnerability factors. However, variability was not achieved in ethnicity as only very few ethnic minorities participated. Also, the heteronormative disposition of the participating groups points to that further variability could be have been achieved if different family forms had been recruited. Lastly, no participants shared experiences with gender-based violence. Overall, some groups of potential participants have not been successfully recruited even though their voices would have been important for the purpose of this study, considering that for example gender-based violence and ethnicity are associated with adverse health outcomes and negative care experiences during pregnancy and the postnatal period (Dahlen et al., 2018; De Graaf et al., 2013; Howard et al., 2013; Raleigh et al., 2010).

However, as previously described, recruitment was a challenge in this study, mirroring general challenges in research with participants in vulnerable positions (Ellard-Gray et al., 2015; Horowitz et al., 2002; Mirick, 2016; Nordentoft & Kappel, 2011). Invitations to participate distributed on social media and printed posters and flyers prompted very few responses from parents. Although such recruitment strategies have been shown to be effective, they rely on participants initiating the first contact, which in the context of vulnerable and potentially distressing life situations may not be the best strategy (Mirick, 2016).

As also discussed in the papers (Frederiksen et al., 2021b, 2021c, 2021a), health visitors and midwives played a central role in the recruitment, as they had direct access to identify and invite potential families. Collaboration with key stakeholders in the community are useful to gain access to the field, particularly in the context of participants in vulnerable positions (Ellard-Gray et al., 2015; Rockliffe et al., 2018). Conversely, stakeholders also want to protect their clients if they find them too vulnerable, and they can worry about jeopardizing their own fragile relationship (Williams, 2020). Thus, there is a risk that parents with primarily positive experiences were invited due to an existing trusting relationship with health care providers. This may have left out parents with highly negative experiences, and parents who did not engage with any services or providers at all. Moreover, some parents may not have been invited if they were found too vulnerable to participate. However, despite these potential barriers, most participants shared positive and negative experiences during our interviews, and the use of midwives and health visitors does not seem to have impacted on the study's overall findings.

Overall, the difficulties with recruitment, low response and the reasons potential participants gave for declining can also be seen in the light of the reported fear of being judged and fear of consequences (Frederiksen et al., 2021b). Despite these challenges, the flexibility of the recruitment strategy and the adjustment of methods along the way allowed for the desired number of participants to be recruited and to reach the aim of maximum variation. Also, the many hours I spent in the field enabled me to form trusting relationships to families and professionals, which proved essential for the recruitment and can be a good strategy for future studies to adopt as well.

4.2.3. INCLUDING BOTH PARENTS IN THE RESEARCH

Although the recruitment strategies proved successful to invite mothers, it was less suitable to recruit fathers. Often, the father was not present during consultations and home visits, and this limited the possibility for me to personally present the project. The participating fathers were recruited through the couple's health visitor; however, further arrangement always took place between me and the woman. In some cases, the father was recruited after the mother had already participated in an interview. In both situations I was thus reliant on reaching the father through his partner, and it might have proved beneficial to find ways to address the fathers more directly.

Moreover, this may explain why fathers had a preference for participation in dyad-interviews. During dyad-interviews one partner may be more active during the interview, and consequently, both voices may not be equally included (Zarhin, 2018), which also was the case in this study as fathers in general spoke less during interviews. The decision to let the parents decide can thus have contributed to less in-depth knowledge on their experiences. Consequently, as fewer fathers than mothers were recruited, as they spoke less during interviews and as less time in general was spent with them, the mothers' voices dominate the study findings.

Conversely, letting the couple decide what type of interview they preferred may have contributed to the inclusion of partners due to the possibility of being interviewed together. In this way, by striving to incorporate both parents' perspectives the study contributes to a sparse field of research although modestly. Even though the majority of fathers did not have first-hand experiential knowledge with vulnerability, their everyday lives and transition to parenthood were shaped by their partners' challenges. To understand their experiences and perspectives on the services they receive, and how this enable them to support their partner, is thus an important area that calls for further research in the future.

4.2.4. ETHICS AND REFLEXIVITY

One central ethical dilemma in qualitative research concerns the production of knowledge through researcher-participants relationships as these relationships are temporal and established with the aim to produce scientific knowledge (Hume & Mulcock, 2004; Tjørnhøj-Thomsen, 2003). In this study, this ethical challenge arose as I became deeply involved in the lives of the participating families.

The balance between protecting vulnerable subjects and allowing their voices to be included (Nordentoft & Kappel, 2011) proved challenging in this study. As the majority of parents had been through difficult or traumatic experiences, either in the past or currently, I was concerned whether inviting parents to share their experiences would cause increased distress.

In hermeneutical research, respecting the autonomy of individuals and not merely as a means to an end has been highlighted (Michrina & Richards, 1996), which guided how I navigated ethical dilemmas that arose in my relationships to parents. This was handled through adopting an empathetic, non-judgmental and respectful approach to families, as recommended by Newton based on her study on abortion (Newton, 2017). To navigate the power imbalance that can exist in researcher-participant relationships, Newton emphasizes the importance of *"(...) being respectful and responsive, talking to participants as an equal, and in that, to be kind, supportive and friendly"* (Newton, 2017, p. 95). Also, as human emotions are integral to doing qualitative research, particularly on sensitive topics, this requires that researchers respond on a personal level (Dickson-Swift et al., 2007). Although the aim was to collect data during encounters with parents, I would always respond to them and their children on a personal level, for example if they were distressed, or if a need for practical support arose during a visit, such as tending to their baby.

Furthermore, this ethical dilemma was handled by exploring parents' reasons for and feelings about participation. Some were motivated to help others, raise awareness about mental illness or improve services, whereas others articulated the importance of being listened to, sharing their story or having company. Others wanted to show gratitude, whereas other were driven by anger and frustration. Alexander similarly identified that participants in vulnerable positions participate for various reasons, including for a therapeutic, altruistic or social purpose (Alexander, 2010; Alexander et al., 2018). Also, Newton highlights the potential therapeutic benefits of being able to tell their story, listened to and met without judgment (Newton, 2017).

Moreover, the emotional work involved when conducting research on sensitive topics, has been highlighted (Dickson-Swift et al., 2007, 2009). Parents' stories of trauma and suffering, including for example mental illness or adverse childhood experiences, had a deep impact on me and struck an emotional and personal note. During the research process, this was handled by allowing myself to feel the impact of their stories and use this proactively in the writing as it reminded me of the importance of the research project, whilst also discussing the findings with my supervisors to regain an analytical distance. In the process of writing up the analysis and present the findings, these considerations continued to linger. This was handled by allowing their voices to be heard whilst also protecting their identify.

4.2.5. TRUSTWORTHINESS

Inspired by Guba and Lincoln's criteria for assessing trustworthiness in qualitative research (Lincoln & Guba, 1985), as outlined by Nowell et al (Nowell et al., 2017), I I will discuss the study's credibility, dependability, transferability and confirmability.

Credibility concerns a study's internal validity (Nowell et al., 2017). As suggested by Whittemore et al, credibility is also a question of authenticity, and the degree to which the researcher succeeds with writing about other peoples' experiences that resonate with the reader, whilst staying 'true' to the phenomenon being studied (Whittemore et al., 2001). The idea of staying true to the social field under study is however less a question of representing this in a positivist sense, but rather relates to whether the knowledge reflects the social field in a reflexive way (Hastrup, 2004). To enhance the study's credibility, I have strived to demonstrate that the developed themes, analytical points and general knowledge claims are deeply rooted in the empirical material by allowing interview and observational data to be extensively used in the presentation. Moreover, as discussed in paper 2 (Frederiksen et al., 2021c), audience and peer validation were used (Kvale & Brinkmann, 2018), as I engaged in a reflexive dialogue with midwives and health visitors as well as with my supervisors, to whom preliminary findings were presented and discussed at conferences, presentations and meetings throughout the process. Also, the ongoing encounters with parents allowed for a reflexive practice and to go back to the field with preliminary ideas. Lastly, the iterative process between the empirical data, theory and writing (O'Reilly, 2004) allowed for a constant dialogue to 'check' the soundness of my interpretations.

Transferability concerns whether the study findings can be generalized to other settings (Nowell et al., 2017). This study has taken place in a Danish municipality and explored the experiences and perspectives of a particular group of parents at a specific time period. Although ethnographic knowledge is highly contextual as it is tied to a particular time and place and produced in the relationship between researcher and participants (Hastrup, 2004), it is also characterized by moving between particularity and universality, and it is thus possible to generate more general knowledge claims (Geertz, 1973). The provision of thick description allows the reader to identify differences and similarities between study settings and to critically examine whether it can be generalized to other settings (Nowell et al., 2017). Without compromising the anonymity of participants, I placed the findings in the service provision context and the personal lives of participants and the challenges they faced. The context is important to take into consideration when applying the findings to parents with other psychosocial vulnerability factors or in settings with different health care sectors and systems, which may differ from the Danish context as described in this study. As described above, study is limited by not including ethnic minorities and gender-based violence, and further research on this topic in Denmark is therefore needed.

Dependability refers to the consistency of a study, which can be achieved through transparency about the research process (Nowell et al., 2017). In ethnography, transparency does not serve to enhance a study's reproducibility, but rather makes it possible for the reader to critically reflect upon the conditions under which the knowledge has been produced, and the methodological choices made by the researcher (Sanjek, 1990). In this study, I have worked to strengthen the study's dependability by being transparent about the methodology, for example how the study was developed in collaboration with practice, the research design and theoretical orientations to medical anthropology, the recruitment of parents, and transparency about data collection and analysis. Also, I have critically reflected upon challenges that occurred, how these were addressed as well as potential consequences for the study findings. By providing insight into the research process, including the study's strengths and limitations, this thus allows the reader to examine the study's dependability.

Confirmability includes the plausibility of the study findings (Nowell et al., 2017). To strengthen my interpretations I have placed the findings in a dialogue with the existing research literature as a way of confirming the study results, but also to examine how the study findings could either challenge or add to the research. Furthermore, a study's confirmability is also contingent on its credibility, transferability and dependability (Nowell et al., 2017). Through the above-mentioned strategies, I have striven towards ensuring transparency regarding all steps of the research process, which overall enhances the study's trustworthiness.

CHAPTER 5. STUDY IMPLICATIONS

The findings presented in this study are particularly relevant to health visitors and midwives, who are working with parents in vulnerable positions during pregnancy, birth and the postnatal period. However, the findings are also relevant to other professionals working with these parents during this time such as social workers, obstetricians or general practitioners.

Given the importance of establishing and maintaining trusting parents-professional relationships to assist parents to meet their goals, it is critical that health care organizations implement models of care and strategies that facilitate relational care. These strategies are required at the individual level, as well as at the organizational level.

At an individual level, the findings highlight that professionals need good relational and communicative skills to be able to approach parents in a non-judgmental way and engage in conversations about their lived experiences and perceived needs for support. Also, professionals need to be attentive to the fact that being identified with psychosocial vulnerability and offered services beyond the standard care program can be an ambivalent experience for parents themselves. In light of recent policy changes and an increased political focus on targeted maternity care services in the North Denmark Region (The North Denmark Region, 2017), further qualification and education of midwives and health visitors may be required. As encountering supportive care practices are particularly important for parents in vulnerable positions, it is paramount that professionals also feel adequately equipped to undertake this line of work.

The findings also emphasize the significance of professionals being reflective about their own role, and how this role is perceived by parents. Even though identification of vulnerability and referral to supportive services is intended as helpful, and that midwives and health visitors are working to support families, it is paramount to reflect upon that this can be experienced very differently by parents due to the tension between support and surveillance. This can further our understanding of why care engagement can create ambivalence in parents and make service engagement difficult or even intimidating. In their practices, professionals can support parents by taking their time to explain the purpose of services, their own role as well as talking with parents about their potential concerns and fears. Clear communication and transparency are required to avoid producing further fear and stigma and to establish trusting relationships.

On an organizational and service system level, policies that support all forms of continuity are recommended, including relational, informational and management continuity, which as demonstrated is important to ensure coherent care pathways for parents in vulnerable positions. Ensuring continuity of midwifery care during pregnancy and where possible during birth is particularly important, as well as providing continuity of carer in health visitation services. Also, the findings demonstrate that the identification of vulnerability and the practice of needs-based services requires that midwives and health visitor have sufficient time to get to know the families in their care as well as flexibility to adjust their care to the family's individual situation as it changes over time to ensure that their health needs are addressed and that this is in accordance with the family's own experiences on the situation.

In line with this, the findings also demonstrate the importance of ensuring easy access to services, and that a varied suite of evidence-based services is available in the community considering the heterogenous needs of the families. At a services system level it is thus important to find ways to ensure smooth referral pathways and improve coordination and communication between services and providers to avoid that parents experience fragmented care, and that their care needs remain unaddressed. The findings particularly underline the urgency of securing support for parents facing perinatal mental health problems as early as possible to minimize the impact on the mother, child and family.

CHAPTER 6. CONCLUSION

The study set out to develop new, in-depth knowledge on the care experiences of Danish parents in vulnerable positions during pregnancy and the postnatal period to contribute to the development of care practices and the organization of maternity care services for this group.

One significant findings to emerge from this study is that the experience of fear is central to parents' care experiences (Frederiksen et al., 2021b). As parents worry about suffering from mental health issues, about being inadequate parents and thus having a negative impact on their children, about being judged and about negative consequences of service engagement, this illustrates that multiple and often co-existing fear are experienced. Rather than viewing the experience of fear as a barrier to overcome, fear arise in and in respond to social situations. Consequently, to understand how and why parents experience fear, these experiences have to be contextualized within their life trajectories, their care journeys and their encounters with the maternity care system (Frederiksen et al., 2021b).

The study also adds to the existing body of literature by identifying key elements of supportive parent-provider encounters (Frederiksen et al., 2021c). Parents value feeling that they are being listened to, met with understanding and taken seriously. Other central aspects include being met on equal terms and feeling reassured they are moving in the right direction. These elements contribute to positive care experiences and make parents feel safe, included and respected, and consequently, find it easier being honest and reaching out for support. In the absence of these practices, parents are however more likely to feel afraid, excluded and judged, which potentially adds to existing feelings of fear and stigma and contribute to highly negative care experiences. Overall, this finding highlights the significance of the approach taken by professionals (Frederiksen et al., 2021c).

To avoid fragmented care experiences, the study underlines that continuity of carer is significant for parents' care experiences as this allows for the development of trusting relationships and give parents a sense of security (Frederiksen et al., 2021a). However, continuity of carer is not enough to ensure coherent care as parents in vulnerable positions often face complex challenges requiring services spanning disciplines and sectors. It is therefore also central that parents experience that information about their individual situation is shared between services and providers, and that parents experience being referred to and having access to relevant services that matches their need for support. Thus, all types of continuity of care are important to ensure coherent care pathways for parents in vulnerable positions (Frederiksen et al., 2021a).

Overall, contextualizing care experiences in the light of parents' lived experiences illuminates, how they interpret and make sense out of their current situation and challenges and their rationales for engaging or disengaging with services and providers. The knowledge that parents often carry past or current difficult experiences with them and can have negative and positive experiences of prior service engagement illustrates that their lived experiences shape their expectations to and anticipation of pregnancy and parenthood as well as encounters with professionals and services.

Moreover, understanding parents' care experiences in the context of trusting relationships highlights that this is essential for parents to feel safe and supported. Trusting relationships can be developed and maintained through repeated positive interactions, including supportive care practices (Frederiksen et al., 2021c) and continuity of care (Frederiksen et al., 2021a). Importantly, the parent-provider relationship is inherently fragile as the experience of trust is not static but highly contingent on how parents' care pathways unfold over time.

The care experiences of parents in vulnerable positions are furthermore impacted by processes of stigmatization as psychosocial vulnerability can be viewed as conflicting with societal norms about parenthood. Parents thus face a dilemma between telling and withholding information as the disclosure of potentially discrediting information entails a risk of being discrimination against. Consequently, engaging with services, seeking out support and being honest is difficult as it is impossible to fully anticipate how professionals will respond, particularly as an unequal power relationship exist-

Moreover, parents' care experiences have to be understood in the context of the maternity care sector due to the felt tension between support and surveillance. Although midwives and health visitors are working to support families, surveillance is also integral to their work. As parents find it difficult to decipher the purpose of services and worry about negative consequences, service engagement is experienced as ambivalent. Transparency and clear communication are thus important to explain the purpose of services and the professional's role and to address the parents' concerns and fears.

Lastly, the care experiences of parents in vulnerable position are influenced by the organization of the maternity care sector, including the practice of needs-based maternity services and availability of services. This can prove challenging due to divergent perspectives on vulnerability with subsequent consequences for referral to services. Inclusion of parents' perspectives is important to ensure that the planning of care is in alignment with their experienced challenges and need for support. Moreover, once a need for support has been identified easy referral pathways and available services are necessary to ensure coherent care experiences.

Overall, by giving voice to a group of parents, whose voices are seldomly included in research and policies, the study contributes with in-depth knowledge on their care experiences during pregnancy and the postnatal period. These experiences have to be placed within the context of the parents' lived experiences, their relationship with professionals, processes of stigmatization, the felt tension between support and surveillance as well as the practice needs-based maternity services targeting parents in vulnerability positions. By identifying key elements that have an impact on parents' care experiences, the study findings thus contribute to the development of care practices and the organization of services for these families.

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APPENDICES

APPENDIX A. POSTER INVITATION

AALBORG UNIVERSITET

Mit navn er Marianne, jeg er 30 år og bosiddende i Aalborg. Jeg arbejder til daglig på Aalborg Universitet, hvor jeg er i gang med et forskningsprojekt om de støttende tilbud familier modtager i forbindelse med graviditet, fødsel og barsel. Som en del af dette projekt vil jeg derfor være til stede i jordemodercenteret de næste par måneder. Du/I kan blandt andet møde mig i Cafe Babystart eller konsultationen.

HVAD GÅR PROJEKTET UD PÅ?

Formålet med undersøgelsen er at få mere viden om, hvordan familier i Aalborg Kommune, der oplever sårbarhed i forbindelse med graviditet, fødsel og barsel , oplever den hjælp og støtte de får tilbudt, hvilke behov og ønsker familierne har, og hvordan man bedst kan imødekomme disse.

Erfaringerne fra undersøgelsen vil blive brugt til at udvikle fremtidige tilbud og indsatser for familier, der har brug for ekstra hjælp i forbindelse med forældreskabet - og projektet vil på den måde være til gavn for andre familier.

Undersøgelsen foregår i et samarbejde mellem Aalborg Kommune og Aalborg Universitet, og gennemføres af undertegnede, der er antropolog og ansat ved universitetet. Projektet løber fra nu og frem til afslutningen af 2019.

HAR DU LYST TIL AT DELTAGE?

For at jeg kan finde frem til, hvordan man bedst kan imødekomme familiers ønsker og behov, har jeg brug for at tale med dem, det handler om, nemlig jer forældre!

Da hver families situation er unik, vil jeg derfor gerne høre om netop jeres overvejelser og tanker, omkring de tilbud I bliver tilbudt for at undersøge, hvornår I oplever at blive hjulpet godt på vej, og hvornår der kan være brug for yderligere hjælp.

Hvis I har lyst til at dele jeres erfaringer med mig, kan jeg kontaktes på tlf. 30 28 13 63 eller på mail msf@hst.aau.dk.

Med venlig hilsen

Marianne Stistrup Frederiksen

APPENDIX B. INFORMATION MATERIAL

Modtager din familie støttende tilbud i forbindelse med graviditeten, fødslen og/eller barslen?

Og har du/I lyst til at dele lige netop jeres erfaringer i en undersøgelse?

Så vil jeg gerne høre fra dig!

AALBORG UNIVERSITET

HVAD GÅR PROJEKTET UD PÅ?

Formålet med undersøgelsen er at få mere viden om, hvordan familier i Aalborg Kommune, der oplever sårbarhed i forbindelse med graviditet, fødsel eller barsel oplever den hjælp og støtte de får tilbudt, hvilke behov og ønsker familierne har, og hvordan man bedst kan imødekomme disse.

Erfaringerne fra undersøgelsen vil blive brugt til at udvikle fremtidige tilbud og indsatser for familier som oplever sårbarhed og vil på den måde være til gavn for andre familier i Aalborg såvel som andre steder.

Undersøgelsen foregår i et samarbejde mellem Aalborg Kommune og Aalborg Universitet, og gennemføres af undertegnede, der er antropolog og ansat ved universitetet.

AALBORG UNIVERSITET

HVORFOR VIL JEG GERNE HAVE DIN HJÆLP?

For at jeg kan finde frem til, hvordan man bedst kan imødekomme familiers ønsker og behov, har jeg brug for at tale med dem, det handler om, nemlig jer forældre!

Hver families situation er unik. Jeg vil derfor gerne høre om netop dine/jeres tanker og overvejelser omkring de tiltag du/I bliver tilbudt, samt hvad der har betydning for, at lige netop din/jeres familie oplever at blive hjulpet godt på vej, eller hvornår der kan være brug for yderligere hjælp.

HVORDAN SKAL DET FOREGÅ?

For at få indblik i jeres erfaringer vil jeg gerne lave et eller flere interviews i løbet af projektperioden. Et interview vil vare omkring en times tid og minde om en åben og uformel samtale.

Da det vil give mig mulighed for en dybere forståelse af oplevelser og erfaringer med den støtte, I får tilbudt, og hvordan den hjælper jer eller kunne forbedres, vil jeg herudover meget gerne følge jer over en periode og være med på sidelinjen, når du/I har kontakter med sundhedsplejersken eller andre fagpersoner, eller når du/I deltager i aktiviteter som forældrekurser, mødregruppe mv. Du/I bestemmer helt selv, hvad jeg eventuelt må være til.

AALBORG UNIVERSITET

HVOR OG HVORNÅR?

Hvor vi mødes, er helt op til dig/Jer. Alt efter hvad du/I foretrækker, kan vi mødes hjemme hos dig/jer selv, et sted i nærheden af, hvor du bor (f.eks. et lokalt bibliotek) eller tage en snak, mens vi går en tur med barnevognen. Vores møder kan foregå, alt efter hvordan det passer ind i dit/jeres program.

Projektet løber fra nu og frem til afslutningen af 2019. Du/I vælger selv, hvor længe du/I vil deltage i løbet af denne periode og hvor meget, vi skal have kontakt.

HVAD FORVENTES DER AF DIG/JER?

Der er ikke særlige krav til dig/jer i forhold til at være med, og du/I skal ikke forberede noget inden vores samtaler. Det vigtigste er, at du/I tid og lyst til at dele dine/jeres erfaringer med mig og på den måde være med til at bidrage til forskningsprojektet.

Vi planlægger din/jeres deltagelse, så det passer dig/jer bedst.
skal har

VIGTIGT:

- Vores samtaler vil blive optaget på lydbånd for at disse kan anvendes til forskning. Disse samtaler vil opbevares sikkert på en låst computer, der kun kan tilgås af mig, og vil ikke blive delt med kommunen eller ansatte, herunder sundhedsplejersken og andre fagprofessionelle.

- Hvis noget af det, du/I har sagt, bliver brugt i projektets rapport, vil du/I være anonym, og jeg vil behandle dine/jeres historier fortroligt og med stor respekt.

- Der vil altid være mulighed for at trække sig fra projektet, uden at det har nogen form for konsekvenser for de tilbud, du/ I får fra sundhedsplejersken, andre fagpersoner eller kommunen i øvrigt.

Du/I vil blive inviteret af din/jeres jordemoder, sundhedsplejerske eller mig. Du/I er desuden velkommen til at skrive en SMS eller ringe til mig på **tlf. 30 28 13 63** eller alternativt skrive en mail til **msf@hst.aau.dk**. Du/I er også velkomne til at tage kontakt i forbindelse med spørgsmål til projektet.

Venlig hilsen
Marianne Stistrup Frederiksen

Antropolog
Aalborg Universitet

APPENDIX C. INFORMED CONSENT FORM

Informeret samtykke til forskningsprojekt

Forskningsprojekt om småbørnsforældres perspektiver på støttende tilbud i forbindelse med graviditet, fødsel og barsel

Erklæring fra projektdeltager:

Jeg har fået skriftlig og mundtlig information om projektet, og jeg ved nok om dets formål, metode og brug af data til at sige ja til at deltage.

Jeg er blevet informeret om, at det, jeg fortæller, eller oplysninger om mig, ikke videregives til andre og opbevares, så det kun er forskeren, som har adgang til disse.

Hvis min historie inkluderes i forskningsprojektets analyse og formidling, er jeg blevet informeret om, at mine personlige oplysninger som navn, bopæl, arbejde mv. vil blive anonymiseret.

Jeg ved, at det er frivilligt at deltage, og jeg ved, at jeg altid kan trække mig fra projektet uden at dette har betydning for de tilbud, jeg modtager.

Jeg giver samtykke til at deltage i forskningsprojektet og har fået en kopi af den skriftlige information om projektet til eget brug.

Projektdeltagerens navn: ____

Dato: ____

Underskrift: ____

Tillader du, at forskeren får indsigt i din journal i forbindelse med projektet?

Ja ____ (sæt x) Nej ____ (sæt x)

Tillader du, at forskeren taler med de fagpersoner, som er involveret i de støttende tilbud, du modtager i forbindelse med projektet? Oplysninger, du har givet forskeren, vil ikke blive videregivet til din sundhedsplejerske, jordemoder eller andre fagpersoner i forbindelse med dette.

Ja ____ (sæt x) Nej ____ (sæt x)

Erklæring fra den, der afgiver information:

Jeg erklærer, at informanten har modtaget mundtlig og skriftlig information om projektet.

Projektforskerens navn: ____

Dato: ____

Underskrift: ____

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