

**Woman-centred care and the socially
disadvantaged woman: an
Interpretative Phenomenological
Analysis.**

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Statement of Originality

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Publications originating from this study

Ebert, L., Ferguson, A. & Bellchambers, H. (2011). Working for socially disadvantaged women. *Women and Birth*, 24(2), 85-91.

Abstract

Background: Socially disadvantaged women have less choice and control over their maternity care and experience poorer birth outcomes than more advantaged women. Midwifery literature suggests that woman-centred care improves birthing experiences for women. However, challenges in providing socially disadvantaged women woman-centred care have been identified.

Method: This paper reports on literature relating to social disadvantage, health inequalities and birth outcomes within the Australian context as well as international literature regarding interpersonal challenges identified by women and midwives during interactions.

Findings: The establishment of positive, mutually respectful relationships between midwives and women has the potential to improve women's emotional wellbeing, birthing experiences and reduce birthing inequalities. Midwives' ability however, to preserve woman-centred care and develop relationships with women have been identified as challenges when working with socially disadvantaged women.

Discussion/conclusion: Midwives, as the primary health professional group working with birthing women, are in the best position to enhance maternity experiences and improve birth outcomes. The midwifery profession is obligated to strengthen its sociological underpinnings to ensure socially disadvantaged women are supported emotionally as well as physically during pregnancy, birth and their transition to motherhood. Midwifery education must endorse woman-centred care from both a theoretical and clinical perspective to generate stronger midwife-woman relationships and assist in the alignment of ideological stances and practice.

Thesis abstract

Woman-centred care, a midwifery philosophy underpinning maternity care, is defined as care that focuses on the individual woman's needs, providing her with choice, continuity of care and control over maternity services. While woman-centred care is currently the dominate discourse related to midwifery practice, debates concerning the meaning and effectiveness of woman-centred care in practice are occurring. A preliminary step in resolving debates regarding woman-centred care and midwifery practice is to develop an understanding of how the recipients and providers of woman-centred care interpret their experiences.

Aim of study

The purpose of this study was to generate understanding of woman-centred care as experienced by socially disadvantaged women, registered midwives and student midwives who observe midwife-woman interactions during maternity care encounters. The research question presented was - *How do socially disadvantaged childbearing women, registered midwives, and student midwives understand woman-centred care?"*

Research approach

Interpretative Phenomenological Analysis was used to gain an understanding of woman-centred care as experienced by midwives working with socially disadvantaged women, the women for whom the care is provided, and student midwives observing maternity encounters involving socially disadvantaged women. Interpretative Phenomenological Analysis is an approach to qualitative, experiential research informed by concepts and debates from three key areas of the philosophy of knowledge: phenomenology, hermeneutics and idiography. The midwifery concept and maternity care philosophy, woman-centred care, was used to guide the interpretative process when analysing the recounted experiences of participants. Data was collected primarily through focus groups with women, midwives and student midwives over multiple sites in Australia.

Findings

There are two major findings from this study. Firstly, that woman-centred care is largely absent within the maternity care encounters of socially disadvantaged women. Participating women understand that midwives are not available for socially disadvantaged women. When the midwife is unavailable, the woman does not feel valued or safe to engage in their maternity care. The second finding is that socially disadvantaged women have a different understanding of what constitutes woman-centred care than midwives have. While women spoke of the actions and interactions within individual maternity care encounters as being either woman-focused or not, midwives and students spoke of models of care and conditions that either support or hinder woman-centred care.

Conclusion

It is time for midwives to consider how care described by the woman as woman-centred can be implemented within every maternity care encounter and every midwifery context. Midwives need to focus on the conditions which may or may not support them to adopt elements of care perceived, by women, to be woman-centred. Women want a midwife that is available for them. In order for the midwife to be available for the woman and create the conditions in which the woman is able to feel valued and safe, the midwife must equally have available the resources and conditions in which they can feel valued in their midwifery choices and safe in their midwifery voices. Local Health District management needs to make available support systems and resources that enable midwives to be available for socially disadvantaged women. Midwifery practice and education needs to incorporate the concepts *being available*, *being valued* and *being safe* into midwifery and maternity care discourse so that all midwives understand that the provision of woman-centred care is possible in all midwifery contexts and is achievable for socially disadvantaged women.

Keywords:

Woman-centred care, Social disadvantage, Midwifery, Interpretative Phenomenological Analysis

Abbreviations

Abbreviation Full Text

ABS	Australian Bureau of Statistics
ACM	Australian College of Midwives
ACOSS	Australian Council of Social Service
AHPRA	Australian Health Practitioner Regulation Agency
AIHW	Australian Institute of Health and Welfare
ANMC	Australian Nursing and Midwifery Council
CMP	Community Midwives Program
HPL	Henderson Poverty Line
IPA	Interpretative Phenomenological Analysis
IRSD	Index of Relative Socio-Economic Disadvantage
LBW	Low Birth Weight
MGP	Midwifery Group Practice
NSW NMB	New South Wales Nurses and Midwives Board
OECD	Organisation for Economic Cooperation and Development

Abbreviation Full Text

PAD Preference Adaption Theory

RWGPS Rural Women's GP Service

SaCC Schools as Community Centres

SES Socio-Economic Status

UNIFEM United Nations Development Fund for Women

WHO World Health Organisation

Section 1: Seeking new understandings

1 Seeking an understanding

This study explored socially disadvantaged childbearing women's, registered midwives' and student midwives' experiences of woman-centredness in maternity care encounters. Woman-centred care, as both the key concept and the underlying philosophy of maternity care, guides the interpretative process.

1.1 What lead me to this research

Many birthing stories narrated to me by socially disadvantaged women and my readings of the reflective journal entries of student midwives, describing situations that occurred during their clinical placements, sparked my interest in the maternity care encounters of socially disadvantaged women. As a midwifery academic, I read student midwives' reflective journals in which they described maternity care encounters of women being treated poorly by health professionals, including midwives. Students wrote of the incongruities between woman-centred midwifery practice as it was taught in the classroom and midwifery practice as it was observed in the maternity care environment. The professional and personal sadness I felt when reading students' journal entries led me to question whether the concept woman-centred care can be successfully taught in the classroom and assimilated within current midwifery practices and maternity services.

Through a friend working at a local School as Community Centre (SaCC), I was able to listen to stories of socially disadvantaged women's maternity care encounters. Socially disadvantaged women spoke of maternity care encounters where they believed their needs were ignored. This led me to question how socially disadvantaged women understand their maternity care encounters. I considered the issues raised by both students and women and decided they could be explored as one connected topic. My considerations and reflections resulted in a desire to gain an understanding of maternity care encounters as described by socially disadvantaged women and student midwives. The decision to include registered midwives in the study was based on my understanding of the midwives' relationships with both women and student midwives, and their role within maternity care encounters. I thought the addition

of registered midwives' descriptions of maternity care encounters, in which socially disadvantaged women are the recipients of care, would provide further understandings of the socio-cultural factors at work during maternity care encounters.

1.2 Background

Woman-centred care is an internationally recognised concept and is also the name of a philosophy of maternity care which gives priority to the wishes and needs of the user, that is, the childbearing woman (Royal College of Midwives (RCM), 2001).

1.2.1 Woman-centred care

The word midwife means to be with woman, so by its very nature midwifery means to have the woman at the centre of care. Woman-centred care therefore, is defined as care that focuses on the individual woman's needs, providing her with choice, continuity and control over maternity services (Carolan & Hodnett, 2007; M. Johnson, Stewart, Langdon, Kelly & Yong, 2003; Leap, 2009; Pope, Graham & Patel, 2001). While choice and control are described as fundamental to woman-centred care (Carolan & Hodnett, 2007), a woman's choice is enhanced or restricted by the information presented, services available, and care options offered. Restriction of access to choice, therefore, can limit a woman's control over health related decisions.

1.2.2 Social disadvantage

The term social disadvantage is used to describe the life circumstances of people who have a level of income, educational attainment and/or social engagement that is determined to be lower than average for their society. Social disadvantage and health outcomes are closely aligned. Within any society, a person who is classified as socially disadvantaged is more likely to have poorer health outcomes in general and be at higher risk of ill health than those who are not classed as disadvantaged (Cox, 2009). In relation to the childbearing woman, research clearly demonstrates the link between social disadvantage and poor birth outcomes (AIHW, 2008; Luo, Wlikins & Kramer, 2006; Moser, Li & Power, 2003; Pattenden, Dolk & Vrijheid, 1999). Socially disadvantaged

women are at higher risk of premature labour and birth, pre-eclampsia, birthing low birth weight infants and infants requiring admission to neonatal intensive care units (Ceron-Mireles, Harlow, Sanchez-Carrillo & Nunez, 2001; Goffinet, 2005; Huijbregts et al., 2006; Phung et al., 2005) .

Social disadvantage and woman-centred care

Woman-centred care may not be practised equally for all women; not all women experience health care interactions the same. Previous research suggests that socially disadvantaged women have fewer resources from which to find information (M. Brodie et al., 2000) and less choice concerning their maternity care options (Carolan & Hodnett, 2007). They are categorised more often as 'high risk'* and assigned to non-continuity of midwifery carer models of maternity care (Carolan & Hodnett, 2007). Socially disadvantaged women have poorer birth outcomes and a higher maternal mortality rate than the general population of birthing women (Habibis & Walter, 2009; Raisler & Kennedy, 2005). Carolan and Hodnett (2007) report that socially disadvantaged women's experiences of maternity services are likely to be different to the experiences of women of higher socio-economic status. Women of lower socio-economic status understand their maternity care is of lower quality than women of higher socio-economic status and express being powerless to change the situation (McCourt, 2003). Furthermore, Stapleton, Kirkham, Curtis and Thomas (2002) argue that women are socially positioned through discourse used within maternity care encounters and that health professionals will often judge women and offer what they perceive to be appropriate choices.

1.2.3 Midwifery in Australia and woman-centred care

The Australian College of Midwives, based on the words with woman, states that midwifery is a woman-centred health care discipline, founded on the relationship between a woman and her midwife (Australian College of Midwives (ACM), 2004). Woman-centred care is the overarching framework of the Australian Nursing and Midwifery Council's (ANMC) National Competency Standards for the Midwife (Australian Nursing and Midwifery Council (ANMC), 2006), and the guiding framework for the Code of Ethics for Midwives in Australia (ANMC, 2008).

During 2010, Australia introduced a national midwifery registration authority - the Nursing and Midwifery Board of Australia (Australian Health Practitioner Regulation Agency (AHPRA), 2010) and national accreditation standards and criteria for midwifery education programs (ANMC, 2009). There are nine standards that educational institutions must fulfil to meet national accreditation. Each standard has a statement of intent which informs the institution of both the rationale behind the standard and how the standard can be translated into models of teaching and practice. Standard eight - *professional experience* states, "the course provider demonstrates policies, procedures, processes and practices to establish that midwifery professional experience provides the learning conditions in which students can achieve the midwifery graduate competency outcomes" (ANMC, 2009, p. 18). The supporting statement of intent stipulates that professional experience must ensure a woman-centred approach. Furthermore, the Australian Nursing and Midwifery Council competency standards describe the graduate midwife as practising within a woman-centred primary health care framework (ANMC, 2006). While all midwifery education providers are expected to provide the experiences that ensure midwifery graduates are competent woman-centred midwife practitioners, all registered midwives in Australia are expected to provide woman-centred care and to role model woman-centred care practices to student midwives.

1.2.4 Midwifery dialogue and woman-centred care

Brodie, Warwick, Hastie, Smythe, and Young (2008), propose that woman-centred care is the dominant discourse related to midwifery practice in general and to continuity of midwifery carer models of practice in particular. Recently, however, there has been debate around both the meaning of woman-centred care in practice (Leap, 2009) and the adequacy of evaluation of woman-centred care models (Carolan & Hodnett, 2007; Freeman, 2006). A preliminary approach to resolving debates about the meaning or evaluation of woman-centred care is to develop an understanding of how recipients and providers of woman-centred care interpret their experiences. This study generates an understanding of how woman-centred care is experienced in Australian maternity services.

1.2.5 The aims of this research

Research in women's maternity care experiences has predominantly been conducted with women whose more advantaged social, economic, and educational backgrounds may result in different experience and understandings than those of women experiencing social, economic or educational disadvantage (Hunt, 2004; Low, Martin, Sampselle, Guthrie & Oakley, 2003). This study, whilst focusing primarily on socially disadvantaged women's recounts of their maternity care encounters, incorporates the experiences of registered midwives' working with socially disadvantaged women, and student midwives' experiences of maternity care encounters in which socially disadvantaged women are the recipients of care. The inclusion of midwives' and students' experiences provides additional interpretations of the social realities of maternity care encounters for socially disadvantaged women, and why they might understand their experiences the way they do.

This study aimed, therefore, to explore the idiographic perspectives of woman-centred care and the translation of theory into practice, as perceived by three different socially and culturally constructed participant groups. I sought to understand each group's idiographic experience of giving or receiving woman-centred care, as interpreted and described by them. The aim was to:

- Explore socially disadvantaged women's experiences and understandings of maternity care encounters during the childbearing year^{*1};
- Explore registered midwives' experiences and understandings of providing care for socially disadvantaged women; and
- Explore student midwives' experiences and understandings of observed and provided maternity care encounters, in which socially disadvantaged women were the recipients of care.

1.3 Research questions

The primary research question, "How do socially disadvantaged childbearing women, registered midwives, and student midwives understand woman-centred

¹ A definition of terms noted with an asterisk* are provided in the glossary

care?” was divided into three sub-questions applicable to the individual participant group:

- How do women encountering social, economic and/or educational difficulties describe their maternity care encounters during the childbearing year?
- How do registered midwives describe maternity care encounters in which socially disadvantaged women are the recipients of care?
- How do student midwives describe maternity care encounters in which socially disadvantaged women are the recipients of care, in the context of learning to be a midwife?

In accordance with the principle of woman-centred care, “ensuring women are equal partners in the planning and delivery of maternity care” (Royal College of Midwives, 2001, p. 1) and the collaborative sense-making element of my chosen research approach - Interpretative Phenomenological Analysis, I also sought participants’ understandings of “How may maternity care encounters be more woman-centred for socially disadvantaged women?” Again, there were three separate follow-up questions, customised to each participant group:

- How do women experiencing social, economic and/or educational difficulties describe woman-centred maternity care encounters?
- How do midwives describe woman-centred care and the conditions required to provide woman-centred care for socially disadvantaged women?
- How do student midwives describe woman-centred maternity care encounters and the conditions required to facilitate midwives practising woman-centred care?

1.4 Research approach: Interpretative Phenomenological Analysis

The qualitative research approach, Interpretative Phenomenological Analysis, was used to gain an understanding of woman-centred care as experienced by socially disadvantaged women, midwives working with socially disadvantaged women, and student midwives observing maternity care encounters involving socially disadvantaged women. Birthing, midwifery work and the concept woman-centred care is complex or multifaceted. It was appropriate therefore, that the research approach selected to explore maternity care experiences also be multifaceted.

Smith, Flowers and Larkin (2009) state that Interpretative Phenomenological Analysis is a qualitative research approach suited to exploring a phenomenon from multiple perspectives and to building multifaceted understandings while maintaining the individual participant's understanding. Interpretative Phenomenological Analysis is informed by phenomenology, hermeneutics and idiography (Smith et al., 2009). The basis of Interpretative Phenomenological Analysis is phenomenological in focus because it explores the individual's lived experiences, perceptions or accounts of an event, situation or phenomenon as a stand-alone unit of understanding. Tomkins and Eatough (2010) suggest however, that an idiographic focus does not necessarily pertain to the individual person, but to an individual experience. It is with this sense of the idiographical focus that I have explored socially disadvantaged women's, midwives' and student midwives' understandings of woman-centred care.

Interpretative Phenomenological Analysis is hermeneutical in orientation because it acknowledges that access to participants' understandings is dependent upon the participants' and researcher's beliefs, values, life experiences and preconceptions. Interpretative Phenomenological Analysis assumes an idiographic focus with the researcher concerned with how the participant makes sense of the world in a particular way; that is, how the participant creates their own social reality.

As a midwife researcher wanting to explore socially disadvantaged women's maternity care encounters, I required a research approach congruent with a person-centred philosophy, one that allowed for multiple realities to coexist. Interpretative Phenomenological Analysis meets these two requirements. Shaw (2001) suggests that Interpretative Phenomenological Analysis is an exploratory tool that uses a co-operative, person-centred approach to enquiry, with the participants' voices central to the process. Smith et al. (2009) asserts that Interpretative Phenomenological Analysis has the capacity to allow the researcher to explore sameness and difference whilst giving participants their own socially constructed voices.

This study involves three participant groups: socially disadvantaged women, registered midwives and student midwives. I required a research approach that

would allow me to look at different understandings of the same phenomenon - woman-centred care, and the various social, cultural and political perspectives of each participant groups. Interpretative Phenomenological Analysis research acknowledges there is no one truth, that different groups of participants tell their own socially constructed stories of the phenomenon: in this case woman-centred care. My role in the meaning-making process is acknowledged and as such I am considered an additional source of data as well as the means through which understanding for the reader will result. As the interpreter of participants' understandings, I will make comment on the multiple positions, providing greater access to the text in its own terms (Benner, 1994). The meanings I arrive at will be shaped from the participants' experiences, based on my personal assumptions of ideas, meanings and experiences located within the focus of the study and cultural belongingness (Lopez & Willis, 2004).

1.5 Potential benefits of this research

Currently, there is little understanding of socially disadvantaged women's experiences of maternity care encounters in relation to the midwifery concept and maternity care philosophy of woman-centred care. There are also limited understandings of midwives' experiences of woman-centred care, in relation to working with socially disadvantaged women. Midwifery educators may benefit from having a greater understanding of how student midwives learn to become woman-centred midwife practitioners. There is also little understanding of student midwives' experiences. Findings from this research could also benefit socially disadvantaged women and the midwifery profession through practice, education, and research in the following ways.

1.5.1 Practice

A greater understanding of socially disadvantaged women's experiences of maternity care could assist midwives to better support this cohort of women and improve midwifery practices for them. Identifying socially disadvantaged women's needs and providing appropriate, individualised care can enhance their birthing experiences, encourage participation, mutual responsibility and engagement in decision-making processes. Supporting socially disadvantaged women to engage in collaborative partnerships with midwives could improve

women's immediate and long term health outcomes, as well as the health of their families. In addition, greater understanding of midwives' experiences of working with socially disadvantaged women can assist local health services improve support for midwives in their provision of woman-centred care for women with complex needs. Insight into the meaning midwives ascribe to woman-centred care, when working with socially disadvantaged women, could improve understanding of the midwife-woman interaction with this group of women.

1.5.2 Education

Within the next decade Australia will see a large increase in the number of registered midwives with midwifery listed as their foundational degree. As more universities introduce an undergraduate degree in midwifery, midwifery curricula are able to give more attention to woman-centred care. A three year program will enable educational providers time to incorporate woman-centred care concepts into all aspects of the childbirth continuum, ranging from normal or low risk to the complex or high risk maternity care encounters. Understanding how student midwives experience woman-centred care through the midwife-woman encounter could assist in the development of successful educational strategies for improving student teaching and learning around the midwifery concept and maternity care philosophy of woman-centred care. This study provides midwifery educators and researchers an opportunity to examine and evaluate student midwives' experiential learning of midwifery and woman-centred care.

1.5.3 Research

Exploring the midwife-woman relationship through recounted observations by midwifery students, as active participants in the relationship, is a relatively new concept. The introduction of the Continuity of Care Experience* requirements in Australian, midwifery educational programs is fairly recent. The introduction of this educational requirement provides educators and researchers an opportunity to explore student midwives' experiential learning, through recounted observations of, and participation in, maternity care encounters. This study contributes to understandings as a basis for future research into all health care encounters involving students as active participants in therapeutic relationships.

1.6 Why this research is important

The overall experience of childbirth is an important outcome for women and society (Lundgren & Berg, 2007). Whilst midwives espouse woman-centredness (Guilliland & Pairman, 1995) and reciprocity, claiming that women are the experts of their own body (Fleming, 1998), some women experience interactions with midwives as disempowering (Barlow, Hainsworth & Thornton, 2007; Eliasson, Kainz & von Post, 2008; Nyman, Prebensen & Flensner, 2010). Women attending health care visits are often socially positioned through discourse used in the interaction, whereby health professionals judge women and offer what they perceive to be appropriate care (Stapleton, Kirkham, Curtis et al., 2002). From this perspective the judgement and direction of care options by health care professionals to care recipients may be more blatant for socially disadvantaged women. If woman-centred care is to be genuinely portrayed as fundamental to midwifery practice and the woman-midwife relationship (Carolan & Hodnett, 2007; Leap, 2009), a clear understanding of how woman-centred care is experienced by socially disadvantaged women, the midwives providing care for this group of women and students learning to be woman-centred midwives, is essential.

The next section of the thesis - *Current understandings*, provides an overview of the current literature of social disadvantage, health inequalities and birthing outcomes in Australia. Midwifery practices and education within the Australian context are also explored in relation to the midwifery concept and maternity care philosophy of woman-centred care and the socially disadvantaged childbearing woman.

Section 2: Current understandings

There is an abundance of research on social disadvantage, poverty and midwifery work in developed and developing countries (Bick, 2007; DeLashmutt, 2007; Loudon, 2000; Peters, 2000; Thomson, 2003). While there is some research emerging from Australia that explores links between disadvantage and maternal health outcomes, this research is primarily concerned with the disparities between rural and remote women and those who birth in 'built up' regions of Australia, with gaps between the birthing outcomes of Aboriginal and Torres Strait Islander women and non-Indigenous Australian birthing women, and with the birthing outcomes and experiences of women from culturally and linguistically diverse backgrounds. There is, however, less Australian research that explores maternal health disparities of (and midwifery practices in relation to) socially disadvantaged childbearing women as a sub-population of all childbearing women. This section examines social disadvantage and health disparities within the Australian context in relation to childbearing women, maternity service provision and midwifery.

The first chapter provides an overview of social disadvantage and the three separate but interrelated features of social disadvantage: poverty, social exclusion and deprivation. Health disparities and the relationship to social disadvantage and maternal health outcomes are discussed, with a brief outline of three approaches commonly used in health care literature to understand the complex relationships between disadvantage and health outcomes. The second chapter provides the reader with an overview of midwifery as a profession and the role of the midwife, including the concepts of midwifery partnership, with-woman and woman-centred care. An outline of current maternity service provision and government documents related to maternity services in Australia are also presented. Following this, socially disadvantaged women's experiences of their maternity care encounters are explored along with the potential benefits of midwifery relationships and woman-centred care. Finally, the deficits in current understandings in the area of social disadvantage, women's experiences and midwifery care are considered.

Search strategy

Search terms used to access current literature included poor, poverty, disadvantage, social exclusion, minority, vulnerable, marginalised, nurse-midwife, midwif*, experienc*, maternity care, childbirth, women and woman-centered, and women and woman-centred. The smart text searching strategy was used, allowing terms selected to be substituted for other terms identified by the searcher. Terms chosen as substitutes for woman were client, patient and person. Limitations used when searching included papers or documents published in English, full-text articles, human subjects, latest update and a timeframe from 1993 till present. Following electronic retrieval of articles and documents, those not relevant to social disadvantage, health disparities, maternity care or midwifery care involving socially disadvantaged women, maternity service provision in Australia or midwives, student midwives and women's experiences of maternity care were excluded manually. The year 1993 was chosen specifically, as a date limitation, as it was the year that the 'Changing Childbirth' report was published in the United Kingdom, a report that formally recognised the elements of woman-centred care.

Databases searched included CINHAL (80 articles retrieved), MIDIRS database (250 articles retrieved), SUPER SEARCH database (122 articles), EBSCO MEGA FILE (excluding CINHAL, 343), MEDLINE (68) PsycINFO (5), Embase (14) and Sociological abstracts (5). Google Scholar and Scopus were used to check for articles not retrieved through the electronic databases. A manual search of Government websites, as well as textbooks, related to midwifery, maternity care, social disadvantage and health disparities was undertaken. Finally, individual articles were manually accessed through the reference lists and other sources already retrieved. Excluding duplications, a total of 774 documents or sources were retrieved for this study with 276 references included in the final document.

2 Social disadvantage, health disparities and the childbearing woman

The degree of disadvantage in modern societies shows the extent to which we ignore each other's welfare...poverty leads to lasting psychological and emotional damage...increase in stress and conflict, and this in turn reduces the capacity of individuals to overcome difficulties, cope with the unexpected and to maintain good health. (Hunt, 2004, p.188)

Social disadvantage is a term used to describe the circumstances of those people in a society who are classified as having a lower than average income, a low level of educational attainment or low level of social engagement within their society. People classified as socially disadvantaged tend to have poorer health outcomes and/or higher risks of ill health than those not classified as disadvantaged in the society (Cox, 2009). The World Health Organisation (2008) reports that socially disadvantaged people are more likely to smoke and be overweight. They are also less likely to exercise or eat fresh fruit and vegetables regularly. These lifestyle behaviours are contributory factors to the increased incidence of cardiovascular disease, arthritis, respiratory illnesses such as asthma, and mental health problems (World Health Organisation (WHO), 2008). Poor health outcomes associated with disadvantage cannot, however, be solely attributed to the individual's lifestyle behaviours.

Recent statistics from developed countries reveal that the gap between the wealthiest and poorest people in these countries is widening at an alarming rate. Populations with health disparities (or inequalities in health) within these countries are also increasing at an equally alarming rate (DeLashmutt, 2007; Henderson, 2005). Defining and measuring health disparities is difficult when there is no consensus on the appropriateness of measurement instruments, there is disagreement on the terms and concepts used as variables to be measured and there is no agreement on which theoretical perspective best suits the concept of health disparity. How a disparity in health is defined has a direct impact on how health resources and services are allocated; which health policy

becomes a political priority and which policy is implemented (Cox, 2009). In 2000 the National Centre for Minority Health and Health Disparities provided the following legal definition for the term health disparity: “a population is a health disparity population if there is a significant disparity in the overall rate of disease incidence, prevalence, morbidity, mortality or survival rates in the population as compared to the health status of the general population” (National Centre for Minority Health and Health Disparities, 2000, p. 2498)

Maternal mortality rates reveal a health disparity between the rich and the poor, and between and within countries, that has consequential outcomes for the woman, her family and society as a whole (United Nations. Department of Economic and Social Affairs, 2009). In September 2000 the United Nations Millennium Declaration (United Nations, 2006) was adopted by the largest gathering of government leaders, at which eight goals were listed to reduce extreme poverty or disadvantage in the world. Goal five ‘improve maternal health’ demonstrates the least progress towards the target to reduce maternal mortality by 75% by 2015. There is some thought that this situation is a consequence of the global economic crisis (GEC), because funding for programs aimed at improving maternal health has been compromised (United Nations. Department of Economic and Social Affairs, 2009). The latest figures reveal that more than half a million women die every year as a result of childbearing complications (United Nations. Department of Economic and Social Affairs, 2009). Although 99% of these deaths occur in developing countries there remain health inequities between groups of women within developed countries.

Townsend (1979) claims that maintenance of social disadvantage and inequity within a society ensures the preservation of those positioned as rich and powerful. Poverty is more invasive and secreted than some sectors of society would like known or portrayed. The maintenance of a large socio-economic gradient in a society ensures wealthy people in that society maintain their position of privilege. Any shift in the balance of assets or income must be controlled by those in power, thus minimising access to higher levels of capital, power and control by people in the lowest socio-economic band. A society that functions in this manner ensures that people will always be categorised, and

any ‘shift’ in capital will only move the relative poverty line. As such there will always be the poor and the wealthy or “the have” and “the have nots” (D. Green, 1998). The view that there will always be a division between populations who are poor and those who are wealthy allows the latter to abrogate their social responsibility to ensure all members of society have equal choice of and access to resources.

Furthermore, it is thought by many that developed societies, as a whole, are moving away from a state of selflessness and collective caring, towards a more individualistic state or one more embracing of self interest. In the 1990s debate highlighted disadvantage by emphasising blame and responsibility as belonging to the individual (Alcock, 1997). Hunt more recently propose that political parties should re-focus their attentions and responsibilities on the social workforce and its employed constituents. She asserts that in Western societies it is the individual’s responsibility to contribute to their society by paid work and that “work is the route to rights and thus citizenship” (Hunt, 2004, p. 35). However, as Lister (1997) points out, the importance placed upon paid work does not reflect the reality of a gendered culture in which women are largely responsible for the unpaid work (or caring roles) required to maintain the social structure of society.

In 2006, the Australian Government further negated the importance of unpaid work associated with caring for children, largely undertaken by women, through the introduction of the mutual obligation policy. The policy directs single mothers receiving parenting payments to commence an employment pathway plan when their youngest child turns six years of age or commences school (Department of Human Services, 2011). Failure to comply with this requirement can result in suspension of payments, which in turn increases the financial burden on the woman and her family. Women engaging in the mandatory employment pathway plan may need to secure before and after school care (dependent upon work times), pay for vocational care placement and can have their welfare payments and concessions reduced or cancelled. For women in low paid or casual jobs, the out-of-pocket expenses associated with childcare and work-related expenses, along with the reduction of welfare benefits, results in a lower expendable weekly income (Coad, Finlay, Raper & Thomas, 2006).

2.1 Social disadvantage in Australia

While Australia's economy grew steadily over the 15 years prior to the 2009 global economic crisis, economic indicators demonstrated that Australia failed to provide a 'fair go' for all people (Australian Council of Social Service (ACOSS), 2007). The Organisation for Economic Cooperation and Development (OECD) reported in 2007 that Australia's economic performance was above average when compared with other developed countries. Corporate profits increased, official unemployment rates fell and government budgets resulted in a surplus. The cost, however, of housing, and the number of people living on less than half the national average weekly wage are two areas where Australia performed poorly (ACOSS, 2007). Australia's economic growth did not benefit all Australians equally; there are clusters of disadvantage within Australia's economically healthy nation. Indigenous populations, people living in remote or rural regions of Australia, refugees, older people and single parent households constitute the major groups of disadvantaged persons in Australia (Saunders, Naidoo & Griffiths, 2007). Even within these groups of disadvantaged persons, women, based on gender alone, incur a greater possibility of being disadvantaged and are known to experience disadvantage more harshly than men in the same circumstances (New South Wales. Dept of Health, 2010b).

2.1.1 Socio-economic status and poverty

A person's socio-economic status is defined as their position in a society relative to others (Australian Institute of Health and Welfare, 2008) and takes into account their social standing, material resources, occupation and working conditions. The higher a person's socio-economic status, the more control they have over access to resources. More opportunities, therefore, present themselves, with greater personal power available to control life circumstances. Disparities in access to, and control over resources create a social gradient, with those lower on the gradient classified as socially disadvantaged due to restricted access to resources and activities available to others higher on the gradient (AIHW, 2008).

A person's position on the social gradient generally correlates with the health determinants and graded outcomes determined for that society. A person with a high socio-economic status (SES), or higher on the social gradient, has better health outcomes than a person who is positioned lower on the social gradient and, *ipso facto*, socially disadvantaged (AIHW, 2008). SES can be measured at the individual, household or local government level. In Australia, the Index of Relative Socio-Economic Disadvantage (IRSD), one of four indices developed to determine socio-economic measurements within 37,000 designated regions, is used to identify regions of advantage and disadvantage in relation to other regions. Data concerning income, educational attainment, employment and occupation are collected. The results position individual regions into one of five grades of SES that range from regions determined to have the highest overall level of disadvantage to those with the lowest overall level of disadvantage. For individual people, the lower their region of residence is on the IRSD, the poorer the health outcomes are for those living there. Statistics from Australian and New Zealand research reveal a strong correlation between the SES of a geographical region and the number of avoidable deaths per head of population therein (A. Page et al., 2006).

Socio-economic status and poverty are inseparable and while there are measurements to determine an IRSD, a region's SES does not indicate how its residents experience disadvantage or how they perceive poverty on a daily basis. Poverty, like all other terms used when discussing social disadvantage, is difficult to define or measure. Hunt (2004) distinguishes between the two most common terms used in relation to the concept of poverty. She proposes that a person is determined to be living in a state of subsistence (or absolute) poverty when they find it difficult to obtain the basics of life, such as food, clothing and shelter. Furthermore a person is determined to be living in a state of relative poverty when their income level is such that they find it difficult to engage in activities in which the majority of the population participate, and consider necessary for a comfortable standard of living (Hunt, 2004). Although Tsumori (2002) reports that absolute poverty in Australia is extremely rare, there is no clearly available determinants of the degree of absolute poverty in

Australia. Therefore, the term poverty, as it is commonly used within Australian statistic reports and literature, is likely to refer to relative poverty.

The Australian Council of Social Service adopts a specified measurement of income to define poverty, which considers the consequences of reduced income on a person's ability to engage in social or community activities. Poverty is a concept used by ACOSS to describe the state of people who are unable to participate in activities enjoyed by most Australians and its determination is by household income measurement. That is, people receiving less than 50% of the average disposable income of fellow Australians are living in poverty (ACOSS, 2005). During 2005-06 it was estimated that 10%, or 2.2 million Australians, were living in poverty and that the number continues to rise (ACOSS, 2007). An Australian study of indicators of social disadvantage in 2007 deemed that a family living in poverty is largely excluded from choice in consumption of essential elements such as food, health visits and daily living activities (Saunders et al., 2007). People living in poverty commonly have no funds allocated for emergencies and have limited support mechanisms in the event of an adverse situation. Essential living requirements, such as access to and affordability of health services, are often not met (Saunders et al., 2007).

The lack of resources experienced by socially disadvantaged people means there is a constant 'juggle' of limited funds to meet essential needs, with housing costs consuming most of the funds available. The notion of a lack of resources, however, does not adequately describe the condition of poverty. It could be argued that most Australians consider they are restricted to some degree in their consumption and participation in social activities because of limited available funds. Lister (2004) proposed that poverty is about having imposed or restricted control over financial resources. It is important therefore to employ an indicator to determine levels or the extent of poverty within the Australian context. The Henderson Poverty Line (HPL) is one instrument used in Australia to assess poverty. The HPL was developed in the early 1970s during a government inquiry into poverty. The HPL is an estimate of the money required by an individual or a family unit to meet their basic needs which are determined by the society in which they reside at that particular time. The HPL is adjusted quarterly and takes into account the variations in needs across a

range of family units (Melbourne Institute of Applied Economic and Social Research, 2009).

Hunt (2004, p. 44), however, highlights that a poverty line or standard cut off point that is based on the family household as a measuring unit, presumes the household is an equitable environment where women share equal say in expenditure issues, assets and income with a partner. A woman and the children in a household may be living in poverty although the household is not classed as such using the Henderson Poverty Line measure. The Australian Government has attempted to address this issue by separating parenting payments from welfare payments and other income support allowances. The logic or rationale for splitting welfare payments is that the woman residing in a house with children and an unemployed partner will receive payments independent of the partner. This strategy is meant to ensure the woman and children will have an independent source of parenting income for living expenses. However, this change in distribution of funds is based on a presumption that all households are the same – that is, that all women in this situation are able to keep their benefits for the purposes the government intended.

Generally, it is accepted that women bear the brunt of “living in poverty” on a daily basis; they are the ones who struggle to feed and clothe the children, pay the rent or house repayments and maintain utility services (DeLashmutt, 2007; Hunt, 2004; Woolhouse, Brown & Lent, 2004). Women continue to be disadvantaged by the polarisation of the labour market; they accept more of the lower paid, casual, part-time and unskilled jobs in order to better balance their childcare responsibilities with financial survival. Women, particular mothers, have extrinsic constraints placed on their consumption patterns through economic and institutional policies failing to account for gender disparities (United Nations Development Fund for Women, 2009). Hunt’s study (2004) found mothers also place intrinsic constraints upon their personal consumption patterns; they often place the financing of their children’s needs before their own and believe this responsibility is a fundamental part of parenting, closely linked with love for their children. An Australian report on poverty and financial hardship published in 2004 supports Hunt’s findings; earning capabilities,

expenditure and ability to accumulate savings are significantly affected for women who are the sole carer for children (Senate Community Affairs References Committee Secretariat, 2004).

Aboriginal and Torres Strait Islander birthing women and non-Indigenous women living in rural and remote areas of Australia are even more likely to suffer the effects of living in poverty than socially disadvantaged women who live in urban regions of Australia. The Australian Institute of Health and Welfare (AIHW) (2009) found that people living in rural and remote regions obtain lower academic levels of achievement which, in turn, (*inter alia*) reduces their educational, employment and earning capabilities: the three indicators of income poverty used by the Australian Government. Indigenous Australians in particular are more likely to be unemployed (Pink & Allbon, 2008); are overrepresented in statistics on homelessness and have a higher chance of living in overcrowded dwellings, particularly in remote geographical regions (AIHW, 2009). There is clear evidence that Indigenous women more often give birth to low birth weight* (LBW) infants, and have a higher perinatal mortality rate* than non-Indigenous women. Infant child mortality rates for this demographic population are three times that of non-Indigenous children (Pink & Allbon, 2008). However, Mayhew and Bradshaw (2005) argue that poverty alone as a causal factor for a poor birth outcome is questionable when other socio-economic factors such as employment, family type, educational level, ethnicity and age of mother at birth are controlled for. When the measure of disadvantage is household income only, the effects of social deprivation and social exclusion are neglected (Saunders et al., 2007).

2.1.2 Deprivation

Similar to poverty, deprivation is not a simple concept to define or measure. Being deprived can be described as lacking what are deemed to be the essential elements of an individual's social group (Saunders et al., 2007). Essential elements are things considered a basic requirement by the majority of that society to achieve a minimum standard of living. Essential elements as identified by Australians include "medical treatment if needed, a safe place for children to play outdoors near their home, a decent and secure home, a car and

to be treated with respect by other people" (Saunders et al., 2007, pp.33-34). Deprivation is different from poverty in that, although essential elements may be established by society as a whole, it is the individual that determines if they are deprived of an element. Saunders et al. (2007) claims people can be deprived without being classified as poor if the availability of, or access to, local resources and services is inadequate. The locality in which a person lives may be unhealthy, unsafe or underserviced. In other words, deprivation is an enforced lack of goods or services regardless of finances and the individual has little or no control over service consumption or participation patterns.

To cope with a lack of essential elements and control over life circumstances, people subconsciously adjust their outlook regarding personal needs and their preference for goods and services. Sen (1985) refers to this reaction to deprivation as the 'Preference Adaption Theory' (PAD), that is, people will outwardly verbalise to self and others that they do not need the required item or service. People self-identify as not deprived in order to maintain their self-worth; they convince themselves that they do not want something they know is not attainable. In convincing themselves they do not require the item or service, they self-identify as not deprived (Sen, 1985). Take, for example, a woman who lives in an area without adequate public transport. The woman has three small children, no car and needs to access maternity care visits, local shopping centres for grocery shopping and social functions associated with child care activities. Using Sen's Preference Adaption Theory, if the woman is without a car due to financial limitations she is deprived, even though she may verbalise that cars are not necessary. This woman is disadvantaged; through deprivation she has limited access to health and welfare services and other social networks that have the potential to improve her well being.

Women living in rural and remote regions of Australia have limited access to health and welfare services. The size of the population in a rural community influences the number and size of health services available (ABS, 2008), with only 1 in 10 Indigenous people living in rural areas having access to a hospital. Lack of access to health services is a contributing factor in poorer health outcomes for rural and remote birthing women and their infants. Twenty five percent (25%) of Indigenous people live in remote areas compared with 2% of

non-Indigenous people (Pink & Allbon, 2008). Essential items and services such as electricity, town water, sewerage systems and good quality housing are absent for a large proportion of Indigenous people living in remote areas of Australia. In 2006, only 28% of Indigenous households in rural communities had access to town water and 30% used a connected sewerage system for waste (ABS, 2008). Twenty eight percent (28%) of the Indigenous population in remote communities used electricity sourced from an electrical grid, with 62% using generators (ABS, 2008).

There are also non-Indigenous groups of people experiencing deprivation in Australia. In 2007, Saunders, Naidoo and Griffiths reported that the mean incidence of deprivation in Australia was 6.1%. That is, approximately 6% of a community is deprived of items considered to be essential by more than half the community (2007). Single parent families are amongst the most deprived people in Australia, with 14.2% lacking essential elements (Saunders et al., 2007). Similar to poverty, it is women who bear the brunt of deprivation, with single parent families headed mostly by women (AIHW, 2007).

2.1.3 Social exclusion

Social exclusion is a broader concept than poverty and deprivation. Social exclusion, while including the lack of, or denial of, resources, rights, goods and services, takes account of the individual's inability to participate in relationships and key activities within their society (Levitas et al., 2007). Key activities are those activities or services that more than half the community perceives to be fundamental. The three indicators of social exclusion are disengagement in social activities, that is no regular social contact with others; service exclusion, that is no access to a local doctor or hospital; and economic exclusion, that is no reserve of money (\$500) for emergencies (Saunders et al., 2007, p.70). Institutional, community and societal attitudes can create barriers that exclude or include individuals and groups in a society's workings. Individuals can be socially excluded through power relationships, gender, race, ethnicity or locality (Sen, 1985). When an individual is excluded, access to support and resources are restricted and deprivation can occur. Poverty and social exclusion can develop or be maintained (Sen, 1985).

Social exclusion rates vary in Australia from 12% of single older people to 36.2% of public renters. Single parent families are amongst the most socially excluded with 31.2% experiencing some form of exclusion (Saunders et al., 2007). Women living without control over household income have limited personal power, access to financial resources and access to social or community activities; the cycle of poverty, deprivation and social exclusion is maintained. Using social exclusion as an added measure of disadvantage shifts the focus from income and consumption as the key indicators of disadvantage. Social exclusion indicators have a strong political use. Policies can be implemented to ensure exclusion is reduced or eliminated (Saunders et al., 2007). Income poverty, enforced deprivation of goods and services and social exclusion impact on a person's choice of, and access to, health sustaining activities.

2.2 Health literacy and health disparities in Australia

In 2006, 59% of Australians were assessed as having less than adequate health literacy levels. Health literacy refers to a person's ability to retrieve, understand and evaluate health information; to make informed choices regarding health, thereby reducing health risk factors and improving quality of life (Zarcadoolas, Pleasant & Greer, 2005). Income and educational attainment influence health literacy levels, with 63% of people assessed as having adequate or higher literacy levels also assessed as having high earning capacity and/or higher educational attainment. Only 26% of people with low educational levels or earning capabilities had adequate or higher health literacy levels (Australian Bureau of Statistics (ABS), 2006a).

Gender, racial origins and place of residence also influence a person's health literary. Of those living in rural and remote areas of Australia, 64% had lower than adequate health literacy levels (ABS, 2006a) compared with 59% for Australians overall. Women up to the age of 45 years generally have higher health literacy levels than men (Australian Bureau of Statistics, 2006a). However, women identified as income poor or having low educational qualifications have lower health literacy than non-disadvantaged women. Australian research indicates that socially disadvantaged women are less likely

to have completed year 12 (Wood, Kettinger & Lessick, 2007), own a computer or have regular access to the Internet to obtain evidenced based health information (M. Brodie et al., 2000). Socially disadvantaged women, therefore, have limited power to access appropriate information and make decisions that will result in healthier birthing outcomes. Reduced access to, or understanding of, health information contributes to the lack of participation in health sustaining activities for the woman and her family. Although health literacy statistics published in the Australian Health Literacy Report (Australian Bureau of Statistics, 2006a) identified vulnerable groups within Australia, including Indigenous persons, statistics specific to Indigenous populations were absent from the document. Given that Indigenous Australians have a greater number of socially disadvantaged persons and health disparities per head of population (Australian Indigenous HealthInfoNet, 2009), it can be assumed that health literacy levels of Indigenous Australians correlates to these disparate levels of disadvantage and health inequities.

As health literacy is the best indicator of improved health outcomes (Wiess, 2007), health professionals need to identify all vulnerable groups who require support in understanding their health information. Wood and colleagues (2007) propose that providing sufficient health information gives women knowledge and therefore gives them power over choice. It is important that midwives understand that Indigenous women and women from lower socio-economic households may have inadequate health literacy, with diminished ability to access and comprehend complex health care issues. Furthermore, the decreased availability of resources associated with social disadvantage can limit a woman's personal power to access options of maternity care and diminish her sense of power or control. The resulting psychological stress associated with a lack of control over personal circumstances, if maintained over a prolonged period of time, is linked to poorer health outcomes.

2.3 Health disparities and perinatal outcomes

Literature consistently demonstrates a link between social disadvantage, health disparities and poor birth outcomes (AIHW, 2008; Luo et al., 2006; Moser et al., 2003; Pattenden et al., 1999). Birthing outcomes for both the woman and her

baby are shaped by biological factors such as maternal weight, nutritional status, parity* and age, or environmental factors such as substance use, stress or reduced access to health care and social services. These factors are impacted upon directly and indirectly by socio-economic status (Dunn, 1984) and health literacy levels (Wiess, 2007). Socially disadvantaged women, regardless of ethnicity, are more likely to have pre-term pre-labour rupture of membranes*, pre-term labour*, prem-term birth* (Goffinet, 2005; Kramer et al., 2001), an increased risk of pre-eclampsia* (Ceron-Mireles et al., 2001), or drug and alcohol problems (Buka, 2002). Socially disadvantaged women give birth to low birth weight infants more frequently (Huijbregts et al., 2006; Kramer et al., 2001) and their babies are admitted to neonatal nurseries (Phung et al., 2005) more frequently than their advantaged peers.

In Australia, Indigenous childbearing women have a higher fertility rate*, are younger on average when they birth and are more likely to have a vaginal birth with less caesarean births (AIHW, 2008). However, the maternal mortality rate for Indigenous women was three times higher than non-Indigenous women during the years 2000-2005. Indigenous women are also two times more likely to birth a premature or low birth weight infant and have higher perinatal mortality rates than non-Indigenous childbearing women. During the same period there were 15.7 perinatal deaths per 100,000 Indigenous births compared to 10.3 per 100,000 non-Indigenous births (AIHW, 2008). As with poverty, the disparities in birthing outcomes between Indigenous and non-Indigenous childbearing women and socially disadvantaged and non-disadvantaged women cannot be attributed to one factor. The complex life circumstances and conditions that result from the interplay of socio-political, generational genetics and cultural discriminations may be more influential on a woman's health than the observable and immediate issues often addressed within maternity care encounters.

2.4 Health disparities: models and theories

There are various approaches used to examine social disadvantage and health disparities. Three approaches that are common in current health policy literature are the 'Social Determinants of Health' model, the 'Allostasis Theory' and the 'Ecosocial Theory'. All three approaches demonstrate strong links between the

individual's social positioning, the organisation of their society, life patterns and conditions and health outcomes. These three approaches are discussed next.

2.4.1 The Social Determinants of Health model

The determinants of a person's health are the factors that determine how likely they "are to stay well or become ill or injured" (AIHW, 2008, p. 109). Determinants can be behavioural, socio-economic, environmental, biomedical or genetic. Behavioural determinants include drug and alcohol use, tobacco use, physical activity, dietary behaviour, sexual behaviour and vaccination status. Social and environmental determinants include the characteristics of the environment (topography, density of housing and level of pollutants), resources available, social cohesion, the organisational structure of society and policies affecting the population. Biomedical determinants include blood pressure, body weight, glucose regulation and cholesterol levels (AIHW, 2008). The economic determinants of a person's health have been discussed previously in this chapter, under the heading - *Social disadvantage*. Each health determinant is complexly interwoven and influenced by the others, with a person's health correlating with the number and intensity of health determinants deemed to be either negative, and therefore a risk factor for poor health, or positive and therefore a protective factor against poor health.

The 'Social Determinants of Health' model adopts the causal effects of social positioning and health. Wilkinson and Marmot (2003) claim that a person's health is sensitive to their social environment and that while genetic factors can cause an individual to be susceptible to certain diseases, the common causes of ill health affecting populations is environmental. Furthermore, physical health and life expectancy are affected by social and psychological influences. People involved in the social, cultural and economic operation of their society are healthier than those individuals excluded due to social or economic inadequacies (R. Wilkinson & Marmot, 2003). The higher a person's level of education, financial independence and social positioning in a society, the higher their access to, and use of, health services is. This results in a higher level of health. The distribution of wealth in any given society mirrors the health patterns across the same society (Cox, 2009). People living in socially or economically

disadvantaged circumstances have poorer health with shorter life expectancy and a greater risk of disease (ABS, 2001; R. Wilkinson & Marmot, 2003). Hunt (2004) states that the proportion of adults reporting ill health increases in direct proportion to the decrease in socio-economic status, with General Practitioner visits increasing in direct correlation to the decrease in economic positioning. However, preventative health measures, such as ophthalmic and dental visits, decrease. The decrease in preventative health measures by socially disadvantaged people may result from the financial burden associated with ophthalmic and dental health visits and reduced Medicare funding.

The lower down people are in the socio-economic hierarchy of an industrialised nation or the poorer they are, the more common are issues of social isolation, stress, anxiety, low self-esteem and lack of control over their life circumstances (R. Wilkinson & Marmot, 2003). Decreased control over allocation of personal funds resulting from financial instability and/or financial dependence results in stress and prolonged stress is linked to poorer health. Although poor health outcomes associated with physical and psychological stressors can be reduced by strong and cohesive social networks (R. Wilkinson & Marmot, 2003), the level of income available to people remains a strong influence on choices of consumption. Access to fresh and varied foods, health sustaining activities, social networking and health care options are restricted by income, choices available within their geographical area and the neighbourhood environment. While the determinants can provide an understanding of the factors that impact on the health outcomes of a population, Wilkinson and Marmot (2003) go on to say that health professionals need to understand how an individual's behaviour and health are shaped by their social environment. Humans are social beings that not only need adequate resources to achieve health. They need also to feel valued, appreciated and useful within their society and have a degree of control over their choices and life circumstances.

2.4.2 The Allostasis Theory

Another approach that can shed light on health disparities is the Allostasis Theory (McEwen & Wingfield, 2003). Allostasis supports homeostasis to achieve the physiological parameters required to maintain the body's optimal

functioning. While homeostasis is the mechanism for maintaining the body's physiological systems within a set operational range to sustain life, allostasis achieves stability of the body's physiological systems through changes in operational set points in response to stress. McEwen and Wingfield (2003) define stress as a threat to homeostasis, either actual or potential. A change in the set point can be initiated due to single events of stress and therefore be a temporary change, such as the increase in catecholamine and glucocorticosteroid levels when running from a threat. A prolonged or permanent change in set operational points, with dysregulated glucocorticosteroid secretion, can occur as a result of an ongoing stressor or stressors, such as living in poverty, domestic violence, social isolation or lack of control over life circumstances. The body is said to be in an allostatic state when functioning at altered operational set points and the number and intensity of stressors impacting on the body's allostatic state is referred to as the allostatic load (McEwen & Wingfield, 2003).

Allostasis, therefore, is a framework for how the body reacts to, or copes with, immediate or long-term social and environmental stressors (McEwen & Wingfield, 2003). The body's physiological systems alter to protect the person and assist them in coping with the stressors. People lower on the socio-economic gradient are more likely to live in unhealthy environments, have genetic vulnerabilities for a range of diseases, have limited choices or control over their life circumstances and engage in unhealthy behaviours. The negative risk factors associated with these social determinates of health increase the individual's allostatic load. When a person's allostatic load is not alleviated, allostatic overload can occur, resulting in chronic elevation of glucocorticosteroid levels and other mediators, leading to pathophysiology (McEwen & Wingfield, 2003). Allostatic overload provides an explanation of the physiological mechanisms involved in the increased incidence of obesity, elevated blood pressure, coronary heart disease and type II diabetes in people experiencing accumulated stressors over time (Cox, 2009). Health interventions, therefore, that fail to address the causes of allostatic overload are unlikely to be effective.

2.4.3 The Ecosocial Theory

The third approach used to examine health disparities is the Ecosocial Theory. This particular theory builds on the previous two approaches to understanding health disparities and suggests that the social, political and economic conditions of a society shape genetic expression, the distribution of disease and health disparities (Krieger, 2008). The human body and psyche develop through interactions with their environment. Furthermore, gene regulation and expression is confined by our ability to control our life circumstances, with control over self mandated by socially structured opportunities. Ecosocial theory, while considering the sociological, biological and genetic, and environmental impacts on the individual's health, population health and health disparities, also takes into consideration the interplay and expression of biological processes at multiple levels of time and space (Krieger, 2002).

Krieger introduced the term Ecosocial Theory in 1994 and describes it as a framework for understanding the intergenerational consequences of embodied social inequalities and the resulting patterns of disease, illness and injury distribution within populations, including the poor perinatal outcomes of particular groups of women. The four core concepts of Ecosocial Theory are:

Embodiment: “a concept referring to how we literally incorporate, biologically, the material and social world in which we live, from in utero to death; a corollary is that no aspect of our biology can be understood absent knowledge of history and individual and societal ways of living” (Krieger, 2001p. 672).

Pathways of embodiment: the causal pathways of disease distribution structured simultaneously through societal power arrangements, the constraints and possibilities of biology (as shaped by evolutionary history, ecological context, and individual histories).

Cumulative interplay between exposure, susceptibility, and resistance to the factors expressed in pathways of embodiment: occurs at multiple levels (individual, neighbourhood, regional, national, inter-national or supra-national), within multiple domains (home, work, school, other locations), in relation to

relevant ecological niches, and manifested over multiple scales of time and space.

Accountability and agency: who and what is responsible for the social inequalities present in health? Who is and can be responsible for rectifying health disparities (Krieger, 2002)?

2.5 Conclusion

This chapter explored the correlation between social disadvantage and health disparities for childbearing women. It was revealed that, while health disparities, including poor birth outcomes, may be attributed in part to an individual woman's unhealthy behaviours, there are complex multidimensional and socially constructed conditions and constraints that initiate, maintain or change behaviours (Cox, 2009). Wilkinson and Marmot (2003) proposed that socially disadvantaged childbearing women are social beings who need to feel valued and have a degree of control over their life choices and circumstances. The provision of material resources and medical interventions without emotional and social support is unlikely to ease health disparities experienced by this group of women. This view was affirmed by Cox (2009), who also advocates for midwifery support that affords the socially disadvantaged childbearing woman a greater sense of control during her childbirth continuum, thereby reducing her allostatic load and the potential for allostatic overload. Reducing the allostatic load of socially disadvantaged childbearing women has the potential to make comparable reductions in health disparity figures, with better birth outcomes for socially disadvantaged women.

Cox (2009) provides 28 practical suggestions for how midwives might better support socially disadvantaged women so that health disparities can be reduced. The first suggestion that she offers, is to ask women during maternity care encounters "what THEY think would most suit their needs" (2009, p.63). This suggestion aligns with the midwifery concept and maternity care philosophy of woman-centred care, in that asking the woman what she wants creates the conditions for a collaborative partnership to develop that is based on valuing and respecting the woman's needs. Other suggestions include the development of educational materials that are relevant and suited to the literacy

levels of the population, knowing the resources and support networks in the local area and providing free talks with women out in the community. These suggestions invite midwives to know local women and their needs, to become part of the women's health care and social networks prior to the woman needing maternity care. Establishing a presence in the community may enhance socially disadvantaged women's health literacy levels and help establish relationships between midwives and women so that access to relevant maternity care information can be provided earlier in their pregnancy, where and when needed by women. Chapter 3 discusses midwifery's role with the socially disadvantaged childbearing woman in depth.

The issue of responsibility for addressing health disparities was raised by Krieger (2002). In relation to the childbearing woman and maternal health disparities, midwives in collaboration with their medical colleagues are responsible for addressing maternal health disparities. Midwives are in an ideal position to socially construct opportunities for socially disadvantaged women to gain self control within their maternity care encounters. There is a potential for optimising gene expression in the next generation when midwives fully support childbearing women to have a greater sense of control over their life circumstances, with a subsequent reduction in the allostatic load for women and their babies. Children born healthy have a greater potential for engaging in the social activities in their society and a greater potential for academic achievement. The consequence of this is a reduction in social exclusion, income poverty and deprivation, with the future generation gaining a higher socio-economic position in society, and a shifting of disease distribution and health disparity figures.

A greater understanding of the consequences of social disadvantage on perinatal health and how social disadvantage might impact on socially disadvantaged women's maternity care experiences is required. Understanding how socially disadvantaged women experience their maternity care encounters has the potential to enable health professionals to be responsive to the needs of socially disadvantaged women and assist in the development of appropriate maternity care services and policies. The next chapter provides an overview of

current understandings of midwifery care and maternity service provision in Australia and socially disadvantaged women's experiences of maternity care.

3 Midwives, midwifery and the socially disadvantaged woman

A midwife is a person who, having been regularly admitted to a midwifery educational program, duly recognised in the country in which it is located, has successfully completed the prescribed course of studies in midwifery and has acquired the requisite qualifications to be registered and/or legally licensed to practise midwifery (ANMC, 2009, p. 3).

The term midwife is thought to have derived from the Middle English word *midwyf*. However, midwifery as a profession, used to describe women assisting other women to birth, was first mentioned in the second book of the Bible (Exodus 1), written somewhere between 1445-1405 B.C. (Slick, n.d.). While the morpheme *wyf* or wife referred to a woman in early history, the meaning of *mid* is less clear and is assumed, therefore, to be a preposition meaning together or with. Hence, the word midwife can be literally translates as ‘together with woman’ (Midwife, n.d.). Other meanings of the word together are jointly, mutually, reciprocally, in relationship to one another, in someone’s company (Together, n.d.). These terms fit the concept of partnership within the midwifery context and are discussed later in this chapter. Today however, the word together is not referred to and the term with-woman is the term commonly used within midwifery discourse.

3.1 A midwifery concept: with-woman

A review of the literature published between the years 1985 and 2000, exploring the concept of with-woman during childbirth and the associated concepts of presence and social support, resulted in the concept *with-woman* being defined as “the provision of emotional, physical, spiritual and psychological presence/support by the caregiver as desired by the labouring woman” (L. Hunter, 2002, p.650). Hunter (2002) concluded that the concept *with-woman* is drawn from two concepts commonly referred to within the context of childbirth - *presence* and *support*.

Presence was introduced into nursing and midwifery literature in the 1980s through Benner's work on being an expert nurse (1984) and through Lehrman's work on continuous intrapartum care and the psychosocial health outcomes (1988). *Presence* was described by Benner as *being-with* the patient and involved behaviours such as therapeutic touching and listening, as well as understanding the person and sharing their humanity (Benner, 1984). Lehrman introduced the term *positive presence* into midwifery dialogue, referring to the provision of one-to-one personal attention and constant availability throughout the labour and birth process (Lehrman, 1988). In the 1990s, the term *presencing* was introduced into Australian midwifery literature (Dickson, 1996). Midwifery *presencing* was described as being with the childbearing woman, both emotionally and physically. Dickson argued that midwifery needed a theory that based on caring and being present to improve the birthing experiences of women. According to Hunter (2002), the concept of *presence* within the birthing context involves the midwife being there physically for the woman as well as psychologically with the woman, and that the concept of *presence* shares similar characteristics to the concept of *social support*.

The notion of social support in childbirth has received much attention in the last decade. A systematic review released in 2002 examining the benefits of caregiver support during birth concluded that social support during labour and birth improves birthing outcomes and women's experiences (Hodnett, 2001). Hodnett reported that caregiver support during birth resulted in fewer caesarean births, fewer infants with low Apgar scores, less incidence of postnatal depression, higher maternal satisfaction of care provided, a greater sense of control over decision-making, higher breastfeeding rates and smoother transition to motherhood (Hodnett, 2001). The findings not only revealed a positive correlation between social support during the birthing process and the benefits for the woman personally, they also demonstrated the potential financial benefits for maternity services, with lower rates of medical intervention and decreased length of confinement. Hunter (2002) discusses the negligence of health service providers in not ensuring that midwives are able to be with women during labour and birth in the face of Hodnett's compelling evidence for the benefits of caregiver support during labour and birth. A second systematic

review carried out by Hodnett and colleagues in 2011, involving 15 countries, 21 trials, and more than 15,000 women reported similar findings to the first review (Hodnett, Gates, Hofmeyr, Sakala & Weston, 2011, February 16). However, to date, one-on-one continuous support during labour and birth is still not provided for all birthing women.

In 2008, two Australian authors (Pembroke and Pembroke) published *The spirituality of presence in midwifery care*. They referred to presence as incorporating the concepts of *responsibility* and *availability* (Pembroke & Pembroke, 2008). *Availability* is a term introduced by French philosopher Marcel to describe being committed to actively participating with and for others. Being in a state of *availability* means that the person is receptive to and accepting of another's experiences and needs (Lantz, 1994). The term availability, therefore, fits well with the midwifery concepts of partnership and woman-centredness. Pembroke and Pembroke drew on the work of Buber when referring to the concept of *responsibility*. Buber (1957), describes the concept of *responsibility* as a person's responsiveness and accountability to meet another's needs. Again this term fits well with a midwife's professional responsibility to meet the needs of the woman. Pembroke and Pembroke (2008) concluded that the *spirituality of presence* in midwifery entails the midwife being receptive and accepting of the woman's experiences and needs as well as accepting responsibility to support the woman in meeting her needs.

Within the context of midwifery, the concepts *with-woman*, *being-with*, and *presence* are largely used within discussions concerning labour and birthing environments, or continuity of midwifery carer models of practice. There is a lack of literature that demonstrates application of these concepts to other midwifery contexts such as antenatal care visits, postnatal care and non-continuity of midwifery carer models of practice. In order for the concept *with-woman* to be more widely accepted and adopted in every midwifery context, midwifery literature needs to demonstrate how the concept should and can be applied in all midwifery contexts.

3.2 Midwifery as a profession

Guilliland and Pairman (2010) describe the midwifery profession exists “to facilitate the optimal experience of birth for pregnant women and their babies” (p. 38). Where the individual midwife, when working with-woman, is seen as a person who is responsible for optimising the individual woman’s experience of childbirth, the profession assumes a broader societal level in supporting women, their babies and the family unit. This broader societal level concerning maternal and newborn health is the primary health care agenda addressed by the midwifery profession.

In Australia, the Australian Nursing and Midwifery Council (ANMC) mandates the profession’s role in addressing the public health agenda through a primary health framework (ANMC, 2006). The Competency Standards for the Registered Midwife include the domain *midwifery as primary health care*, and provide details of how the midwife, as a member of the midwifery profession, is expected to practice. Within primary health, the midwifery profession is seen as an approach to public health encompassing the broad social context of protecting the rights of women, their families and communities, as well as promoting wellness of women, their family unit and society (ANMC, 2006).

While midwifery is seen as a profession that works with and for women, Bates (2004) argues that the term profession is problematic for midwifery in that traditionally the word profession was understood to be a discipline with a defined body of expertise and knowledge that set it apart from other disciplines, and that this exclusivity of expertise guaranteed a degree of power over others. Bates suggests that the notion of professionalism and midwifery are incongruent in nature. Leap and Pairman (2010) however, maintain that midwives who work in partnership with women are open to the woman and receptive of her needs. The traditional distancing by the expert is not possible when midwives work collaboratively with women (Guilliland & Pairman, 2010). In Australia, the ANMC national competency standards for the registered midwife requires the midwife to “communicate information to facilitate decision-making by the woman, (to develop) effective strategies to implement and support collaborative midwifery practice, (and) plan and evaluate care in

partnership with the woman" (ANMC, 2006, p. 10). Furthermore, the Australian College of Midwives Philosophy Statement for Midwifery describes midwifery as "a woman-centred, political, primary health care discipline founded on the relationships between women and their midwives" (ACM, 2004). Midwifery, while working at the individual woman's level and at the community level, works across professional boundaries related to maternal health, newborn health and childbirth, and seeks to apply the professional body of midwifery knowledge in a collaborative and woman focused manner.

The midwifery profession also recognises that the social context of each woman is different and that meeting the individual woman's needs requires negotiation between the woman and midwife. Freeman and Griew (2007) propose that midwives, in collaboration with the woman, negotiate their roles and degree of participation in the decision-making processes throughout the different stages and events within the relationship. It is this level of shared responsibility and negotiation throughout the relationship that demonstrates respect and allows for the development of a mutually trusting midwife-woman partnership. Midwifery as a profession is based on a sharing of knowledge within each individual relationship with women and is therefore a partnership (Guilliland & Pairman, 1995).

3.2.1 The Midwifery Partnership model for practice

In 1995 a monograph *The Midwifery Partnership - a model for practice* was published in New Zealand (Guilliland & Pairman, 1995). The authors proposed that the Midwifery Partnership model for practice came into being in the 1980s and 1990s as a consequence of the social and constitutional positions of the New Zealand culture. It was founded on the principles of the Treaty of Waitangi and the demands of New Zealand women that midwifery care be provided within the context of partnership. The Treaty of Waitangi was signed between the Maori (Tangata Whenua peoples, the indigenous inhabitants of New Zealand) and the Crown in 1840. The four principles on which the treaty was based were partnership, participation, protection and equity, with the partnership principle encompassing equity in negotiation processes, participation and protection of the other (Guilliland & Pairman, 2010).

The term partnership within midwifery is operational on two levels. There is a negotiated partnership between the individual woman and midwife and there is a partnership between the midwifery profession and socio-political agendas (Guilliland & Pairman, 1995). While a midwife works with an individual women, they also continue to work politically to uphold every woman's right to birth according to her wants, relating to the place, people and processes she has chosen. Control and power is invested with the woman, and care is directed towards the self-identified needs of the woman so that she might develop new knowledge of herself and take responsibility for her decisions and actions (Guilliland & Pairman, 2010).

The theoretical frameworks for a partnership model of care

The Midwifery Partnership model of practice positions the concept of partnership within a theoretical framework based on the work of nursing theorists Rosemarie Parse, Martha Rodgers, Margaret Newman and Judith Christensen. In 1987 Parse described the nurse-patient relationship as one in which the nurse goes 'with' the person wherever they are, not attempting to change, control or judge the situation or person (1987). This relationship can be likened to the midwife-woman relationship, as continuity of midwifery care refers to the midwife following the woman wherever she chooses to birth, being available for the woman regardless of her health status, working with the woman in her own environment and valuing the woman's way of knowing. In other words, the midwife acts as the woman's knowledgeable companion (Guilliland & Pairman, 1995).

Similarities in professional accountability to society are evident in nursing and midwifery. Rodger's theory of 'unitary human beings', published in 1970, describes nursing as existing to serve people with a direct and over-riding responsibility to society (Rogers, 1970). Nurses, like midwives, are required to see the whole person as existing within an environment made up of simultaneously interacting facets, being mindful of the social complexities of their existence (Rogers, 1970). The midwifery profession, similarly, is promoted as reflecting the needs of childbearing women in society and as a force for

social change through working with and for women (ICM, 1993 cited in Guilliland & Pairman, 1995).

Newman's (1986) 'health as expanding consciousness' theory discusses a number of concepts that have been adopted as foundational to the Midwifery Partnership model and therefore the notion of woman-centred care. Newman asserted that primary health care involves continuity of care and argued that nurses need to accept responsibility for the planning and implementation of care for a person for their entire period of hospitalisation. Newman (1986) also suggested that nurses become 'involved' with their patients by forming mutually trusting partnerships and by assisting the person to evolve to a higher level of consciousness within the context of their own environment and needs. Midwives who provide continuity of care accept responsibility for the complete maternity care needs of the individual woman throughout her childbearing experience. Furthermore, midwives are "concerned with assisting women in the emergence of consciousness and their different ways of knowing" (Guilliland & Pairman, 1995, p. 29) so that women may have a voice.

Midwives work with women throughout the childbirth continuum to optimise the birth experiences for the individual childbearing woman and childbearing women in society. The philosophical beliefs for the partnership model of midwifery practice are:

- Pregnancy and birth are normal life events;
- Midwifery's primary professional role is with women experiencing a normal pregnancy, labour, birth and postnatal period*;
- Midwifery provides women with continuity of caregiver throughout her childbearing experience; and
- Midwifery is woman-centred (Guilliland & Pairman, 2010, p.32).

A cardinal feature of the Midwifery Partnership model of practice is woman-centred care, which positions the woman as the focus of care and values her experience within the partnership.

3.2.2 Woman-centred care

Woman-centred maternity care is commonly described as care that ensures the woman has continuity of care, control over maternity care decisions, and choice in all aspects of her care (Carolan & Hodnett, 2007; Pope, Graham & Patel, 2001; Sandall, 1995; Tinkler & Quinney, 1998). The term woman-centred care received formal recognition in 1993, with the release of the 'Changing Childbirth' report in England (Department of Health, 1993). The government initiated report was in response to the findings of an investigation into maternity services between the years 1991 and 1992 which produced the Winterton report (House of Commons Health Committee, 1992). Following the Winterton report, an expert maternity care panel was established to consider the report's findings. The subsequent report, known as the 'Changing Childbirth' report, recommended that "the woman must be the focus of maternity care. She should be able to feel that she is in control of what is happening to her and able to make decisions about her care, based on her needs, having discussed matters fully with the professionals involved" (Department of Health, 1993, p.9). The midwifery profession, using the 'Changing Childbirth' report recommendations as an impetus for change, developed and implemented models of care that centre care on the needs of the individual woman. Guilliland and Pairman (2010) propose that woman-centred midwifery care does not exclude or separate the needs of the baby. This means the needs of the woman are integrated; the midwife supports the health of the woman through a supportive relationship with her, and she, in turn has a relationship with the baby.

While the term woman-centred care was not introduced into midwifery discourse until the release of the 'Changing Childbirth' report, the elements of care that constitute the maternity care concept of woman-centred care were discussed in relation to maternity service provision in New South Wales, Australia, as early as 1989, with the release of the Shearman report (New South Wales Department of Health [NSW DoH], 1989). The Shearman report was the result of an investigation into how maternity service administrators, providers and consumers perceived the delivery of obstetric services in New South Wales. Although the term woman-centred care was not used within the report, the recommendations made in the report clearly demonstrated that a woman-

centred approach to maternity services was required. The Shearman report recommended that:

- Women's choice regarding options of care be maximised;
- Continuity of maternity care for childbearing women be promoted;
- Sufficient information be provided to ensure woman can participate in decision-making;
- A range of services be implemented to meet local birthing needs; and
- Quality of care programs be implemented in health services to ensure the needs of local birthing women are met (NSW DoH, 1989).

The concept of woman-centred care within midwifery has evolved as perceptions about women's position within society have shifted. In 2001 the Royal College of Midwives in Britain published a document endorsing 'woman-centred care' as a philosophy underpinning maternity care. It also listed the underlying principles and key priorities required to achieve woman-centred care within the National Health Service (RCM, 2001). The position paper not only elaborated the original three elements of woman-centred care, which are, continuity of care, choice and control, but also recommended two additional elements for consideration. The fourth element is that women are seen as equal partners in the planning and delivery of maternity care, with involvement deeper than a tokenistic gesture. The fifth and final element is that childbearing women's needs are seen as a priority over organisational or health care provider's needs.

In 2009, Leap provided some additional guidelines for woman-centred midwifery care which have been alluded to, but not made explicit, in earlier documents. She asserted that the midwife includes the needs of the baby, family and other people important to the woman; follows the birthing woman across all midwifery and community contexts; recognises the woman's expertise in decision-making; and addresses the woman's social, emotional, physical, psychological, spiritual and cultural needs and expectations (Leap, 2009). The Changing Childbirth report, the RCM's Position Paper 4a: Woman-centred care and Leap's guidelines for woman-centred midwifery care are applicable to the provision of maternity care and midwifery practice in Australia.

3.3 Maternity service provision in Australia

Maternity services in Australia cover the antenatal, labour, birth and postnatal care of the woman and her baby up to six weeks following birth. Maternity care is available from private and public health providers and offered in a variety of clinical and non-clinical settings and through various models of care. The National Maternity Services Plan, published in 2011, states that more than 90% of Australian women receive their maternity care through one of four models of maternity care:- private, combined maternity care, public hospital care and shared maternity care - and proposes that standardisation of nomenclature for models of maternity care will assist in the analysis and comparison of birthing outcomes and ensure better services. The classifications as stated do not differentiate private care provided by a midwife or obstetrician. It is also unclear how midwifery-led models of care fit into, or are separated out from, public hospital care, which includes non-continuity of midwifery carer models of practice. Comparing outcomes between midwifery-led care and non midwifery-led care is not possible when there are many models of midwifery-led care. The next chapter heading – *Providing midwifery care in Australia*, provides a brief overview of models of midwifery care available to Australian women.

In 2008 the Australian government initiated a review of the Nation's maternity services in recognition of the fact that not all Australian women's maternity care needs were being met. The resulting report was known as the *Improving maternity services in Australia: A discussion paper from the Australian Government*. This report identified a number of issues that impact on the maternity care experiences and outcomes of particular groups of birthing women. The review concluded that women living in rural and remote areas of Australia have little or no local maternity services, that maternity services are mostly provided in tertiary centres and by specialist doctors and that there are inequities in access to models of maternity care with more than 97% of women birthing in hospitals in standard delivery wards. The review recommended changes to maternity services, with greater choice of, and more access to a range of, models of care that are responsive to the needs and circumstances of local communities. Recommendations included extending the role of midwives, including support for indemnity insurance and changes to commonwealth

funding arrangements; improved access to maternity services for rural and Indigenous women; and improved access to health information so women are able to be more fully involved in decision-making processes (Australia. Dept of Health and Ageing, 2009a).

The National Women's Health Policy (Australia. Dept of Health and Ageing, 2010) set four priority health issues to be addressed, with the aim of improving the health and well-being of Australian women, and with specific emphasis on improving the health of socially disadvantaged women. The National Women's Health Policy, acknowledging the relationship between physical and social determinants of health, listed four social determinants of health that were thought to significantly impact on women's health outcomes. The determinants were sex and gender, the differing health needs throughout women's life stages, equity of access to resources, and the marginalisation of, and discrimination against, women of diverse backgrounds. The policy, taking into consideration the social determinants, offered a range of strategies aimed at meeting the specific needs of disadvantaged women. One of the strategies, *sexual and reproductive health*, covers the area of maternal health and refers to the *Improving maternity services in Australia* document, when discussing strategies to improve maternity service provision.

More recently, the Australian Government released the National Maternity Services Plan (Australia. Dept of Health and Ageing, 2011). The plan provides a framework for maternity service policy and program development that addresses four areas of priority, as identified by key stakeholders. This policy builds on and refers to the earlier documents, the National Women's Health Policy and the Improving Maternity Services in Australia: The Report of the Maternity Services Review, to improve maternity services for all women, while closing the gap between the birth outcomes of Aboriginal and Torres Strait Islander women and non-Indigenous women in Australia. Although the plan states that "particular attention is given in the plan to meeting the needs of women and their families" (p.iii), women, in particular, do not appear to have been consulted, as suggested by the following comment, "significant consultation with key medical professionals and midwifery stakeholder groups occurred...." (Australia. Dept of Health and Ageing, 2011, p. iii). The four areas

to be addressed in the next five years are access to services, delivery of services, workforce issues and infrastructure. Each priority has a number of actions to be undertaken to meet the plan's vision of providing all Australian women a "high-quality, evidenced based, culturally competent maternity care in a range of settings" (Australia. Dept of Health and Ageing, 2011, p. iii). While women may have been consulted in the planning processes, the wording of the document would suggest women's birthing needs, as determined by the women themselves, have not been explicitly sought or taken seriously in the reporting process.

Government reports, health initiatives and directives often do not achieve sustained improvements at ground level for women. While access to care for Indigenous and rural woman is high on the Government's agenda, the Rural Women's GP Service (RWGPS), implemented in May 2000, provides services to women in areas with 1,000 or more residents only (Australia. Dept of Health and Ageing, 2009b). The RWGPS visits are scarce, with visits scheduled for 1 to 6 monthly and maternal health is not listed as a service provided. Coordinated policies that link government department and services such as health, education, housing and social services are better suited to ensuring disadvantaged women have available to them, and are able to access, support services as needed. The New South Wales Government has implemented one such program, the Schools as Community Centres (SaCCs) initiative, linking socially disadvantaged women with children from birth to 8 years of age with government and private services as required (West & Badham, 2008). The aim of SaCCs is to improve health and reduce the impact of social disadvantage on women and children in their local area by forming social networks and including women in both informal and formal systems and services. Although no current data are available regarding the measured health benefits of this initiative, other research findings support the notion that improved access to health services and health information in a way that demonstrates a valuing of the woman and her needs will improve health literacy and therefore health outcomes (Cox, 2009; Goleman, 2007; R. Wilkinson & Marmot, 2003).

3.4 Providing midwifery care in Australia

Currently, in Australia, a woman may receive her midwifery care from a registered midwife who practices independently; a midwife who works within a Midwifery Group Practice model of care; a small team of midwives (team midwifery or Community Midwives Program) who carry a caseload of women; a midwife who is rotated throughout all areas of a maternity service; or a midwife who works within one specific area of the maternity service. Midwives may work full time, part time, on a casual basis or be self-employed. The following is a brief description of some examples of the way midwives might work.

Independent midwifery practice or the private practice midwife: entails the midwife having gained authority to practice, works privately (self-employed) and independently of a hospital provider. The midwife provides total care throughout the childbirth continuum for women who seek her services. The midwife provides continuity of midwifery care with the ability to establish an ongoing relationship with the woman. Eligible midwives have prescribing rights and are able to provide Medicare rebateable maternity care to women.

Midwifery group practice or caseload: a model of care in which the midwife works in a small group of midwives (usually 4-6) to provide total care for women throughout pregnancy, labour and birth and the postnatal period. Each midwife in the team has a ‘case load’ of women and is the primary midwife/carer for each of those women. The midwife, therefore, provides continuity of midwifery care throughout the childbirth continuum, with the ability to establish an ongoing relationship with the woman.

Team midwifery: is similar to the Midwifery Group Practice in that a team of midwives work together to provide total care for a number of women. However, in a team midwifery program it is common for up to 20 midwives to be in the team and the women are not formally allocated to one particular midwife. Therefore the woman is less likely to establish an ongoing relationship with a midwife and may never have met the midwife who supports her during labour and birth. Team midwifery programs are often located within hospital grounds.

Standard or hospital-based midwifery care: generally means the midwife is employed by a local health district service or private provider and is rostered to work allocated shifts. The midwife may or may not see the same woman for more than one shift, depending on the woman's length of stay, health status and the midwife's roster and rotation within the maternity unit or ward. In this model there may be little opportunity for the midwife to establish an ongoing relationship with a woman and it is usual for the woman to not know the midwife providing care during labour and birth. The ability to form a relationship with the woman also depends on staffing, the geographical location of the maternity service and the size of the unit.

Early discharge program: a midwife employed by the local maternity service visits women in their home following discharge from the hospital. The midwife performs postnatal checks on the woman, and newborn screening tests and check-ups on the baby. The midwife also provides support and education about normal postnatal care, breastfeeding and other issues relevant to the woman. Each maternity service determines the length of care provided through the program. While the timeframe is short, the midwife has the ability to establish a relationship with the woman.

Community midwifery clinic: is similar to midwifery group practice and team midwifery. The midwife works in a small group of midwives to provide care for women in the community. The range of midwifery care can vary, with some clinics offering only antenatal care. Other clinics offer antenatal and postnatal care and still others offer care throughout pregnancy, labour and birth and the postnatal period. Each midwife in the team has a 'case load' of women and is the primary midwife/carer for each of those women. The midwife, therefore, has the ability to establish an ongoing relationship with the woman.

Regardless of the model of care in which a midwife works or the midwifery context, all midwives in Australia are regulated and therefore required to practise in accordance with relevant laws, policies, standards and guidelines. These include the Code of Ethics for Midwives in Australia, the Midwife's Guide to Professional Boundaries, and the National Competency Standards for the Midwife (ANMC, 2008; 2010b; 2006). In Australia the National Competency

Standards for the Registered Midwife are embedded within a conceptual framework of woman-centredness. Midwives are directed, and professionally bound, to provide woman-centred care within a partnership model of practice (ANMC, 2006). However, the majority of Australian women currently receive their maternity care in standard hospital-based maternity units and 97% of Australian women birth in a hospital (Australia. Dept of Health and Ageing, 2009a). It can be assumed, therefore, that the majority of midwives in Australia continue to provide midwifery care within hospital-based environments. Hospital-based maternity units are part of larger local health district organisations with operational parameters that require rotating rosters, staff-patient ratios, workplace routines and workloads aimed at meeting workforce efficiencies.

Fahy (2007) found that hospital-based maternity care environments are dominated by medical professionals and, according to Pollard (2010), midwives working in these environments are often placed in a position where they are obligated to meet institutional needs. Furthermore, the environment in which care is provided influences both the model of care provided and the communication techniques used by midwives (McCourt, 2006). The consequence of situating midwifery care within medically dominated maternity care environments is a medicalised model of care - midwifery care that fails to focus on the needs and wants of individual women (Hollins Martin & Bull, 2006; Pollard, 2010; Stapleton, Kirkham, Thomas & Curtis, 2002). Maternity care that is institution-centred directs midwives to focus on task completion and care standardisation which is risk averse, rather than providing women-centred care (B. Hunter, 2004).

Furthermore, findings from an Irish study that examined communication between women and midwives revealed incongruities between professional ideologies and practice. The authors, Hyde and Roche-Reid (2004), found that although midwives expressed the desired outcome for woman-midwife interactions as an opportunity to empower women, communication strategies used by midwives within the maternity care encounters focused on meeting institutionally required outcomes. Hunter (2004) proposed that a person's professional ideology that contradicts clinical practice is a major cause of

emotional stress for midwives, with student midwives and newly qualified midwives experiencing the greatest emotional discord. Moreover, midwives who strive to practise woman-centred care within institutionally-focused environments not only experience personal conflict, they also experience intra-professional conflict with midwifery colleagues who support institutional foci or the status quo (B. Hunter, 2005). Australian midwives who have been educated with woman-centred philosophy of care and who are practising in hospital-based maternity units may also be at risk of emotional and cognitive dissonance. They too may be working under similar emotionally stressful conditions as their midwifery colleagues in other countries, who attest that conflicting philosophical requirements in the workplace are a source of emotional and professional stress (B. Hunter, 2004; Jones, 2005; Ng, 1997).

3.4.1 Midwifery education in Australia

In the last decade midwifery education in Australia has undergone significant changes. Prior to 2000 Australian midwives obtained their qualification by means of a postgraduate education. Entry into midwifery programs was available to a person with a registered (RN) nurse qualification. A number of factors triggered the development of a Bachelor of Midwifery program with direct entry pathways. Some of the driving forces behind the change in midwifery education included a recognised ‘push’ from both the midwifery profession and birthing women for models of care that meet the needs of women and allow midwives to work in partnership with women in a more autonomous manner. There were inconsistencies and inequities in state and territory funding for midwifery programs. In addition there were variations in the length of the programs, clinical placement experiences and graduate attributes (Australian Health Workforce Advisory Committee, 2002). Midwifery candidates were drawn primarily from the nursing workforce, with three subsequent negative outcomes. Firstly, any issue that affected the nursing workforce indirectly affected the midwifery workforce. Secondly, midwifery students commenced their program after having been enculturated into the medical model of health care. Lastly, people who wanted to become midwives were first required to complete a nursing degree, which resulted in a longer period of study and a significant financial outlay.

Both the Australian Nursing and Midwifery Council's National Framework for the Accreditation of Nursing and Midwifery Courses document (ANMC, 2009) and the Australian Health Workforce Advisory Committee (2002) recommendations support midwifery graduates that are able to practise in ways that meet the individual childbearing woman's needs regardless of the midwifery context. The ANMC document requires midwifery education providers to ensure graduates have common and transferrable skills and knowledge, relevant to their context of midwifery practice (ANMC, 2009, p. v). The Australian Health Workforce Advisory Committee (2002) recommends that midwifery workforce needs be assessed according to the needs of childbearing women, with preferred outcomes aimed at ensuring the provision of optimal models of care for women.

An increasingly common way to attain an entry level midwifery qualification in Australia is through a university based Bachelor of Midwifery program. The implementation of a three year degree in midwifery is thought to be the most appropriate way to prepare practitioners to work in models of midwifery-led care that are woman-centred. It is anticipated that the Continuity of Care Experiences students are provided and the longer period of time undertaking a midwifery specific educational program will facilitate the development and expansion of midwifery models of care and woman-centred midwifery practitioners. However, learning midwifery theory and translating that theory into practice is a complex issue. The length of the program and proposed clinical experiences are but two factors that influence students' application of knowledge.

An Australian study by Levett-Jones and Lathlean (2008) explored the factors that influence experiential learning. The authors concluded that the most significant factor in student learning is the registered nurse/s with which they spend the shift. A student's need to belong and be accepted within the clinical environment is paramount to their ability to learn. When the student works with registered nurses who fail to value and support the student's need to learn, the student adopts the work practices of the clinical environment to gain a sense of belongingness. Midwifery research undertaken by Bluff and Holloway (2008) also suggests that student midwives learn how to midwife from the midwives they work with. Bluff and Holloway looked at student midwife learning in pre-

registration courses in England. They concluded that students emulate the role model they observe. While more senior students are able to differentiate between a model of care they deem to be midwifery appropriate and one that is not, vicarious learning in the clinical venue is a major influence on student learning. Students who worked with midwives who practiced within a woman-centred framework emulated a similar way of working with women. Equally, students who worked with midwives practicing institutionalised models of care emulated that model of care (Bluff & Holloway, 2008). Concurrent with the push for midwifery education to be embedded within the tertiary education sector as a direct entry degree is the drive by some parts of the tertiary education sector for programmes to be delivered increasingly on-line (Brown, Anderson & Murray, 2007). If midwifery education adopts e-learning for the delivery of theory alone, without consideration of experiential learning, the clinical placement experiences and vicarious learning may have an even greater impact on student learning and future midwifery practice.

3.5 Social disadvantage and midwifery relationships

As previously stated much contemporary midwifery practice is framed within a continuity of carer model, wherein a woman can develop a relationship with her midwife throughout the childbirth continuum. DeLasmutt (2007) asserts that a sense of connectedness, established through the midwife-woman relationship, is a cost effective way to improve birth outcomes and the health of future generations. While there are some examples of supportive models for socially disadvantaged women, this group of childbearing women are commonly allocated to a model of maternity care that fragments their care encounters between them and doctors, midwives and allied health professionals. The establishment of an ongoing relationship with a known midwife can be difficult under these conditions, a situation which further disadvantages these women and their birth outcomes.

Through the development of positive woman-midwife relationships midwives are able to provide social support for women throughout their childbirth continuum. Current research in the area of social intelligence indicates that participation in positive relationships improves a person's emotional and physical wellbeing and

boosts the body's immune system (Goleman, 2007). Continuity of midwifery carer models of practice can facilitate a sense of connectedness for the woman by acknowledging and addressing her needs. Additionally, midwives who link a socially excluded, isolated or disadvantaged woman to local support services and other women can contribute to positive community relationships and further improve the woman's capacity for emotional and physical wellbeing. Improved maternity care experiences and birthing outcomes for disadvantaged women is grounded in the establishment of mutually respectful midwife-woman relationships and the midwife's knowledge of, and ability to link socially excluded women to local support networks.

The importance of positive relationships between health care professionals and socially disadvantaged women emerged as a major finding in a Canadian study involving women living in temporary accommodation (Woolhouse et al., 2004). Participating women felt 'respected' and 'valued as members of society' when they perceived that their relationship with their doctor was collaborative. Similar findings were reported in a Swedish study involving women and birth centre midwives (Berg, Lundgren, Hermansson & Wahlberg, 1996). Berg and colleagues (1996) concluded that women perceived their birthing experience as positive when the midwife respected them, treated them as an equal and was able to meet their needs as an individual. In addition, a randomised controlled trial involving 1,000 women receiving various models of maternity care reported that the quality of individual interactions with health care providers is a significant indicator of women's satisfaction of care (Biro, Waldenstrom, Brown & Pannifex, 2003). Biro and colleagues concluded that midwifery led models of care provide women with a higher level of emotional support and more opportunity for involvement in decision-making processes (Biro et al., 2003). In Australia, an evaluation of the Southern Aboriginal Maternity Care Project, implemented in South Australia, was undertaken in 2008. An outcome of the evaluation process was a recommendation that health care professionals develop "trusting and respectful relationship[s]" with Aboriginal women to improve their maternity experiences (Power, Nixon & O'Donnell, 2008, p.29).

3.6 Social disadvantage and maternity care experiences

Socially disadvantaged people say that bureaucracy often fails to provide respect and support and that distrust of government agencies is common. People who are socially disadvantaged feel ‘unheard’ when requesting assistance and they complain that insufficient information is provided so they can make informed health choices (Saunders et al., 2007). As discussed in the previous chapter, gender can impact negatively on a person’s health outcomes. However, gender also influences a person’s experience of their health care visit. Ferguson (2008) proposes that women attending health care visits are socially positioned through values expressed during the interaction; health professionals judge women and offer care options that they perceive to be appropriate.

Midwives espouse woman-centred care and reciprocity and claim women are the experts on their own body; however some women perceive their interactions with midwives as disempowering (Barlow et al., 2007; Eliasson et al., 2008; Nyman et al., 2010). An observational study of Swedish midwives illustrated that midwives ‘manipulate’ antenatal visits by initiating and directing the majority of dialogue, such that women become reluctant to engage in discussion or to dispute information provided (Olsson & Jansson, 2001). Similarly, Hunt (2004) reported that socially disadvantaged childbearing women sense a lack of respect from midwives during their maternity care encounters. Socially disadvantaged women’s understandings concerning the attitudes and behaviours of midwives is supported by the findings of Beverley Skeggs (1997). Skeggs interviewed a cohort of impoverished women in England during the 1990s who were using the National Health Service for their maternity care. She found that the women were aware of midwives’ attitudes towards them and of being ‘weighed up’ by midwives (Skeggs, 1997). The women conveyed that midwives made assumptions regarding lifestyle options and circumstances based on clothing and appearance, area of residence, number of partners and number of pregnancies (Skeggs, 1997).

This finding is supported by Hunt (2004), who suggests that socially disadvantaged women perceive that midwives discriminate between the ‘deserving poor’ such as widows and orphans and the ‘disreputable

'undeserving poor' such as teenagers, single parents, substance abusers, or multi-gravid women from lower income households. Hunt (2004) further claims that midwives often make assumptions relating to social disadvantage, with some midwives voicing that social disadvantage would resolve if women simply ceased to engage in unhealthy behaviours and allocated finances appropriately. When women believe they are intimidated, ignored or disempowered by health professionals, they feel unable to voice their needs (Woolhouse et al., 2004). Socially disadvantaged women, therefore, may be less likely to verbalise their needs or seek clarification when they do not understand the information provided by midwives. In this context, midwives are seen as government agency employees. An inability to adequately express one's needs can result in inappropriate access to and utilisation of, health care services.

Women with complex needs, such as those who are socially disadvantaged, require care from health professionals who understand the interrelated issues impacting on their lives, as well as knowledge of the relevant services required (G. Johnson, 2007; Lundgren & Berg, 2007; Williams & Thorpe, 2008). According to Richen (2003), all women, regardless of colour, ethnicity, race or socio-economic standing want to be accepted, to be respected and to be included in dialogue around choice. However, Canadian research into patient-physician relationships (Woolhouse et al., 2004) found that disadvantaged women experience difficulty in being assertive or proactive regarding their health information, particularly with health professionals with whom they have no relationship. Women participating in the Woolhouse (2004) study reported that health care visits were more hurried and that health professionals were less likely to listen to the woman's needs when a relationship had not been established. Furthermore, these women felt that, in the absence of an ongoing relationship, health professionals were distrustful of the women's voiced concerns and responses.

Socially disadvantaged women also believe their social status directly influences the style and quality of maternity care they receive. They express that their care is of poorer quality due to their social status and feel powerless to do anything about it (McCourt, 2003). This understanding may be a consequence of existing evidenced based maternity care practices. Current

literature demonstrating a correlation between social disadvantage and poor birth outcomes highlights that socially disadvantaged women are exposed to a secondary level of bureaucratic disadvantage and disempowerment, with disparities in the availability of models of care and level of choice concerning options of care. This group of women is often excluded from continuity of midwifery carer models of maternity care designed for 'low risk'* women. Furthermore, health professionals are more likely to categorise socially disadvantaged women as 'high risk'* and deny them the opportunity to birth naturally or unassisted by medical intervention (Carolan & Hodnett, 2007). When institutional support systems fail to meet women's needs their sense of worth is further decreased, which, in turn, can reinforce feelings of disconnectedness, isolation and depression (Mitchell & Hodson, 1983).

3.7 Social disadvantage and potential benefits of woman-centred care

A systematic review published in 2008, involving more than 12,000 women classified as low or mixed risk, concluded that women receiving midwife-led maternity care had better birth outcomes, with fewer antenatal hospitalisation episodes, fewer episiotomies and less analgesia requirements and instrumental births (Hatem, Sandall, Devane, Soltani & Gates, 2009, July 9). Furthermore, women receiving midwife-led care were more likely to have a known midwife in attendance at their birth and express that they had control over decision-making processes during childbirth (Hatem et al., 2009). These findings strongly suggest that socially disadvantaged women would benefit from a midwifery-led model of maternity care.

Midwives are in a position to intimately view socially disadvantaged women's lives and the effect health disparities have on these women and their families. Women who experience positive relationships with a health care professional gain a sense of emotional support and feel respected and valued (Woolhouse et al., 2004). Trusting and mutually respectful relationships between health professionals and women result in more frequent visits to health services, increased health literacy and better health outcomes for women and their families ("Health visitors to tackle inequalities," 2008). A supportive relationship

between the woman and the midwife throughout the childbirth continuum can improve the woman's health and reduce poor birth outcomes associated with social disadvantage (Goleman, 2007). The provision of woman-centred maternity care has the potential to reduce the health disparity of premature birth. In 2011, Wisanskoonwong and colleagues undertook a systematic review of the effectiveness of medical interventions aimed at preventing pre-term birth. The authors concluded that medical interventions are not effective in the prevention of pre-term birth and that the provision of holistic, woman-centred midwifery care holds great promise in addressing the health disparity of pre-term birth at a population level (Wisanskoonwong, Fahy & Hastie, 2011).

While the recent plans and documents released by the Australian government, (as discussed under the chapter heading – *Maternity service provision in Australia*) may improve access to services and increase the number of care models available for socially disadvantaged women in Australia, the actual maternity care received and the relationship between the woman and the midwife may have a greater impact on women's experiences and birthing outcomes. The provision of woman-centred care has the potential to improve the individual socially disadvantaged woman's birth experience, both physically and emotionally, as well as reducing perinatal health disparities at the population level.

3.7.1 Deficits in current understandings

Before claims can be made that woman-centred care is the answer to perinatal health disparities, health professionals need a clearer understanding of the current maternity care experiences of socially disadvantaged women. In order to measure or evaluate the outcomes of woman-centred care, we need to understand what aspects of care are currently understood to be woman-centred by socially disadvantaged women. We also need knowledge of midwives' understandings of woman-centred care in relation to the socially disadvantaged woman and to have an understanding of the factors that impact on midwives' ability to provide woman-centred care within Australian maternity services. Current understandings provided in this section of the thesis reveal a deficit in available knowledge around the maternity care experiences of socially

disadvantaged women in Australia. That is, how do socially disadvantaged women make sense of their maternity care encounters and understand woman-centred care? There is also a deficit in available knowledge concerning registered midwives' and student midwives' understandings of woman-centred care within the context of Australian maternity services. These deficits lead me to pose the question, "How do socially disadvantaged childbearing women, registered midwives, and student midwives understand woman-centred care?"

3.8 Conclusion

This section of the thesis provided an overview of social disadvantage in relation to childbearing women and midwifery work. Current literature in this area demonstrates that socially disadvantaged women have less control or choice over their maternity care options and are more likely to experience a poor birth outcome than non-disadvantaged women. Furthermore, socially disadvantaged women perceive that their social position in society results in the provision of a poorer quality maternity care, adding to their sense of powerlessness. Midwives, as the primary health care professionals working with socially disadvantaged birthing women, are ideally positioned to enhance maternity care experiences and improve birth outcomes for socially disadvantaged women. However, midwives can find it difficult to provide midwifery models of care that can empower socially disadvantaged women within hospital-based or institutionally focused maternity care environments.

Woman-centred maternity care appears to be the means to develop midwife-woman relationships that will provide greater emotional and physical support for socially disadvantaged women. However, there is currently little understanding of how socially disadvantaged women in Australia experience their maternity care encounters in relation to the midwifery concept and maternity care philosophy of woman-centred care. There is also limited evidence of how midwives in Australia experience working with socially disadvantaged women within the context of providing woman-centred care and how student midwives understand the midwifery concept of woman-centred care.

The next section of the thesis - *Processes enabling new understandings*, provides a detailed account of the research approach and methods used to

address the deficits in midwifery knowledge regarding woman-centred care and socially disadvantaged women in Australia, and to answer the research question, “How do socially disadvantaged childbearing women, registered midwives, and student midwives understand woman-centred care?”

Section 3: Processes enabling new understandings

The last section of the thesis provided an overview of social disadvantage in relation to childbearing women and midwifery within the Australian context. What is not known is how socially disadvantaged women, registered midwives and student midwives working with socially disadvantaged women make sense of woman-centred care. This section provides the reader with an understanding of the research processes used to answer the research question, *“How do socially disadvantaged childbearing women, registered midwives and student midwives understand woman-centred care?”* It is in this section that I make known my way of viewing the world; my position as a researcher, practising midwife and midwifery academic. I share with you how I came to have an interest in exploring woman-centred care and explain why I chose the research approach used to explore women’s, midwives’ and student midwives’ understandings of woman-centred care. A detailed account of the research approach and methods are provided to ensure the reader can understand the steps taken to access and construct new understandings concerning maternity care encounters, socially disadvantaged women and woman-centred care. This research was approved by the University of Newcastle’s Human Research Ethics Committee, Approval No: H-2009-0194 in July, 2009.

4 Researching understandings

There are multiple ways of viewing experiences we have and the world in which we live. There are also multiple ways of processing those views, which leads to our individual ways of knowing or understanding. Discussions around ways of understanding can be divided in a variety of ways. The most obvious differentiation we make is that of the quantitative and qualitative paradigms. These paradigms are further differentiated into a number of research approaches or methodologies. To simplify the discussion around ways of understanding I briefly discuss quantitative and qualitative paradigms under the next heading - *Ways of viewing knowledge*. Later in this chapter I provide a more detailed discussion of the qualitative research approaches considered for this study.

4.1 Ways of viewing knowledge

Muijs (2004) asserts that quantitative research involves measurement; the collecting of numerical data or information to gain statistically relevant knowledge about a phenomenon. Mathematical formulas are usually employed to reach conclusions regarding the validity, reliability and generalisation of findings. Quantitative research includes positivistic and some postpositivistic methodologies. Researchers using positivistic methodologies view data as facts, discovered through, and validated by, measurable reproducible experiments which are hypothesis driven. The researcher is more likely to consider themselves an objective observer (Lincoln & Guba, 2000). Researchers who view the world from a postpositivist stance are likely to see data as information that is credible or plausible. The researcher maintains an objective observer position with study designs that either build on or expose falsifications of previous knowledge (Lincoln & Guba, 2000). Quantitative research methods handle certain investigative issues or questions involving numerical data well. Quantitative research adds to the body of knowledge pertaining to normative and statistical interpretations of findings. It does not, however, handle data derived from questions relating to human experiences or understandings easily. While quantitative research provides statistical knowledge such as percentages,

risk-ratios and probabilities, not all events or experiences in a person's life can be understood through measurement. This is where qualitative research can add to the body of existing knowledge.

"Qualitative research helps us make sense of the world", providing a certain type of knowledge and the tools to resolve confusion about events and experiences (Morse & Richards, 2002, p. 5). Denzin and Lincoln (2000) explain that qualitative researchers acknowledge that the nature of reality is socially constructed. That is, a phenomenon cannot be experienced outside of the individual's pre-existing world and known meanings. Knowledge existing within a group is maintained by group members and passed on to those entering the group. An individual's understanding of their experience is always constructed through an existing and shared social reality. The sharing of their experience with group members strengthens and shapes shared reality. Audi states "that knowledge of the world is possible only by imposing pre-given categories of thought" onto an experience (2006, p. 855).

Qualitative enquirers seek to answer questions about meanings associated with particular social experiences. Qualitative writing is an unfolding story in which the researcher progressively "makes sense, not only of her data, but of the total experience of which it is an artefact" (Holliday, 2008, p. 122). Knowledge resulting from qualitative research processes is fashioned from the situational context and researcher-participant relationship. The qualitative paradigm was chosen for this study because I sought to gain an understanding of participants' understandings of their experiences of woman-centred care within the socially constructed context of maternity care encounters.

4.2 How I view the world

Because qualitative research is itself a social action, the presence and influence of the researcher must therefore be acknowledged (Holliday, 2008). How I view the world, through pre-existing values and beliefs, influenced the research processes undertaken to complete this study. It is for this reason that I acknowledge my position within the research process. The researcher's ways of making sense of the world they wish to examine can be explained by three basic belief systems; their epistemological, ontological and axiological beliefs. A

person's epistemological way of viewing the world is concerned with how the knowledge or understanding under examination is formed (Steup, 2010). The ontological perspective refers to how knowledge is constituted and expressed as truth (Hofweber, 2011). The researcher's axiological stance is concerned with their values system; what can be classed as good morally, ethically and aesthetically (Axiology, 2011).

My ontological view of the world is that there are many realities. My realities are open to change depending on the context, timeframe of my life history and addition of new experiences and understandings that alter awareness. The women, students and registered midwives participating in this study, as well as myself and the readers of this thesis, have different understandings of the same phenomenon, woman-centred care. My epistemological view is that the understandings brought into being as a result of this thesis will be co-created by researcher and participants. The registered midwives, student midwives, women and I will create understandings through reflective sense-making of recounted experiences of maternity care encounters. It is understood that the reflection and recounting of maternity care encounters are heavily influenced by the individual's familial, cultural, social and contextual backgrounds. The readers of this thesis will also interpret, through their understandings of the world, the recounted and documented experiences presented. Understandings, therefore, are continually co-created between participants, author and reader/s. My axiological view of research is that personal values are inherent in all research. A person's values influence the topic to be studied, the research paradigm and design selected, as well as the specific research question and final format of the thesis. Whether or not a person chooses to be explicit about their biases is an individual decision and often aligned with the research paradigm.

Research within a quantitative paradigm makes use of the explicit articulation of hypotheses to make any bias transparent. However the nature of qualitative research is such that sources of potential bias need to be managed through a range of methods but primarily involving identification of personal perspectives of the researcher (as provided here), and the preservation of the 'voices' of the participants in the presentation of findings; that is, making researcher

interpretation open to inspection. Gadamer (2004) proposes that disclosing personal views and existing understandings assists in clarifying the processes involved in the creation of new understandings. The research approach selected for this study, Interpretative Phenomenological Analysis, is within the qualitative paradigm and as such my values and beliefs will be open and transparent. The researcher is viewed as a source of data as well as pivotal to the meaning making process. My values, beliefs, background and experiences are expected, therefore, to be part of the interpretative and meaning making process.

4.2.1 The researcher's voice

Holliday (2008) argues that the researcher is not only a “major ingredient of the written study, but must be evident for the meaning to become clear”(p. 122). This thesis is written in the first person throughout as a way of writing the researcher into the data and the text. Use of the first person creates a transparent relationship between the writer and reader, and opinion is not hidden within the text as factual details by the use of impersonal language (R. Clark & Ivanic, 1997). There is no pretence that the information presented is an inventory of objective facts discovered in the unexplored territory of participants' minds. As the thesis took shape, my way of viewing and understanding the world shifted. What is included or excluded from the thesis, along with how information is presented, altered. The completed thesis document or outcome is different from what was originally drafted, for “writing is itself part of the process of qualitative investigation” (Holliday, 2008, p. 121). The thesis was born as the data became familiar to me and words were positioned on the screen in a way that aligned with my existing view of the world. The text within this thesis, therefore, is the product of thought arising from my voice and my representation of others interconnected at the time of writing.

4.2.2 What led me to this topic area

Researchers play a significant role in what topic is researched as well as how the issue will be examined and reported. Topics are selected based on varied and complex issues such as work commitments, funding requirements or the researcher's background, values, culture, gender, family circumstances and

position within their own culture/s. It would be too simplistic of me to claim that my choice of topic was related directly to one of the following: growing up in a public housing area; undertaking nursing and then midwifery education within perceived submissive, patriarchal and medically dominated maternity services; having a sense of powerlessness in a society that values social standing, financial independence, high educational and income levels and maleness.

These issues have influenced my decision to explore woman-centred care. I believe, however, that the findings from my Masters of Philosophy-Midwifery and my position as a midwifery educator were more of a direct influence over my decision to seek a greater understanding of the midwifery concept and maternity care philosophy, woman-centred care. A major finding from my Masters of Philosophy-Midwifery was that, the midwives in my study were unable to provide a woman-centred or partnership model of dialogue around smoking cessation when interacting with women who continue to smoke during pregnancy (Ebert, 2008). The findings from my Masters of Philosophy-Midwifery prompted me to consider how midwives work with and for women experiencing socially objectionable situations such as drug and alcohol use, child sexual abuse, domestic violence, mental illness and other socially silenced topics. Social disadvantage correlates closely to socially determined problems such as drug and alcohol misuse, mental health issues, crime and violence (Draine, Salzer, Culhane & Hadley, 2002). Midwives work with women experiencing the realities of social disadvantage every day. A greater understanding of how the women and midwives understand woman-centred care, within the context of social disadvantage, appeared to me an important issue to explore.

The final conscious influence directing me to explore woman-centred care, as it occurs within maternity care encounters, was the reflective journal entries of student midwives to which I had access as a midwifery academic. Student midwives wrote in their journals of the discrepancies between midwifery theory and midwifery practice, as observed in the clinical setting. A greater understanding of how student midwives experience the midwifery concept and maternity care philosophy woman-centred care also appeared to me to be an important issue to understand.

4.2.3 Making choices around research approaches

Birthing, midwifery work and the concept of woman-centred care is complex and multilayered, the research approach chosen, therefore, must also be. As a midwife researcher wanting to explore the phenomenon of woman-centred care I looked for a research approach congruent with a midwifery, woman-centred philosophy. I sought a research approach that allowed flexibility in data collection and analysis; one that allowed the researcher to explore sameness and difference whilst giving participants their own socially constructed voices. Because my study involved three different groups of participants, socially disadvantaged women, registered midwives and student midwives, I required an approach that would allow me to look at differences of understandings concerning the same phenomenon, woman-centred care. I also required an approach acknowledging the absence of a fixed truth, one that recognises that participants' understandings change.

Research approaches using an interpretive framework provide access to understandings of a particular experience, with the emphasis on the context in which the participant resides (Benner, 1994). Researchers using an interpretive approach assume a relativist ontology; that is, multiple realities may be viewed through different lenses at any one time and place. Each person's version of reality is true for him or her. Interpretative research approaches also recognise that the researcher plays a collaborative role in the meaning making process; meaning develops through a shared understanding between the participant and researcher. A partnership connecting the researcher, participant and data is formed to create text that provides a cohesive understanding around the issue being explored. An interpretive research approach was chosen for this study because multiple understandings of maternity care encounters, as interpreted by participants, were sought.

Other research approaches considered

When considering the most appropriate research approach for my study a number of qualitative research approaches were explored, such as Interpretative Interactionism, Ethnography and Constructivist Grounded

Theory. These approaches are discussed briefly and my rationale for declining them is provided.

Interpretive Interactionism, as originally proposed by Denzin (2001), is guided by “the social construction of gender, power, knowledge, history, and emotion” (p.39). The approach involves the researcher entering the natural environment, or social setting, in which participant interactions occur. The researcher accepts ontologically that there are multiple ways of knowing and expressing truths. Each participant within the interaction may present a different truth. Epistemologically the researcher accepts that knowledge is co-created by researcher and participants. Interpretive Interactionism is appropriate for examining the interactions between people within the broader social context of public policies, organisations and systems. The researcher compares and contrasts the perspectives of participants through the use of thick descriptions, identifying and evaluating strategic points within the interaction that are contained by the social situation and public policies (Denzin, 2001). For this study, I would have preferred to recruit participants, both women and midwives, involved in the same maternity care interactions. Previous experience however, in attempting to recruit marginalised women for my Masters of Philosophy-Midwifery research, lead me to believe that socially disadvantaged women may not want to speak of their carer while still a recipient of care, making recruitment of woman-midwife dyads difficult.

The local government area in which women were recruited for this study had midwifery-led, continuity of carer models of practice available, and midwives at the women’s local maternity service were provided an opportunity to participate. However, no midwife from the local maternity service took the opportunity to participate and with one exception, all women recruited for this study did not receive continuity of maternity care with a known midwife. Exploring the recounted understandings of both participants involved in a single interaction with this group of women was not possible. It is for this reason that Interpretive Interactionism was considered not appropriate for this study.

“An ethnography is a description and interpretation of a cultural or social group or system” (Creswell, 1998, P.58). While participants of this study belonged to

specific social or cultural groups, there was no interaction between or within the various groups. As far as I am aware, participants in the various focus groups, with the exception of midwifery students, did not know, or have contact with, participants in any other group. Ethnography calls for the researcher to immerse themselves in the participant's naturalistic setting. That is the environment in which the participants experience the phenomenon under study. The ethnographer observes the everyday interactions and actions of a culture-sharing group over an extended period of time. Participants are also interviewed regarding meanings given to their actions and interactions with people and artefacts. A description, along with the researcher's interpretation of everyday occurrences within a specific culture-sharing group, results from prolonged engagement between the researcher, situated in the field, and the group under study (McCormack Brown, 2011). While valuable information may have been obtained through this research approach, time constraints associated with my study time line restricted prolonged immersion within the multiple natural settings of each participant group and the various settings within each group. The women, midwives and students did not share a common environment. Observation of the everyday interactions between those who participated in this study would have been difficult to achieve. Ethnography was considered, therefore, not the best approach for this study.

Constructivist Grounded Theory is also a qualitative research approach that seeks to explore a known phenomenon. It recognises the shared meaning-making process between participant and researcher and accepts that understandings are subjective (Charmaz, 2000). Similar to Ethnography, Constructivist Grounded Theory calls for studying participants in their natural environment. While Constructivist Grounded Theory uses many of the research processes applied within this study, the intent of a Grounded Theory study is to generate theory related to the phenomenon. It is not my intention to generate a theory around woman-centred care. My study involves three different participant groups. There is no attempt to combine their understandings or look for saturation of data. Saturation of data occurs when no new information or understanding is obtained through additional collection of data (Charmaz, 2000). For this study, I acknowledge that each group's understanding of

woman-centred care is presented through the shared interpretation of participants and me at the time of writing. Participants did not come to a fixed point in their understanding. Grounded Theory methods ask that the researcher limit where possible their pre-conceptions (Matevera & Kroeze, 2009). As discussed earlier, failing to acknowledge my pre-conceptions is not appropriate for this study. I am examining a midwifery concept and maternity care philosophy that is well known to the researcher and at least two of the three participant groups. The initial reading and coding of transcripts during analysis entails searching for participant quotes related to the pre-determined elements of woman-centred care. Constructivist Grounded Theory was considered not appropriate for this particular study.

4.3 Interpretative Phenomenological Analysis

For this study, which explores the understandings of woman-centred care as described by three different participant groups, I adapted the research approach Interpretative Phenomenological Analysis. Interpretative Phenomenological Analysis was introduced to the research community in 1996 when Jonathon Smith published his article ‘Beyond the divide between cognition and discourse: using interpretative phenomenological analysis’. Although Interpretative Phenomenological Analysis is relatively new when compared with other qualitative research approaches, it draws on concepts established well before the 1990s. Smith, Flowers and Larkin (2009) state Interpretative Phenomenological Analysis “is an approach to qualitative, experiential and psychological research which has been informed by concepts and debates from three key areas of the philosophy of knowledge - phenomenology, hermeneutics and idiography” (p.11).

The basis of Interpretative Phenomenological Analysis is phenomenological because it explores individuals’ lived experiences, their perceptions or accounts of an event, situation or phenomenon. The underlying principle of any study with a phenomenological focus is to gain an understanding of a particular phenomenon, from people who have experienced it (E. Clark, 2000). Participants were asked to provide detailed descriptions of their experiences of the phenomenon. The researcher develops a clearer understanding of the

phenomenon, through comparing and contrasting individuals' recounted experiences, looking for shared and idiosyncratic accounts. Smith et al. (2009) assert that the value of phenomenological research approaches is their ability to provide a wealth of knowledge around how to examine and understand the lived experience. The phenomenological approach most closely aligned with Interpretative Phenomenological Analysis is Heideggerian phenomenology. From a Heideggerian perspective all knowledge, or understanding of a phenomenon, is derived from persons already existing in a world with shared, pre-existing meanings (Leonard, 1994). A person is always in a state of interpreting their world. No attempt to provide meaning can be offered to the researcher outside the person's lived timeline and history, without interpretation and incorporation of understandings already in existence. Participants, in the phenomenological recounting of experiences, are performing an interpretative act through the use of reflection and language (van Manen, 1990). This study has a phenomenological perspective. I am asking socially disadvantaged women, registered midwives and student midwives to recount their lived experiences of maternity care through interpretative descriptions of encounters in which they played a part.

Interpretative Phenomenological Analysis moves beyond the phenomenological approach by assuming a hermeneutical perspective. It is acknowledged that meaning making on the part of both participant and researcher is fundamental for the creation of new understandings. Levesque-Lopman suggests that meaning can only evolve from "an interpretation of a past experience looked at from the present with a reflective attitude" (1988, p.168). Access to participants' understandings is dependent, therefore, upon the participants' and researcher's beliefs, values, life experiences and preconceptions. Interpretative Phenomenological Analysis acknowledges that a double hermeneutic process occurs during analysis, with the researcher attempting to make sense of the individual participant's attempt to make sense of the phenomenon being studied. The hermeneutic enquiry goes further than providing a description of the individual's experience. The focus is on what the individual's reflective account implies about their experience (Lopez & Willis, 2004) and how their

taken-for-granted understandings are constructed by their consciousness to make meaning (Denzin & Lincoln, 2000).

Interpretative Phenomenological Analysis is a research approach that allows me to be transparent regarding my preconceptions and pre-understandings around maternity care encounters and openly use the midwifery concept woman-centred care as my interpretative tool for analysis. For “researching an understanding is not a matter of setting aside, escaping, managing or tacking one’s own standpoint...on the contrary, understanding requires the engagement of one’s biases” (Schwandt, 2000, p. 194). I am exploring the concept and maternity care philosophy woman-centred care and as such will use my pre-understandings of the concept to view data obtained from three different participant groups. There is no attempt to hide or quieten my midwifery pre-understandings. The elements of woman-centred care as defined by the Royal College of Midwives (2001), are used during preliminary analysis to identify instances of woman-centred care within each participant’s recounted maternity care encounters. This study has a hermeneutic or interpretative perspective. I am attempting to interpret or make sense of socially disadvantaged women’s, registered midwives’ and student midwives’ interpretative descriptions of maternity care encounters. Participants, in reflecting on their experience, are attempting to interpret or make sense of the phenomenon of woman-centred care through descriptive accounts.

Smith et al. (2009) assert that Interpretative Phenomenological Analysis studies must be idiographic in their enquiry. Seeking understandings through an idiographic perspective “offers a detailed, nuanced analysis of particular instances of lived experience” (Smith et al., 2009, p.37). The researcher, when looking at data from an idiographic perspective, is concerned with why an individual creates their social reality, why the individual makes sense of the world in a particular way. The individual participant’s experience may be viewed as a valid stand alone unit of understanding. However, Tomkins and Eatough (2010) suggest an idiographic focus does not necessarily pertain to the individual person, but an individual experience.

The term idiographic came into use through the works of a German philosopher, Wilhelm Windelband (1848-1915). Windelband used the term idiographic to distinguish a knowledge different from nomothetic (Audi, 2006). Nomothetic knowledge is usually associated with general statements related to large social patterns. Nomothetic knowledge results from studies that claim to examine a phenomenon objectively. New understandings from nomothetic knowledge are often generalised in relation to populations, events or situations that share similar characteristics to the original data source (A. Johnson, 2000). Idiographic knowledge is created through the recounting of unique events, interactions and situations as described by individuals experiencing the phenomenon. New understandings or knowledge created through idiographic enquiry is not generalisable (Kuper, 2004). Research with an idiographic focus endeavours to make available meaningful accounts from people who experienced the phenomenon being studied. It is the unique experience of the phenomenon being studied that is idiographic (Kuper, 2004).

The terms idiographic and nomothetic have different meanings within the social sciences of psychology, sociology and anthropology. Smith et al., (2009) use the term idiographic whose meaning aligns with the discipline of psychology. A psychological understanding of an idiographic enquiry involves the creation of new understandings derived from an individual participant's recounted experience of the phenomenon under study. Although Interpretative Phenomenological Analysis asserts that idiographic understandings are the unique recounted experiences of particular people in particular contexts, it also recognises people share a worldly and relational experience. This means a person is not discrete, but related to others in their sharing the experience. Wilkinson (1999) states that psychology's individualistic view of studying phenomena has been criticised by feminist and social psychologist researchers because people do not experience a phenomenon in the absence of social, political or cultural contexts. People interpret their lived experiences as members of a socially or culturally constructed society, with shared pre-existing understandings. It is not possible to focus on an individual's experience without considering their social environment and the interactions that occur within their environment.

I have used the term idiographic from an anthropological perspective due to the nature of my study. In anthropology, an idiographical study examines a cultural or socially constructed group, acknowledging every group is unique, with specific properties that set it apart from other groups (Barfield, 1997). Maternity care encounters involve interactions between childbearing women and health care professionals, within a socially constructed situation. I am exploring the idiographic perspective of woman-centred care as experienced by three different socially and culturally constructed participant groups. I have sought to understand each group's idiographic experience of woman-centred care as it is experienced, interpreted and described by them.

4.3.1 Steps taken to gain new understandings: data collection

Qualitative research is designed to take account of particular characteristics of the human experience. Data gathered, therefore, must consist of first person accounts of lived experiences. Interpretative Phenomenological Analysis, while using qualitative data collection methods such as in-depth interviewing, semi-structured interviews, and focus groups to gain access to people experiencing the phenomenon under study, acknowledges the researcher's role in meaning making. The researcher is considered an additional source of data as well as the means through which understanding will result. Polkinghorne supports this notion that "qualitative data is created through the interactions between participant and researcher" (2005, p.138).

Data collected for this study were obtained through segregated focus groups with socially disadvantaged women, registered midwives working with socially disadvantaged women and student midwives observing maternity care encounters in which socially disadvantaged women were the recipients of care. Further explanation as to why focus groups were selected as the preferred method of data collection is discussed under the heading - *Acquiring the data: focus groups*, later in this chapter. As the researcher, I facilitated all focus groups. While attempting to minimise my contribution to group discussions, conversations took place in which participants actively sought to engage my participation. Any text within transcripts created with my words is not used within the findings chapters. My contribution to new understandings comes

through my research journaling for movements of understanding (Benner, 1994; Smith et al., 2009). See the next heading - *Self as source of data*, for a more detailed discussion of this.

Self as source of data

Benner (1994) suggests that a dialogue between practical issues and the lived experience of the research process is developed by the researcher through engaged reasoning, and becoming involved in the participants' world. When the researcher is so closely involved in the meaning-making process, the value laden nature of the study needs to be made explicit. The researcher needs to be open in reporting their position on the phenomenon under study (Denzin & Lincoln, 2000). As discussed earlier in this chapter, my position as midwifery academic is not silenced. My pre-understandings of maternity care and woman-centred care shape the unique meaning-making processes I employ to interpret participant's understandings.

Researchers employing Interpretative Phenomenological Analysis are required to keep a trail of movements in reasoning through journaling. It must be transparent to the reader how the researcher includes or rejects themes or units of understanding around the phenomenon under study; how the significance of themes are developed and analysed. The researcher makes it transparent how issues are aligned with or against earlier thoughts or meanings of the experience being studied (Benner, 1994). Thoughts and understandings attained through an engaged reasoning process were included in the data analysis process. See table 4.1 - data analysis sequence, step two with extracts from my engaged reasoning processes included in table format throughout each findings chapter and a complete table of emerging themes derived from engaged reasoning processes is included as Appendix H: Emerging themes table for socially disadvantaged women. An extract from my reflective research journal is also included as an appendix (Appendix J) with further insight into my personal research journey and processes related to this study discussed in the final chapter.

Participants as source of data

Researchers attempting to understand the lived experience of any phenomenon need to recruit participants who have experienced the phenomenon. Purposeful sampling processes are employed to ensure the researcher can access participants' understanding of the experience under study. The aim of this study was to gain new understandings of woman-centred care through the recounted descriptions and interpretations of maternity care encounters in which socially disadvantaged women were the recipients of care. It is therefore appropriate that purposeful sampling was employed for recruitment and selection processes. Purposeful sampling involves selecting participants for their ability to recall personal experiences and understandings of the phenomena being studied, woman-centred care. For this study, a small number of socially disadvantaged women, registered midwives providing care for disadvantaged women, and student midwives who had observed maternity care encounters in which socially disadvantaged women were the recipients of care were purposefully recruited.

Women participants

Socially disadvantaged women were recruited through two Schools as Community Centres (SaCCs) within one local government area of a coastal region in New South Wales, Australia. Schools as Community Centres provide educational, social and health programs for parents and in particular women who are pregnant or have young children. They are run in partnership with a collective of state health and welfare services. Schools as Community Centres are operational in local government areas identified as areas of high social disadvantage.

The latest published figures for the local government area from which the women were recruited reveal an unemployment rate of 9.1% (ABS, 2010), almost twice that of the national average of 4.9% (ABS, 2011). The area is the eighth most disadvantaged district on the 'Sydney statistical district for indicators of disadvantage' list, which is comprised of 43 districts (ABS, 2006b). The area has the lowest median weekly household income level of all areas in the Sydney Statistical Division and the percentage of teenage pregnancies of

2.6% is considerably higher than the state average of 1.5% (New South Wales Dept of Health, 2010a). The area selected to recruit socially disadvantaged women was also close to my area of residence, which assisted in the organisation and facilitation of focus groups.

Recruitment and selection processes for the women

Discussions with a SaCCs facilitator commenced in July 2009. The aims of my study were discussed with the facilitator, who agreed to relay information about my study to women attending the centre. The facilitator provided women with the information sheets and consent forms and organised suitable times for the focus groups, which were to be held during one of their usual meetings. Based on a literature review by Yancey, Ortega and Kumanyika (2006) examining effective recruitment strategies for minority groups, recruitment through the SaCCs facilitator was thought to be the best means for recruiting socially disadvantaged women.

All women attending the SaCCs were invited to participate in the study. For further information on the selection criteria for participating socially disadvantaged women, see appendix A: Women's Information Statement. Three focus groups were scheduled but did not take place as no woman attended the venue on the scheduled days. Following modifications to the recruitment process, three focus groups with socially disadvantaged women were undertaken between September and December, 2009. For further details regarding the change in recruitment processes, see chapter heading titled – *Challenges associated with recruiting women to this study*.

Challenges associated with recruiting women to this study

The recruitment of socially disadvantaged women to this study proved difficult. Current literature supports that marginalised groups are less likely to participate in health research and therefore be appropriately and proportionately represented in research or have health interventions that best meet their needs (Boyce, 2001; Janson, Alioto & Boushey, 2001; Kelly & Cordell, 1996; Senturia et al., 1998; Yancey et al., 2006). Various explanations have been proffered as to why people who are socially isolated, racially marginalised, impoverished women, educationally deprived or physically disabled are difficult to recruit or

retain in research projects. Recruitment challenges associated with health research derive predominantly from participation in clinical trials. There is limited research on non-participation in qualitative health research by marginalised populations who are not indigenous or racially diverse. To gain an understanding of the difficulties I experienced in recruiting socially disadvantaged non-Indigenous women into a qualitative study, I examined current literature related to the recruitment and retention of disadvantaged groups in health promotion and quantitative research projects.

Participation deterrents for the women

Kelly and Cordell (1996) claim to have developed a woman-centred approach to recruiting socio-economically disadvantaged women into clinical trials for Human Immunodeficiency Virus (HIV) research. They discuss the barriers to women participating in research and how these barriers might be overcome using a woman-centred approach. Although this article is about quantitative research, the use of the term woman-centred caught my interest as it aligns with the phenomenon under study and my philosophical approach to this study. Women, according to Kelly and Cordell, prefer to be recruited and researched by women; recruitment and retention rates in which the researcher is female are double those in which the researcher is male (1996). Impoverished women are also less likely to access environments in which research is occurring, such as their local health district setting. Socially disadvantaged women, therefore, miss research participation opportunities (Kelly & Cordell, 1996). Failure by researchers to schedule participation opportunities in a woman-centred manner results in poor participation. Women are less likely to participate if they have problems with transportation, child minding responsibilities, or they fail to see the direct relevance of the research topic to their circumstances (Kelly & Cordell, 1996).

In 2006, a review of public health literature was undertaken to identify barriers to recruitment and retention of minority groups in health related research (Yancey et al., 2006). The review focused on recruitment and retention of ethnic and racial minority people in clinical trials. While qualitative studies involving culturally dominant socio-economically disadvantaged people were not included, similarities may be drawn as to why socially disadvantaged women do

not participate in qualitative research. Yancey et al. (2006) assert that distrust is a barrier to recruitment and that distrust can be eliminated through effective communication about common goals between researchers and potential participants. Community involvement also facilitates participation; community based organisations provide a captive audience for recruitment because the participants trust the leader of the community group.

Improving recruitment of women in this study

During initial attempts to recruit women I had not been present when women were provided with information about the study. The SaCCs facilitator spoke to women about the study and offered interested women the information sheets and consent forms. This strategy was appropriate as, according to the findings of Yancey et al. (2006), participation is facilitated when community group leaders are involved in recruitment processes. Thus, I had complied with Kelly and Cordell's (1996) woman-centred approach to recruitment by having the SaCCs facilitator involved in recruitment processes as she was a woman known to potential participants. It was the facilitator who provided initial information about the study and explained that a woman would be undertaking the research and facilitating the focus groups.

The recruiter's gender, scheduling of focus groups and environment, child minding and transportation concerns did not appear to be an issue in the recruitment and participation of women for my study. I purposefully went to the environment in which the women usually convene. The SaCCs facilitator had arranged child minding facilities with a play group in the next room. I travelled to meet with the women to ensure they were in their comfort zone. The environment was external to the setting in which their maternity care was likely to have occurred or to occur in the future. Women wishing to participate were not inconvenienced by additional travelling requirements. I was the outsider visiting the women's familiar environment.

The issues of direct relevance and benefit to participants can be difficult to recognise in qualitative research. I was not able to guarantee a direct benefit to the participants and reported as such in my ethics proposal. Although I provided information to the SaCCs facilitator to pass onto women, and supplied

information sheets and flyers, the facilitator informed me that the women had indicated that they saw no benefit in participating. I had incorrectly assumed they would gain a sense of empowerment through the voicing of their collective experiences and increased awareness of self, following reflection of their maternity care encounters. It is fair to assume this was the reason women failed to attend the scheduled focus groups days; these women did not see any direct benefit to them. While the Schools as Community Centres facilitator stated non-attendance was a common occurrence, Yancey et al. (2006) propose participants' attitudes towards a topic and perceived importance of results can affect their determination to enrol, and remain, in studies. This finding is supported by Kelly and Cordell (1996), who report women are more likely to participate in studies when the researcher makes known any direct benefits to them.

Following the failure to initially recruit women, it was suggested that securing an additional SaCCs venue may increase the number of potential participants. Approval to include the second SaCCs venue was obtained and a meeting took place with facilitators from both participating SaCCs. During the meeting it was suggested by the facilitators that I meet with the women in person to explain my study; that it might be better for recruitment if the women met the researcher. This recruitment approach was successful and led to three focus groups being organised.

Registered midwife participants

Midwives involved in this study participated through focus group discussions or individual interviews. Two methods were employed to recruit midwives. The first method of recruitment involved sending an invitation to participate to all registered midwives who reside in Australia, via the web-site ozmidwifery@birthinternational.com. The second and more successful method was through a presentation at the 'Australian College of Midwives 16th National Conference' held in Adelaide in 2009. All midwives participating in this study resided in Australia, were registered to practise as a midwife in Australia, and had worked with socially disadvantaged childbearing women within the previous 12 months. Participating midwives varied in professional demographics, including number of years worked as a registered midwife, educational

qualifications attained leading to registration as a midwife, country in which midwifery education was undertaken, current models of practice and clinical roles. For further information on the selection criteria for participating registered midwives, see appendix B, Conference Midwives' Information Statement.

Recruitment and selection processes for the midwives

An invitation to participate in this study was sent nationally to all registered midwives in Australia via the web-site ozmidwifery@birthinternational.com. Midwives, childbirth educators, community health workers, doctors and other maternity care providers are able to freely access or be accessed through the ozmidwifery website and emailing list. No midwives were recruited through the ozmidwifery emailing list.

In September 2009, I presented at the 'Australian College of Midwives 16th National Conference' held in Adelaide. Following my presentation titled 'Working for socially disadvantaged women' I briefly discussed my study and invited registered midwives in attendance to participate. Information sheets and consent forms were available in the conference room. Recruitment at the conference was successful as three midwives enquired if they could participate as individuals. I provided an opportunity for individual interviews to take place at the conference and data from the interviews were included in data analysis and the midwives' findings chapter.

Other midwives at the conference asked if they could take the information sheets back to their colleagues interstate. Contact details were exchanged and I followed up all potential recruitment leads. Five Midwifery Group Practices, in four States external to New South Wales, initially agreed to participate. Two focus groups eventuated, each consisting entirely of midwives from a Midwifery Group Practice. Midwives participating in these focus groups elected to have a focus group involving their whole group practice. Both of the exclusively Midwifery Group Practice midwife focus groups were held at sites external to New South Wales. Midwives in both Midwifery Group Practice focus groups confirmed that their group practice worked exclusively with socially disadvantaged women.

A third midwife focus group was undertaken within New South Wales. Recruitment of midwives for this focus group was serendipitous. A midwife colleague, who worked at a maternity service in a regional area of New South Wales, discussed my study with her midwifery colleagues. Seven midwives from the maternity service contacted me to ask if they could participate in the study. Six midwives elected to participate in the third midwife focus group. Participants in this focus group worked in various clinical capacities including community midwife teams, hospital based midwifery practice and midwifery management. Participants confirmed that their current midwifery role involved working with socially disadvantaged childbearing women.

Student midwife participants

Student midwives involved in this study participated through focus group discussions. All students were recruited through one university in New South Wales, Australia. At the time of the current study it was usual for Australian universities to offer post graduate entry programs of midwifery study. The university selected to recruit student midwives only offered postgraduate midwifery studies, therefore all student midwife participants were registered nurses enrolled in a Graduate Diploma in Midwifery. The Graduate Diploma in Midwifery is a post-graduate qualification for registered nurses with a Bachelor of Nursing qualification. Participating students had practised within a local health district facility, as a registered nurse, prior to commencing their midwifery program. Participating students were at two different stages of their midwifery education program. Student midwives were eligible to participate in the study if they had observed maternity care encounters involving women identified as socially disadvantaged. For further information on the selection criteria for participating student midwives, see appendix C, Student Midwives' Information Statement.

Recruitment and selection process for student midwives

The Head of School, Nursing and Midwifery and the Head of Discipline-Midwifery at the selected university were approached to discuss my study. I also met with the Graduate Diploma in Midwifery program convenor to discuss the best way to recruit student midwives. Permission was gained from the Head of School, Head of Discipline-Midwifery and program convenor to recruit student

midwives and conduct focus groups within university grounds. An invitation to participate was posted on-line in Blackboard, via a discussion board forum in the courses in which students were enrolled. Blackboard is an online teaching and learning platform used by the university. Discussion board forums are the students' principal means of learning and communicating in their midwifery program. An information sheet and consent form was uploaded into the discussion forum for students to download should they wish to participate. An email directing them to the discussion board was sent to all students in the program as a final measure in ensuring potential student participants were aware of the research opportunity. The program convenor also discussed the study with students during their face-to-face teaching day. Information sheets and consent forms were available on the day of the focus group. The program convenor collected all consent forms. I had no contact with students prior to the scheduled time of the combined teaching session-focus group. The initial student midwife focus groups took place in late 2009.

4.3.2 Acquiring participant data: focus groups

A focus group is a group of people with a specific composition, purpose, procedures and number of participants. Krueger and Casey (2009) suggest the following five features are essential in distinguishing a focus group from other conversation circles or gatherings:

- There must be a sufficient number of participants to provide diversity of perceptions, yet few enough to allow contribution by all participants;
- Participants must have access to a particular knowledge; have experienced the phenomenon of interest;
- Participants must be able to provide the type of information that the researcher requires - qualitative data by means of descriptions, reflections and interpretations of a phenomenon;
- Participants are guided in their conversations; the focus of the group discussion is purposeful; and
- Participants are of assistance in generating new understandings about a phenomenon under study.

Focus groups are in alignment with the interpretive paradigm; participants are provided the opportunity to share their lived experiences of a phenomenon with others who have experienced the same phenomenon. Focus groups allow group dynamics and collaborative reasoning to be observed and provide information unable to be easily elicited through individual interviews. The artificiality of single researcher-participant interviews is avoided, with a glimpse of the social context within which participants operate provided (S. Wilkinson, 1999). Owen suggests that, particularly for vulnerable populations, there is a “tendency to reveal more in a discussion with others than they would in a one-to-one situation” (2001, p.656).

The goal of focus groups is to obtain participants’ experiences as recounted by the individuals; not to provide explanations or theories. Focus groups offer participants a safe environment where they can share ideas, beliefs and attitudes in the company of people from similar backgrounds. The opportunity for participants to direct the discussion and reduce the control or power of the researcher is increased (Denzin & Lincoln, 2000). Focus groups allow the conversations of participants to occur more freely, absent of pre-determined questions (Morse & Richards, 2002). As the conversation amongst group members evolves, the researcher may direct questions to gain a deeper understanding of the topic being discussed. However the participants retain a greater level of control over the conversation.

Tompkins and Eatough (2010) question why focus groups should be used with Interpretative Phenomenological Analysis, given a principal underpinning of this approach is the idiographic understanding of a phenomenon. As discussed earlier in this chapter, I have taken a more social anthropological understanding of the concept of idiography. The focus group method of data collection was selected in an attempt to increase participants’ sense of control and power around the research process. Focus groups are described by Wilkinson (1999) as tapping into the everyday social processes. Women traditionally meet and use conversation with other women as a way of dealing with oppressive situations or to talk about issues important to them (Denzin & Lincoln, 2000). The ordinary social process of gathering to construct reality assists the individual to make sense of their lived experiences. It seemed appropriate,

therefore, to collect data through a means similar to which participants interpret their experiences; through shared understandings. Tomkins and Eatough (2010) suggest that group discussions can be a stimulus for understandings, with group interactions improving the individual and collective attempts at sense-making.

As discussed on page 4-78 of this chapter, recruitment of vulnerable groups to research has been identified as problematic. It was a purposeful decision to use focus groups to collect data for this study, based on the difficulty I encountered in recruiting women participants for individual interviews in a previous study which led to my Masters of Philosophy. This time I wanted to ensure women would feel more comfortable speaking with a researcher/outsider. Webb (2008) suggests that focus groups may be viewed by minority groups as less threatening than single interviews. The group, having access to a shared knowledge to which the researcher is not privy, maintains a collective strength. Participants can choose to share their description of events, to normalise or make-sense of their experiences (Madriz, 2000; Smithson, 2000), creating an empowering environment.

Participants were invited to take part in one group discussion that was related to their role in maternity care encounters. Socially disadvantaged childbearing woman were asked to describe and discuss their maternity care encounters, as the recipients of maternity care. Registered midwives were asked to describe and discuss their experiences of working with socially disadvantaged women. Student midwives were asked to describe and discuss observed maternity care encounters in which socially disadvantaged women were the recipients of care. All focus group discussions were audio-recorded. The recordings were transcribed verbatim with participants' voices made non-identifiable. Further details about focus group processes are provided later in this chapter. See chapter headings – *Women's focus group processes*, *Registered midwives' focus group processes* and *Student midwives' focus group processes*.

It must be mentioned at this point that, although data were collected through multiple focus groups, the process of data analysis was not based on a focus group methodology. The interactions between participants within groups were

noted during preliminary analysis and, where appropriate, presented sequentially within the findings chapters. The dynamics of participant interactions, while generating additional information through discussions and responses, are not presented within the data analysis or findings chapters. This approach is proposed by Smithson (2000). Participants' words were taken as their individual understandings within the group. Analysis was more closely aligned with the processes established in the Interpretative Phenomenological Analysis approach. This process is discussed further in the chapter heading – *Data analysis*.

Participant numbers

Qualitative research is concerned with the richness of meaning derived from participants and not the quantity of participants (Denzin & Lincoln, 2000). This sentiment is echoed by Smith et al. who claim "there is no right answer to the question of sample size" (2009, p.51). A small number of cases, usually three to six, are recommended for Interpretative Phenomenological Analysis studies; however a larger number of data sets can be used (Smith et al., 2009). Each focus group is understood to be a case for this study. Therefore, there are nine cases or data sets.

In relation to participant numbers and focus groups, it is the number of participants required for a group that is debatable, not the number of groups. Peek and Fothergill (2009) claim that three to five participants in a focus group is ideal, as this number allows participants to contribute while reducing the dominant voice phenomenon. Guided by Peek and Fothergill's recommendation for participant numbers, I planned a minimum of three initial focus groups for student midwives. Three groups were calculated to allow every student midwife the opportunity to participate. In an attempt to ensure all research study participant groups were represented equally, I planned for three groups of socially disadvantaged women and three groups of registered midwives. It was, however, difficult to control the final number of focus groups and participants attending each focus group.

In each focus group, participants determined how many people would be involved and to what extent they would participate. Socially disadvantaged

women arrived at the venue and wanted their friends to participate. Student midwives wished to take part in a group consisting of all the students in a particular university intake (commencing studies at the same time). Midwives in the Midwifery Group Practice midwife focus groups requested their focus group be scheduled at a time when they normally met so that all midwives in the group practice could be present. In line with a woman-centred philosophy I affirmed participants' choice to nominate who participated and to what extent. Participants also had choice over venue, control over the duration of the focus group or interview and number of participants involved in each focus group. A more detailed account of the focus group processes for each group of participants is provided later in this chapter.

The final number of participants for initial focus groups totalled seventeen (17) socially disadvantaged women in three separate focus groups. Often the women were not present for the whole group session, some leaving early to do other activities within the Schools as Community Centres venue, while some women arrived late to join the discussion. Eighteen (18) registered midwives participated in three separate focus groups, with an additional three (3) individual midwife interviews. There were twenty eight (28) student midwives in two self-moderated focus groups.

In all follow-up focus groups there was a drop in the number of participants. Only ten (10) socially disadvantaged women attended the collective follow-up group. A number of these women were not participants of the initial focus groups; however, they wanted to be involved in the study. I followed the process as described in the next chapter heading – *Women's focus group processes*, and welcomed the women as participants. As discussed earlier in this chapter, retention of socially disadvantaged women in research is difficult. Issues commonly cited for reducing retention rates are lack of transportation, unfamiliarity of the physical setting, childminding responsibilities and lack of connections with other participants. These issues were not the reason for reduced participant numbers in this study. The drop in numbers was attributed to the usual attendance patterns of Schools as Community Centres, which operate as drop-in centres. Attendance is variable; women are not obliged to attend on any particular day.

Not all midwives who participated during the initial data collection phase participated in the follow-up focus group. Six registered midwives participated in the collective follow-up focus group and all were from one Midwifery Group Practice. Timing of the collective follow-up focus group for midwives may have affected the retention rate. The follow-up group was planned in order to meet the needs of as many participants as possible. However no date was mutually suitable for every group or individual midwife. A date and time that met the majority of midwives' needs was arranged. As discussed later in this chapter, teleconference facilities were organised for midwives who wished to participate in the follow-up group, but who could not attend in person. All six participating midwives selected the teleconference option.

Not all student midwives who participated in the initial focus groups participated in the follow-up focus group. Nineteen student midwives participated in the collective follow-up focus group. The nine students who did not participate in the collective follow-up focus group were not scheduled to attend campus the day of the focus group. While an invitation to attend was sent to every student, the drop in number of participating student midwives was expected. As discussed earlier in the chapter, recruitment and retention in research can be difficult when transport, childminding responsibilities and work commitments are not addressed. Students who were not on campus the day of the follow-up focus group were invited to participate electronically through Blackboard, but no student selected this option.

Women's focus group processes

Three initial focus groups were undertaken, with women attending one of the two participating Schools as Community Centres. For women, the time spent participating in each focus group was less than the time usually allocated for the SaCCs drop-in sessions. Before each focus group, I discussed the aims of my study, answered any questions from the women and reiterated that participation was voluntary. Women were reminded before each focus group that the session would be audio-recorded and the information, while non-identifiable would be used for research purposes. The focus group venues for participating socially disadvantaged women were their usual environments for gatherings. This

approach was premised on the notion that using the participants' own or naturally occurring setting diffuses the power of the researcher and increases comfort through familiarity for participants (Denzin & Lincoln, 2000). Women were also able to attend to their usual activities whilst participating in the focus group discussion. For example, during one focus group, women were making Christmas decorations. There was minimal disruption to the SaCCs planned activities. While the focus of discussion may have been altered by my presence, the drop-in session remained a group discussion amongst women that usually met and discussed issues relevant to them, while undertaking scheduled activities.

During initial discussions with the SaCCs facilitator, she suggested I provide women with an interview schedule (appendix D) prior to the focus groups, as she believed that the women were more likely to participate if they knew what questions would be asked. This approach and rationale is supported by Yancey et al (2006) who conclude that distrust of outsiders reduces research participation rates of marginalised groups. I viewed the provision of interview schedules as sharing information with the women; as giving greater control around decision-making and choice regarding participation. When participants have increased knowledge in relation to expectations of both the researcher and participant, they have a clearer understanding of their role and responsibilities. The research process is more collaborative. This process was in alignment with the principles of woman-centred care and therefore appealed to my way of working and researching with women. Allowing women to see what information was required of them enabled them to reflect on their maternity care encounters prior to commencement of the focus groups. Women had a longer timeframe to select the maternity care encounters they most wanted to recount. Again, this shifted the power balance slightly, providing women time to choose the experience they wish to share. So as not to disadvantage any group of participants, an interview schedule was provided to participants prior to every focus group.

All women were invited to meet for one collective follow-up focus group, with the date and venue arranged by the Schools as Community Centres facilitator. Prior to commencing the collective follow-up focus group, I read to the group my

interpretations of their recounted descriptions of maternity care encounters. I did this so all women present had knowledge of what I had documented. Providing women a verbal account of my interpretations ensured women with poor literacy skills were not disadvantaged. Women were invited to make amendments, add or detract information they deemed inconsistent with their lived experiences. No woman chose to alter my initial interpretations. All women present affirmed it was an accurate representation of their experiences. I provided the women with a brief explanation of the principles and elements of woman-centred care. The women were encouraged to discuss how maternity care encounters might be more woman-centred for them. Information gained from the follow-up focus group has been included in the findings chapters as well as the discussion chapter.

Registered midwife focus group processes

Three initial focus groups and three individual interviews were undertaken with registered midwives. The process for individual interviews was similar to the focus groups with the exception of number of participants and venue. As stated under the chapter heading – *Participating midwives*, individual midwife interviews took place at the conference venue in Adelaide. Only focus group processes are discussed here unless a difference in process is notable.

The initial focus group for registered midwives residing in New South Wales was carried out on campus, at a regional university in New South Wales. The university was in close proximity to the employing maternity service of the participating midwives. Various times and dates were offered and the midwives selected those most convenient for them. This focus group, while not considered a constructed focus group (Leask, Hawe & Chapman, 2001), where participants have never met, was not as homogenous as the other midwife focus groups. The focus of discussion by this group was more directed, with the researcher encouraging discussions more so than the other two initial midwife focus groups. The interactions between participants were not as animated. There appeared to be more of a social and professional etiquette. There was less talking over and participants were more likely to wait until a person had completed their conversation before talking. They were less likely to disagree or

question other participants. This is contradictory to the findings of Leask and colleagues (2001) who report that constructed group participants are more likely to interrupt each other and are more lively in their contribution. It may have been that these participants were not in their usual work environment and felt uneasy with the surroundings or the issue being discussed.

Participants in the remaining two midwife focus groups worked in separate Midwifery Group Practices, outside the state of New South Wales. Each focus group consisted of members of a naturally occurring and socially constructed group. For these focus groups I travelled to the locale of the midwives' employing maternity service. The focus groups were organised to coincide with their usual meeting times and venues. Again, the focus of discussion for this group may have been different to the discussions that would have occurred naturally without the focus group, or my presence.

Before each initial focus group I discussed the aims of my research and answered any questions. I reiterated that participation was voluntary. Midwives were reminded before each focus group that the session would be audio-recorded and the information, while non-identifiable, would be used for research purposes. An interview schedule (appendix E) was made available to midwives prior to the focus groups. A previous decision had been made to provide participating women with an interview schedule. It was therefore appropriate to provide all participants with similar information. Providing one group of participants with information not made available to others is inequitable. It also may have caused a difference in the depth and range of experiences described across the groups.

All midwives were invited to meet for one collective follow-up focus group. I informed all midwives that I would provide a number of hard copies as well as an electronic copy of my preliminary understandings. A copy of the Royal College of Midwives Position paper 4a: woman-centred care (2001) was also made available for participating midwives (see appendix F). The collective follow-up focus group for registered midwives took place in 2010. Midwives were invited to attend either in person or via teleconference. The focus group was held on campus at a regional university in New South Wales. Participants

in one focus group, external to New South Wales, selected the teleconference option for the follow-up focus group.

During the follow-up focus group I recounted my understandings of their descriptions of maternity care encounters involving socially disadvantaged women. Midwives were asked to comment on the preliminary findings and were provided with the opportunity to delete or modify any information that they believed to be a misrepresentation of their own wordings. No midwife chose to alter my preliminary interpretations. The participants were then encouraged to discuss how maternity care encounters might be more woman-centred and how midwives might be better supported to provide woman-centred care. The discussion focused on elements of woman-centred care as defined in the Royal College of Midwives (2001) document. Data collected from this follow-up focus group have been included in the findings and discussion chapters.

Student midwife focus group processes

All focus groups for student midwives were carried out on campus, at their institution of study. The focus group venues for participating student midwives were their usual environment for student gatherings. The follow-up focus group was also held on campus at their institution of study. Both the initial focus groups and follow-up focus group were scheduled on face-to-face student learning days to reduce student inconvenience. No additional travel was required, the face-to-face learning days were no longer in duration and childminding responsibilities were not affected. While it can be argued that there is always a power differential between researcher and participants, the researcher at the time of the study was not in a direct line of authority or power in relation to student participants. The researcher was not a course coordinator, tutor, or assessor for any course or program in which participating students were enrolled.

The initial focus groups were incorporated into a face-to-face teaching session in 2009. All students enrolled in the Graduate Diploma in Midwifery, from two different intake cohorts, were present at the teaching session. The students requested to organise themselves into two groups. Each focus group consisted of students who commenced their midwifery studies on the same date. Students

also requested to self-moderate their groups. This was possible as the students had been provided an interview schedule (see appendix G). Agreeing to self-moderated focus groups demonstrated a releasing of power by the researcher, so that students could take control of their own group discussions. Students were reminded at the end of the focus group that there would be a follow-up focus group.

As discussed earlier in the chapter, not all students who participated in the initial focus groups were in attendance at the follow-up focus group. Half the students were not required to attend the face-to-face teaching day. In anticipation that students enrolled in the midwifery course not scheduled a face-to-face teaching day might not attend the follow-up focus group, I provided an opportunity for all students to submit comments anonymously within their relevant Blackboard discussion board forum. While the Blackboard discussion board forum was set up with the ability to post responses anonymously, no student chose to post a comment. The Blackboard learning platform allows for users enrolled as instructors to monitor usage. As an instructor I was able, therefore, to establish that students had accessed the documents prior to participating in the follow-up focus group. In the Blackboard discussion board forum I also uploaded the following questions for consideration so that students wishing to participate electronically would have the same prompts for discussion as face-to-face focus group participants:

- How can students learn to be woman-centred practitioners in the university environment?
- How can students learn to be woman-centred practitioners in the clinical environment?
- What would support you personally to achieve and maintain a woman-centred focus when you are a registered midwife?

The collective follow-up focus group for student midwives was undertaken in early 2010. A summary of the findings from the initial student midwife groups was uploaded into the students' Blackboard courses along with the Royal College of Midwives document, Position paper 4a: woman-centred care (2001).

Students were asked to read both documents prior to attending the follow-up focus group. During the follow-up focus group I recounted my understandings of their descriptions of maternity care encounters involving socially disadvantaged women and being a student midwife in the maternity care environment. Students were asked to comment on the preliminary findings. They were provided the opportunity to delete or modify any information that they understood to be a misrepresentation of their own wordings. No student chose to alter my preliminary interpretations. Student midwives were then encouraged to discuss how maternity care encounters might be more woman-centred. Students were also asked to discuss how midwives might be better supported to provide woman-centred care and how they, as new graduate midwives, might become woman-centred midwife practitioners. The discussion focused on elements of woman-centred care as defined in the Royal College of Midwives document (Royal College of Midwives, 2001). Information gained from this follow-up focus group is included in the findings chapters as well as the discussion chapter.

4.3.3 Data Analysis

Smith et al. (2009) suggest that Interpretative Phenomenological Analysis continues to evolve and while there are guidelines to ensure methodological rigour is maintained, there is no one method to follow when undertaking Interpretative Phenomenological Analysis studies. Analysis is driven by the data derived from participants; it is person or participant-centred (Shaw, 2001). This approach appealed to me, as the focus of my study was participants' recounted experiences of woman-centred care. Holliday (2008) declares the research approach needs to fit the research question, the most appropriate methods of data collection, the participant characteristics and the disciplinary requirements of the researcher. As discussed earlier in this chapter, I adapted the research approach to capture the idiographic understanding of woman-centred care as described by socially constructed groups rather than an individual existing within a group. Adapting research processes is necessary to answer the increasingly complex questions associated with qualitative research (Finlay, 2009), so that research approaches can be dynamic and continue to develop.

The researcher, as interpreter in IPA studies, comments on what has been presented from multiple positions, providing greater access to the text in its own terms. Interpretative Phenomenological Analysis affords me, the researcher, the ability to allow different groups of participants to tell their stories of the phenomenon, woman-centred care, without unease. There is no declaration by the researcher that participants will be completely understood or that meaning is absolute (Benner, 1994). Understandings arrived at by the researcher have been shaped by both participants and researcher, based on various assumptions, ideas, meanings and experiences located within the focus of the study (Lopez & Willis, 2004). The researcher, while striving to accurately present individual voices of participants, also offers understandings as to how variations might be possible within a given cultural context (Benner, 1994).

Using an IPA approach meant that the focus of analysis was the participants' attempts to make sense of their experiences of maternity care encounters in which socially disadvantaged women were the recipients of care. When using focus group data, Smith et al. suggest "the [idiographic] emphasis may shift more to assessing what the key emergent themes are for the whole group" (2009, p.106). Smithson (2000) concurs with Smith et al, stating the focus group is a collective discussion with individual participants; the whole group, however, can be the unit of analysis. When using group interview data the researcher moves from the particular (meanings derived from one group) to shared meanings across groups. Analysis also moves from descriptive participant recounts of the experience to interpretive, researcher driven, units of meaning (Smith et al., 2009).

According to Smith et al. (2009) the IPA approach to analysis should not be linear but an iterative process involving the researcher and participants at all stages. Morse and Field (1995) also agree that qualitative researchers do not adhere to a strict method or set of steps for data analysis. The sequence of analytical steps in IPA, based largely on the work of Smith et al. (2009), is presented in table 4.1.

Table 4-1 Data analysis sequence

Steps	Processes undertaken
1.	Data derived from audio-recorded focus groups [the unit of analysis] was transcribed verbatim. A feeling for the participants' ideas was achieved by listening to audio-tapes whilst reading the transcripts (Goulding, 2005).
2.	Line by line analysis [of the transcript] of participants' understandings of experiences occurred with identification of predetermined themes aligned with the elements of woman-centred care and emergent themes [as determined by the researcher] (Smith et al., 2009).
3.	Significant statements [as determined by the researcher] were extracted with the identification of key words and sentences related to the phenomenon under study; woman-centred care (Goulding, 2005).
4.	I moved from descriptive instances, developing provisional [interpretive] meanings formulated from participants' significant statements [as determined by the researcher] (Goulding, 2005).
5.	Using reflective journaling, I reflected on my perceptions, conceptions, position and understanding of the phenomenon under study (Smith et al., 2009). The shared world of understanding between researcher and researched is made explicit using a trail of movements through engaged reasoning by means of journaling concurrently while collecting and analysing data (Benner, 1994).
6.	The previous steps [1-5] were repeated for all focus group transcripts with the clustering of recurrent meaningful themes [as determined by the researcher] (Goulding, 2005).
7.	A frame illustrating relationships [including divergent, convergent, commonality and nuances] was developed (Smith et al., 2009). NVivo software was used to assist with data storage and retrieval.
8.	Organisation of data from all sources was formatted so that the process of analysis can be traced from beginning to end (Smith et al., 2009).
9.	Identified themes were integrated into a rich description of the phenomenon: woman-centred care (Goulding, 2005).
10.	I returned to participants to seek validation of their interpreted descriptions and elicit their views on possible developments in woman-centred care (Goulding, 2005).
11.	A full narrative from each group of participants, with a detailed commentary on data extracts, was developed. The reader is guided through the interpretation theme by theme. Tables were used to visualise interpretative theme development (Smith et al., 2009)
12.	In the discussion chapter I engage in a dialogue between the findings and extant literature (Smith et al., 2009). My interpretations are extended to include considerations of commonality and difference that may offer new understandings of participants' recounted experiences of woman-centred care (Benner, 1994).

Smith et al., (2009) describe data analysis as “a process that generates meaning, with analysis open to adjustments, set only through the writing up” (p. 91). Following preliminary data analysis, see steps 1-5 in table 4.1, the researcher returned to the participants to elicit their opinions and validate the researcher’s interpretation of their voices (step 10). This step is supported by Smith (1994) who proposes that participants can be self-reflexive co-researchers. Partnership and collaborative processes are in alignment with the midwifery concept of woman-centred care and therefore appropriate for the research processes applied to this study. During the collective follow-up focus groups, literature defining woman-centred care was introduced to initiate discussions around what woman-centred care might look like for each group. Participants were asked to make recommendations to improve woman-centred care, in relation to their role in local health district maternity services. Women were invited to make suggestions that could improve midwife-woman interactions and the provision of maternity care. Registered midwives were asked to make suggestions that could improve maternity care for socially disadvantaged women and support the provision of woman-centred care, and student midwives were asked to make suggestions related to the improvement of educational processes, student learning and the clinical applications of woman-centred care.

Asking participants’ opinions for future developments in practice and educational strategies related to woman-centredness is in alignment with midwifery educational guidelines (NSW NMB, 2008b) and participatory curriculum development ideologies (Taylor, 2001). Participatory Curriculum Development (PCD) uses the experiences of, and information from, stakeholders to develop educational curricula (Taylor, 2001). A stakeholder is defined as a person or group of persons with vested interests in the outcome of a project or plan (New Mexico State University, 2008). Strategies that foster collaboration between stakeholders is in alignment with woman-centred care (Royal College of Midwives, 2001) and has the potential to improve midwifery education, quality of care and safety for birthing women (NSW NMB, 2008a). Student midwives, registered midwives and socially disadvantaged women are indeed stakeholders in the learning and practical application of the concept,

woman-centred care. It is considered essential, therefore, to give participants a chance to validate the researcher's interpretation of their experiences.

The findings are initially presented as narratives. The narratives are made up of units of meaning in the form of extracts from participants' words. Following each narrative the researcher guides the reader through the narratives, interpreting participants' words. The researcher's understanding is located within the context of woman-centred care. Smith et al. suggest findings should be presented without reference to existing literature (2009). In this study, three 'findings' chapters are presented from data collected. One chapter explores socially disadvantaged women's experiences, one chapter explores registered midwives' experiences, and one chapter explores student midwives' experiences. Lopez and Willis (2004) state that "the researcher must go further by interpreting the meanings for practice, education, research and policy to create informed and culturally sensitive health care knowledge" (p. 732). This aligns with the theory of Smith et al. (2009) who propose that in the discussion chapter the researcher draws on existing literature, and in the case of health care, existing policies, to shed light on the participants' experiences. The thesis section – *New understandings*, will draw together literature and information from the findings chapters to address the research question and discuss implications for midwifery practice and maternity care, midwifery education and future midwifery research opportunities.

4.4 Validity and this research

Yardley (2000) suggests that qualitative research, with such diversity of approaches, can lead to uncertainty regarding validity. Qualitative researchers accept that knowledge and truths are constructed through shared understandings. Therefore, it is not deemed appropriate to assume there is one fixed way of assessing the processes that lead to a truth. Smith et al., (2009) refer to Lucy Yardley's work - Dilemmas in qualitative health research (2000), when discussing quality and validity in Interpretative Phenomenological Analysis research. Yardley (2000) recommends that rules for assessing qualitative research be as flexible as the research approaches. She offers four

characteristics defining good qualitative research applicable to any qualitative research approach. They are:

- Sensitivity in context;
- Commitment and rigour;
- Transparency and coherence; and
- Impact and importance (Yardley, 2000, p.219).

Each characteristic can be adapted to suit the research approach used and the context in which the research was undertaken. These four characteristics will be briefly discussed in relation to this study.

4.4.1 Sensitivity in context

Smith et al., (2009) argue that the selection of IPA as a research approach demonstrates sensitivity in context. As discussed earlier in this chapter Interpretative Phenomenological Analysis is described as a person-centred research approach. My research aimed to explore socially disadvantaged women's, student midwives' and registered midwives' descriptions of maternity care encounters involving socially disadvantaged women. I sought to understand their understandings of the phenomenon of woman-centred care. The data collection method, focus groups, is described as sensitive to the needs of vulnerable groups and particularly fitting for groups of women who were provided with an opportunity to share their stories (Owen, 2001). I considered the research approach to be sensitive to the context. I minimised, where possible, power inequalities by attending participants' usual meeting environments and by the methods of data collection. The strongest way in which Interpretative Phenomenological Analysis studies are sensitive in context is through the handling and presentation of data. Smith et al, (2009) advocate for large numbers of verbatim extracts to be offered, to support the researcher's argument and give participants a voice. Raw data extracts are included in my findings chapters and collective follow-up focus groups were undertaken to allow all participants an opportunity to discuss my interpretations of their understandings of maternity care encounters involving socially disadvantaged women. Allowing participants to verify the researcher's interpretations also

demonstrates sensitivity to participants' contribution to the research process. During the collective follow-up focus groups I asked participants to contribute their views of the conditions or actions required to improve maternity services for socially disadvantaged women. Given the context of the phenomenon under study and the participants involved, seeking their involvement in possible maternity service development was sensitive to the context of the research.

4.4.2 Commitment and rigour

Commitment is concerned with the degree of attentiveness to the participant. Commitment closely aligns with sensitivity in context for IPA studies. As stated throughout this chapter, attentiveness to the needs of participants was demonstrated through the use of sensitive data collection, analysis and verification processes. Rigour refers to the completeness of data collection and analysis (Yardley, 2000). Smith et al. (2009) state that the quality of the interview and analysis depends largely on participants' ability to provide rich data. Careful selection of participants is required, therefore, to ensure participants are able to provide data on the phenomenon under study; to enable the researcher to answer the research question. All participants in this study had the ability to describe a maternity care encounter in which a socially disadvantaged woman had been the recipient of care. Thoroughness of data collection and preliminary analysis is demonstrated through the large number of extracts in the beginning of each findings chapter. The extracts of emerging themes tables offered in each findings chapter provide the reader the opportunity to follow the development of themes. Finally, at the completion of each findings chapter the inclusion of a recurrent themes table demonstrates the recurrence of themes across groups of participants. While documenting the numbers of instances in which themes are located within transcripts is not required in Interpretative Phenomenological Analysis studies, Smith et al. (2009) suggest measuring recurrence is important in enhancing the validity of findings. To be classified as recurrent or super-ordinate theme, a theme must be present in greater than half the interviews. I adapted the procedure to measure recurrence across focus groups instead of individual interviews.

4.4.3 Coherence and transparency

Coherence refers to the consistency and logic between the research approach selected to explore the phenomenon under study and the philosophical perspective adopted by the researcher. This study, using Interpretative Phenomenological Analysis, explored the phenomenon of woman-centred care. As stated previously, Interpretative Phenomenological Analysis is considered to be a person-centred research approach. Participants were women and data was collected using approaches appropriate for women. The analytical process involved a collaborative woman-centred approach, with participants engaged in preliminary interpretative processes. The presentation of findings, using participants' own words to create a collective narrative, is in alignment with person-centredness and increases transparency of data analysis processes with the reader privy to the raw data. Smith et al. (2009) suggests that coherence can also be judged by the reader; does the thesis present a coherent argument, with themes presented as plausible conclusions arising from the data?

Transparency refers to "the degree to which all relevant aspects of the research process are disclosed" (Yardley, 2000, p. 222). When the research approach has been modified, the researcher must be clear as to why such a step was necessary and how the integrity of the research process has been maintained. Detailed descriptions of the research processes undertaken to complete this study have been provided in this chapter, including the rationale for modifying the data collection method. A table outlining the data analysis sequence is included in this chapter (see page 4-98) to demonstrate transparency in the analytical process. Further discussions evaluating the research processes and procedures used during this study are provided for the reader in the final chapter of the thesis.

Smith et al. (2009) argue that transparency of the analytical process can be achieved through inclusion of extracts from the 'emerging themes' tables. Extracts from each group's table of emerging themes are presented in the second half of each findings chapter to ensure coherence and transparency of the data analysis process. The following extract of such a table (Table 4.2)

shows the development of the emerging themes 'being available', being safe' and 'being valued'. A socially disadvantaged woman's original words are displayed in the first column. My comments and thoughts are found in the second column along with the pre-determined and preliminary themes. These themes are displayed as subheadings that are bolded and italicised. The pre-determined themes are also underlined. Emerging themes are displayed in the third column. The colour coding demonstrates some of my engaged reasoning processes, that is, how I align participants' words, my thoughts and the final themes to be discussed chapter 9 – *New understandings*. The complete 'emerging themes' table for all socially disadvantaged women is included in the appendices, see appendix (H). Finally, at the conclusion of each findings chapter a recurrent themes table is presented. These tables are included, not to draw attention to numbers or quantitative measurements related to the findings, but to enhance transparency around decision-making processes by the researcher. Themes that were found to recur throughout different focus groups are presented to strengthen the validity and coherence of my interpretations.

Table 4-2 Example of emerging themes table

Socially disadvantaged women – emerging themes		
Original Transcript	Exploratory Comments	Emerging Themes
<p>Sharon: The doctor was performing my perineal repair "and I could still feel it, and I'm looking at the midwife, I was crying and she's going "I know" and I'm thinking why you can't say anything. She [the midwife] didn't say anything she was just, I don't know. Cause he'd jumped in and say "I will do it" and she was supposed to do it".</p>	<p>Autonomy, Power and Control</p> <p>This statement aligns with what midwives and students say about the medical staff. The woman felt unsafe to speak up and looked to the midwife to speak on her behalf. The midwife does not feel safe here to be available for the woman. No one was advocating for the woman. When the midwives are not valued, how can they practice to their full potential and advocate for the woman? The woman felt unimportant and unsafe here.</p>	<p>Being safe</p> <p>Being available</p> <p>Being Valued</p>

Note: this stage of analysis occurs after reading the transcripts from all participant groups. Therefore, in the exploratory comments column I have been able to identify that this woman's comment is similar to comments from other participant groups.

4.4.4 Impact and importance

The final characteristic that Yardley defines for good qualitative research is the ability to inform intended audiences of something that is interesting and important (2000). She proposes that results, particularly for health research,

need to have an impact on, and utility for, practice. The results from my study have highlighted the difference in understandings, as described by socially disadvantaged women, registered midwives and student midwives, around what constitutes woman-centred care. Conditions that are perceived to assist or hinder the provision of woman-centred care are also reported, through the recounted experiences of multiple participant perspectives. A clearer understanding of what woman-centred care means for all participants in maternity care encounters, and how it might be accomplished for socially disadvantaged women, is important for midwifery practice.

4.5 Conclusion

This section of the thesis provided the reader with a detailed description of the research processes involved in undertaking this study. I explained the focus of the study; to explore the understandings of woman-centred care as described by three different socially and culturally constructed participant groups. The rationale for modifying the idiographic assumption of Interpretative Phenomenological Analysis from the single person participant, to a socially constructed single group of participants, was provided. I then argued why the data collection method and analysis processes needed to be modified from single participant-researcher interviews to focus group discussions. The next section of the thesis – *Participants' words*, contains three findings chapters shaped by the research approach, and steps taken to create new understandings as described in this chapter. The three findings chapters are created out of words from participating socially disadvantaged women, registered midwives and student midwives.

Section 4: Participants' understandings

Within this section of the thesis three findings chapters are presented. Chapter 5 - *Sharon's story* - represents the recounted maternity care experiences of socially disadvantaged women. I have created a narrative using the common experiences and episodes of difference found within participating women's transcripts. The pseudonyms Sharon, Cath, Suzie and Tina are used in this discussion group. Chapter 6 - *A discussion with Delvin* - represents midwives' descriptions of working with and for socially disadvantaged women. Again, common experiences and episodes of difference found within participating midwives' transcripts are made known through the voices of different midwives to create a midwifery discussion group. Chapter 7 - *Julie's journal* - is the final chapter in this section. This chapter represents student midwives' descriptions of observed maternity care encounters in which socially disadvantaged women were the recipients of care. Again, common experiences as well as episodes of difference found within participating student midwives' transcripts are presented in Julie's journal entries as reflections on different childbearing women and situations. Also included within each chapter are participants' descriptions of conditions or actions that they understand could facilitate woman-centred care within the maternity care encounters of socially disadvantaged women. These understandings form the basis for discussions in chapter 10 - *Reflecting on new understandings: implications for midwifery practice, education and research.*

The midwifery concept and maternity care philosophy of woman-centred care was used as my 'view finder' to explore participants' recounted experiences of maternity care encounters and to assist in answering the research question, "*How do socially disadvantaged childbearing women, registered midwives and student midwives understand woman-centred care?*" Maternity care that features the following five elements is determined to be woman-centred:

- The woman has choice regarding her maternity care options
- The woman has control over her decision-making during maternity care encounters

- The woman has continuity of care from a known health care professional, in this instance a midwife
- The woman's needs have precedence over those of the health care provider's needs
- The woman is collaboratively consulted regarding maternity service provision (Royal College of Midwives, 2001).

Because the phenomenon being explored was the concept of woman-centred care, I specifically looked for episodes of care that related to choice, control, and continuity of carer within participants' recounted experiences during the preliminary analysis. I also sought instances where an individual woman's needs were given precedence over local health district needs or when women were viewed as equal partners in the development and provision of maternity services. These pre-determined themes, arising from the concept of woman-centred care, are clearly indicated in each findings chapter with the text being bold, italicised and underlined. Themes that emerged during analysis and considered to be significant are also indicated with bold and italicised text that is not underlined (see table 4-3 key for understanding).

Text	Meaning
<i>Italicised font</i>	Direct quotes from participants
Plain text	My words – connecting participants' quotes for ease of reading
[Plain text within brackets]	My words inserted within participants' quotes for ease of reading
<u>Bold, italicised and underlined</u>	Pre-determined themes aligned with the woman-centred care
<u>Bold and italicised</u>	Additional themes that emerged from the data

Table 4-3 Key for understanding

In accordance with the Interpretative Phenomenological Analysis approach, the researcher is a legitimate part of the research process and data contribution. Biases are not bracketed or hidden, but open and transparent.

Within each chapter I am visible, shaping the presentation of data and therefore understandings in various forms. My conscious biases are made known through questions raised in each chapter. In the socially disadvantaged women's chapter – *Sharon's story*, I am the voice of the 'new woman'. Questions and issues raised by the new woman reflect my questions regarding socially disadvantaged women's maternity care encounters. Although the questions posed by the new woman are not identical to those asked during the focus groups, I understand them to be similar in meaning. In the registered midwives' findings chapter - *A discussion with Delvin*, I am Delvin, who seeks to understand how socially disadvantaged women might experience their midwifery care through discussions with midwifery colleagues. Questions raised by Delvin are similar to questions and issues raised, during interviews and focus groups with registered midwives. In the student midwives' findings chapter – *Julie's journal*, I am present in the form of reflective questions and thoughts raised by Julie. My words are made obvious through differentiation of text styles (see table 4.3: key for understanding). Again, the questions are not identical to those raised during student midwife focus groups, but are of a similar nature.

Each findings chapter presents a different group of participants' descriptions, of maternity care encounters in which socially disadvantaged women were the recipients of care. The first half of each findings chapter demonstrates the initial phase of analysis where participants' words are grouped together to create a narrative, representing the collective experiences of that group. Participants' words, written in italics, are used wherever possible, connected by my text to enhance ease of understanding for the reader. Following the narrative an illustration depicting the group's view of woman-centred care, as interpreted by me, is provided as a visual representation of understanding. The second half of each chapter provides the reader with insight into the descriptive or exploratory process of analysis. It is in this section of each chapter that I explore the collective experiences of the group and begin the initial process of making sense of participants' attempts to understand maternity care encounters involving socially disadvantaged women.

5 Sharon's story: socially disadvantaged women's experiences

In this chapter a narrative has been created weaving direct quotes to reveal common experiences and episodes of difference as communicated by participants from every focus group, and interpreted by the researcher. Fictional characters have been designated either the voice of shared understandings or the voice of different or individual understandings, expressed by participants. In this chapter the researcher is present through the voice of 'the new woman'. My words are made obvious through differentiation of text styles (see table 4.3: key for understanding, p.S4-ii). Questions raised by 'The new woman' are not necessarily those posed during focus groups. They are part of the creative process in bringing together participants' words and improve readability for the reader.

Following the narrative, an additional method of presenting participants' understandings of woman-centred care is provided through a visual representation of their view of maternity care encounters and woman-centred care. Finally, the second half of the chapter provides the reader with insight into the descriptive or exploratory process of analysis through the inclusion of extracts from my 'emerging themes' tables. In each extract the participant's words are displayed in the first column. My comments and thoughts are found in the second column along with the pre-determined and preliminary themes. Emerging themes are displayed in the third column. The colour coding demonstrates part of my engaged reasoning processes, that is, how I align participants' words, my thoughts and the final themes discussed chapter 9 – *New understandings*.

5.1 Introducing Sharon

Sharon is a woman in her mid twenties. She recently gave birth to a baby boy. This was Sharon's third pregnancy and birth. Sharon has a partner and her two other children are under ten years of age. Sharon is not in paid employment. Her oldest child attends the local public school and her second child attends the Schools as Community Centres playgroup each week while Sharon attends the

centre. Sharon was not upset that she was pregnant for the third time, although the pregnancy was not planned. Sharon attended her local medical centre for her maternity care initially because she had an established relationship with her doctor and the practice provided a ‘bulk billing’ payment service.

Sharon is having coffee with her friends, Suzie, Cath and Tina, at her local Schools as Community Centre (SaCC) venue. This is Sharon’s first visit back after she gave birth. Sharon is asked by a new woman to the centre, recently moved to the area, to tell her everything about her maternity care. The new woman believes she is pregnant and would like the women’s views on where to go, and who to see, for her maternity care. Sharon starts to tell the women about her maternity care encounters. The women engage in a discussion of their pregnancy and birthing stories.

5.2 Sharon’s story

Sharon commences her story by telling the new woman to go to the chemist first and confirm her pregnancy before going to a doctor. Sharon explains that the doctor will tell her where to go: “*...after being to the chemist myself, [I went] to a GP and [had] a blood test to confirm it [the pregnancy]*”. Then “*they [the medical centre] just sent me off to the [local] hospital*”. Suzie confirms Sharon’s experience “*after about, I don’t know, I think it was a month of going to see my doctor, he said you have to go to [name of] hospital*”. The new woman interrupts to ask Suzie if she was given a choice of where she went for her maternity care. Suzie replies, the doctor “*give[s] you a referral letter [and] just send[s] you off to the hospital. You don’t really get a choice; you got to go to wherever the boundaries of the [local] hospital are*”.

The new woman then asks Sharon whether she had a choice as to who looked after her when she was pregnant. “*It [choice of care models] was never even mentioned, I did ask my doctor when I found out [I was pregnant]. I said, ‘how do I go about seeing a midwife?’ and he said, ‘you don’t.’ I never had any option really with having a personal midwife*”. Tina interrupts, “*During my antenatal care I don’t think I really saw the midwives, it was just whoever was in the room that day to do your check up*”.

The new woman is concerned about finances and asks whether she will have a choice regarding tests that cost money. Tina responds, “*They just say, you need to have that [screening test] because of your age and your history of your body or pregnancies... they didn't put that option to me* [choice to have or decline a particular test]”. Cath interrupts, “*I wasn't expecting to pay for it [my 18 week ultrasound] and then... she [the receptionist at the radiology rooms] said I had to pay.... still, you have to have it done, because, well you [think] they know best and... you do whatever they tell you, [even though] you've got other things to pay out. You don't get your money from the government to help you pay for other things until after you've had the child*”. Tina continues, “*it's just conditioned in us [women], especially like if it's your first pregnancy [you] put all your faith in the carer that you've been given [and] you'd be scared not to [do what they tell you], cause it's all about you don't want to do the wrong thing by your child*”. Sharon comments, “*I think you do what they say because like, you're going to be a mother and you want to do everything the special people who are the professionals tell you to do because you don't want anything to happen to your baby and if that's what they need you to do, you jump through the hoops*”.

Sharon is asked how she got all the relevant information she needed about her pregnancy. “[When] *I was seeing midwives at the hospital, they were like, this is what's going on. It was like you were walking in to a motel room, and you've got all those pamphlets and that's it, that's all you got*”. “*I think part of that is a symptom of the hospital system where they [the staff] are so overloaded and everything has to run a certain way or they're going to, you know their lives are hard enough as it is*”. Tina interrupts Sharon to say that she received her maternity information from her local doctor “*because she knows about my family history and stuff [relevant information] and I mean I did like to go over it with her as well...*”. Suzie agrees, saying she received information about her antenatal care from her local doctor. “*She would say, 'I really recommend that, because of your age, you have this' because I was thirty six when I had [name of baby]. This sort of thing isn't really necessary, but it's an option, but it has these risks associated with it*”. Tina explains that it is easier to get information from someone who knows you, “*if they've known you and got to know who you are*

and how you fit in your family, and how the family goes it's just much more comfortable because you feel like you can trust [them], and if you need to ask for something you don't, you know [understand], you know the person?"

The discussion then turns to care perceived as going above and beyond the call of duty: Suzie says “*My doctor knows us pretty well, and she's done a lot and gone out of her way like to advise us of the services*” [and one of the paediatric community nurses,] “*she was very good and she went over and beyond her job and she made sure she rang the hospital, she just didn't say she'd do it, she actually did it and then she rang me back to confirm that she did it, and let me know what was going on... Whereas the other ones yeah they might have said they were going to do something and then didn't do it, they got busy so I don't know I think that it's a lot of your job I guess, she obviously loves her job and knows what she does and she goes that [bit] further*”. Tina states, however, “*you never knew what you were going to get with the midwives, we might have got a nice one that would go the extra mile and other times you would get, I usually found the older ones were the ones that didn't want to help you as much*”. “*The first time when I had [a baby] I had one [midwife] that was really good and would go out of her way and I had one with [2nd baby] and they were all younger*”. Sharon agrees. “*I'm not saying the older ones aren't [helpful] but it was for me, it was always the younger ones that went further and I even observed one of the ones that even helped me with him [the baby] came in a little bit more than what the others did and a lot of them didn't come in at all, only to give me the medication*”. “*The older ones, yeah the old school yeah set ways that don't want to change*”. “*She [the young midwife] obviously loves her job and knows what she does and she goes that [bit] further...*” Suzie disagrees with Tina and Sharon. “*The younger ones [midwives] that are coming through that are working by the book not having those life experiences [of] having had children don't have the ability to communicate and to actually follow through. They're following it in black and white*”.

The new woman informs the group that she had the same midwife for all her care last pregnancy. She states that she formed a relationship with the midwife, and asks if any of the women were able to form a relationship with someone other than their local doctor. Sharon responds, “[I] literally saw someone

different every time. If you don't have constant care with the same carer, that relationship isn't there. Cause it takes time to build up the trust. You know what I mean? There's no attempt at continuity with who you see, I mean if you're having to see whoever you get when you go in, then there's no real chance for [getting to know anyone]". Tina agrees saying, *"if you're constantly seeing the same person, they'll ask how your day is, you know, how have you been, and whatever. Whereas the next person would be, just seeing someone different, they have to spend the time there with you, [during] the consultation, catching up, like getting up to speed with where you are in your pregnancy".* Cath interrupts, telling the woman that she had the same midwife every visit for the second half of her pregnancy. When questioned, by the new woman, as to how she came to see the same midwife each visit, Cath could not recall. *"Someone just asked me if I wanted to see the same midwife for every visit and I said yeah, [so] I don't have any complaints about my care".* Tina continues, *"Even when you're in the actual hospital, like after you've given birth, there's like a different lady [midwife] everyday, but that's more the nurses, that's not the midwives".* Cath suggests that in the hospital, *"They're [midwives] just going round and round, trying to look after everybody".* Sharon interrupts, *"[It's] not that they don't have the time [to form a relationship with you], it's just that that's sort of a secondary thing, 'Oh how are you feeling? Is there anything that's going on that you want to discuss?'."* Tina agrees, *"I didn't get introduced to them [the midwives] at all. Afterwards [after the birth] before they left, I actually called one back in and got my partner to take a photo of them, just so I could show my daughter later on these were the people in the hospital".*

The new woman asks what the local hospital's antenatal clinic is like. Sharon describes her experiences. *"Half the time you go up there and you've got a ten o'clock appointment and then they see you at.....11 o'clock or 12 o'clock cause they're running so late...you get in at 1 o'clock"*. Suzie agrees with Sharon, *"it was like you'd have to wait and wait and wait, and you've got like a two year old and a three year old"*. Sharon continues *"especially if you've got other kids, you sit up there for three hours at the hospital [and] you're not just sitting there with pregnant ladies; you're waiting for the [sick] people to go to have their check, physiotherapy and whatever"*. Suzie interrupts, you're *"treated like a number*

[and] until something about the whole system's done I don't think you're going to get that extra attention and care that you'll get from your GP or someone that's got the time to go the extra mile, it's just the public system is the way it is with the hospital". "It's just harder to get anything you want really, isn't it? It's a struggle and you have to explain yourself. It's not expected". Sharon goes on to say, "if we [birthing women] were treated differently, like we were the centre of what's happening to us and our body, perhaps then we would feel a bit more in control to say, this is me and part of me and this is what I'd like. But, you feel that it's part of them, like you're having the baby but they'll get it for you". Midwives "either didn't have the time or the inclination to find out anything other than what they need, what you were there for. It was very much, a little bit like a factory thing. Churn you in one end, churn you out the other. Give you an appointment card for the next appointment and off you go".

Sharon is asked what her hospital stay was like. Sharon responds, "I was left alone and not told a lot and you know when I was told something was happening, well this is what's going to happen because you've got no choice and [that's] just the way it is". With "the sheer mayhem at the hospital no-one paid any attention to what was going on because they were all so run off their feet. You know they were running just to keep up with everything that was happening rather than being able to take time and care to see what was really going on with women". Cath spoke up, saying that she found the maternity ward isolating. "When you're in a room with four other people and they all close their curtains and they don't talk to you for the whole day and you're just in your bed with no one talking to you and you're waiting going I hope I get a visitor today you're like oh it's visiting time. Yeah people close their curtains and they won't talk to you and all you've got is a magazine to read, yep finished this one now what do I do". "All the curtains were closed up, the midwives come and they opened the curtains and then the mothers come and closed them [again]". Suzie interrupts with "I wanted my privacy [by closing the curtains] and that was because you lose all dignity having a baby ...and to hide from that nurse [midwife]".

Sharon continues, "It was all just absolutely crazy [but] there was one very nice nurse [midwife] when I was recovering that night [after birthing]...I don't know

who it was, no-one who had been looking after me [previously, just came in the middle of the night with him] and just put him there next to me. So someone was really lovely and did that". Cath agrees, "[I] found that the night staff were a lot more helpful than the day staff so maybe it could be something that ...it is a lot quieter through the night". Suzie says, even during labour and birth, the midwives were "not [there] all the time, they did come in every hour, poke their head around and say 'are you alright?' and then walk away, like they're busy and haven't got time for you". Sharon states, "you know you should be able to find a midwife when you're in labour so that was probably the worst thing about being in hospital". Tina disputes the busyness of midwives "[I] see them at the desk they are sitting there just talking and they said earlier that they were busy, like you think, well that's what they were doing there before, just sitting there talking and I mean just after the caesarean I couldn't walk straight away so that's what they could have been doing I don't know".

Tina recalls the enforced rules of the hospital. "*The nurses [midwives] and that kept to themselves and every now and then if I wanted to go have a cup of tea or something I'd have to go out and wait and ask them to just keep an eye on [my baby] we weren't allowed tea in the wards at all, any hot drinks, you had to go outside for that". Suzie agrees, recalling "*When I had her [the baby] he [my partner] wasn't allowed to stay, and I've gone, 'He was allowed to stay when I had premmie labour, why the hell can't he stay now?'" [The midwife replied] "It's against our rules and regulations". Sharon recounts, when in labour "*I wasn't allowed to actually leave the ward because he [the baby] was lodged sideways and I was carrying three times the amount of water, and he [the doctor] said if my waters had broken and the cord had come out, and as they explained to me, someone has to jump on you and shove your hand there and reach you around. And when I was labouring, one of them [a midwife] was really nasty actually. She was telling me not to make a sound. She was yelling at me saying, 'you're not even trying, you're putting too much energy in to noise.' And she's saying, 'you're not supposed to make any noise'. I was, wow that's crazy, you can't. I'll just sit here and sing a song in my head".***

Suzie talks of the labour ward laws, "*I had midwives saying we're going to break your waters for you and I'm going, 'No you will not'. You know you don't want to*

be having a baby and having to argue about whether or not your waters are going to [be] artificially broken". "I just think it sucks that you have to be a bolshy cow and you have to go and find out all the stuff for yourself in order to get the choices that you want. It's not just finding out everything yourself, but it's the combination of finding out everything yourself and being strong enough and having someone with you who is strong enough and able to enforce what you want". Sharon recalls a similar experience when she was told to lie on her back during labour. *"I said 'I don't want to lie down on my back because I have a deformed vertebrae and I don't want the weight of the placenta of the baby on my spine.' And she [the midwife] just said, 'Stop talking as if you know what you're talking about', and she said, 'You are going to lie on your back and you are going to have the monitoring on it and that's the way it's gonna be.' I just said, 'Excuse me, you're going leave the room and you're gonna get me someone who is going to talk to me properly'. And I wouldn't let [that midwife] touch me. She picked the wrong person".* Suzie continues, "[After the baby was born, the doctor was performing my perineal repair] and I could still feel it, and I'm looking at the midwife, I was crying and she's going, 'I know', and I'm thinking why you can't say anything. She [the midwife] didn't say anything she was just, I don't know. Cause he'd jumped in and sa[id], 'I will do it', and she was supposed to do it".

Sharon talks of the lack of understanding from midwives regarding the physical demands of birth. *"When I got to the ward I said, 'you'll have to take him [the baby] for the night because I just need to have a sleep.' I hadn't done that before. I used to sleep with the other two in the bed and I was fine, I was just buggered. And she [the midwife] goes, 'you'll be right, it's your third one, get over it.' And so he was, I just didn't attend to him. I couldn't. I just physically couldn't. I was just so tired. So that wouldn't have been very nice for him [the baby] either".* Suzie spoke of the necessity to stay in an environment where women do not feel welcome. *"I didn't want to stay in hospital; I did for her [baby's] safety and my safety, because I felt like I was in a gaol because there was no one to talk to".* Cath interrupts, *"I was nearly crying [I said] 'listen I don't want to be here by myself...' I ended up finally getting the transfer [but the transfer was conditional] it wasn't a choice, it was you have to do this before*

you leave". Sharon adds "[but] if you've got other kids at home you stay in hospital, it's the only way of getting a rest".

The new woman states that she formula fed her last baby and thinks she might try breastfeeding this time. She asks what infant feeding support local midwives provide. Sharon states, “*...the third time they didn't seem to want to help me as much and so I struggled a bit with that [breastfeeding] by myself...they just figured that I knew what I was doing and they just left me. I want[ed] more [support] and [the midwives would] come around basically to give me my tablets and that was it*”. Suzie says that it is even worse for women who do not breastfeed. “*They [midwives] get really mad at you [if you choose not to breastfeed] and like make you feel so bad that you do it [formula feed]*”. “*If a mother choose[s] to bottle feed, not that they [the midwives] judge them, it's just okay well you're, you know, you're sort of on your own. You know what I mean? Like you want to bottle feed? Okay [you do not need feeding support]*”. Tina states that midwives do not always leave you alone when you are formula feeding. “*Every time I had her [the baby] on the bottle there was this one midwife, she kept coming in, 'Aren't you going to try her on the boob? She needs to go on the boob. Better for her.'*”. Sharon replies that regardless of the chosen feeding technique, “*they [midwives] assume with your second and your third child, you'll be okay, and they shouldn't cause it's all different... they ignore you and leave you alone*”.

Sharon recalls, however, “*one [midwife did sit] there for 40 minutes to help me feed him, and then she'd come back and check on me. But then I never saw her, I saw her once more and then I didn't see her again because she was on a different shift and she wasn't working. She just took that extra time whereas the others would come in and they'd just attach him and then they'd leave. But she actually stayed [with me] and made sure that he was attached to me and sucking properly yeah and had a bit of a chat to me when I was feeding*”. Tina says, “*I had some really nice nurses [midwives]. As they'd end their shift, they'd come and say goodbye or as they'd start they'd come in and say, 'If you need anything, I'll be looking after you for the night. Just press the button'*”. Suzie agrees “*one of the midwives we had was very nice like that. She'd actually come and say my shift's ending... they were just heaps nice, and talked to you*”.

And “*I remember a midwife giving me a foot massage when I was in labour. That was lovely. [It's] Just the little things, you know, [when] they [the midwives] were just heaps nice, and talked to you*”.

The women finish their coffee and are about to collect their children from the crèche. While washing up their coffee cups the new woman asks, how can it (maternity services) be better for us? Sharon responds “[I would like] *someone who is very helpful and tells you all the things that you actually want to know like [the things] you ask about, [not] someone just rushing you through, and not taking the time to explain to you properly. Someone who asks you how you're feeling*”. “[I would like] *to be treated as an individual; midwives should listen to [my] needs and care about [my] lifestyle regarding appointments*. Cath interrupts, “[antenatal care in my home], *that would be awesome ...especially if you've got other kids. Students should learn more about home care [providing care in the woman's home]*. Suzie suggests “*the hospital [could] coordinate some form of continuity. That would be a nice approach. I know that's hard but you know if you could get the same midwife or the same few midwives when you went in, that would be great rather than, I mean I went to [name of hospital] and I literally saw someone different every time*”. Tina states that she wants choice around her birthing environment. “*I wanted to look into a water birth as and one of my friends just told me that you can't just have it at any hospital, it's only like private hospitals*”. Sharon makes one final comment “[I would like to] *not be the guinea pig where they go, 'do you mind, once I feel how far dilated you are, if someone else has a go up there?' They need to respect if you don't [want students to do additional vaginal examinations], and you feel like you can't [say no], and you go all right, [because] if I say no then they're going to leave me alone all the time. So you sort of go, yeah, okay, even if you don't want them to [so] you're [not] going to be treated differently*”.

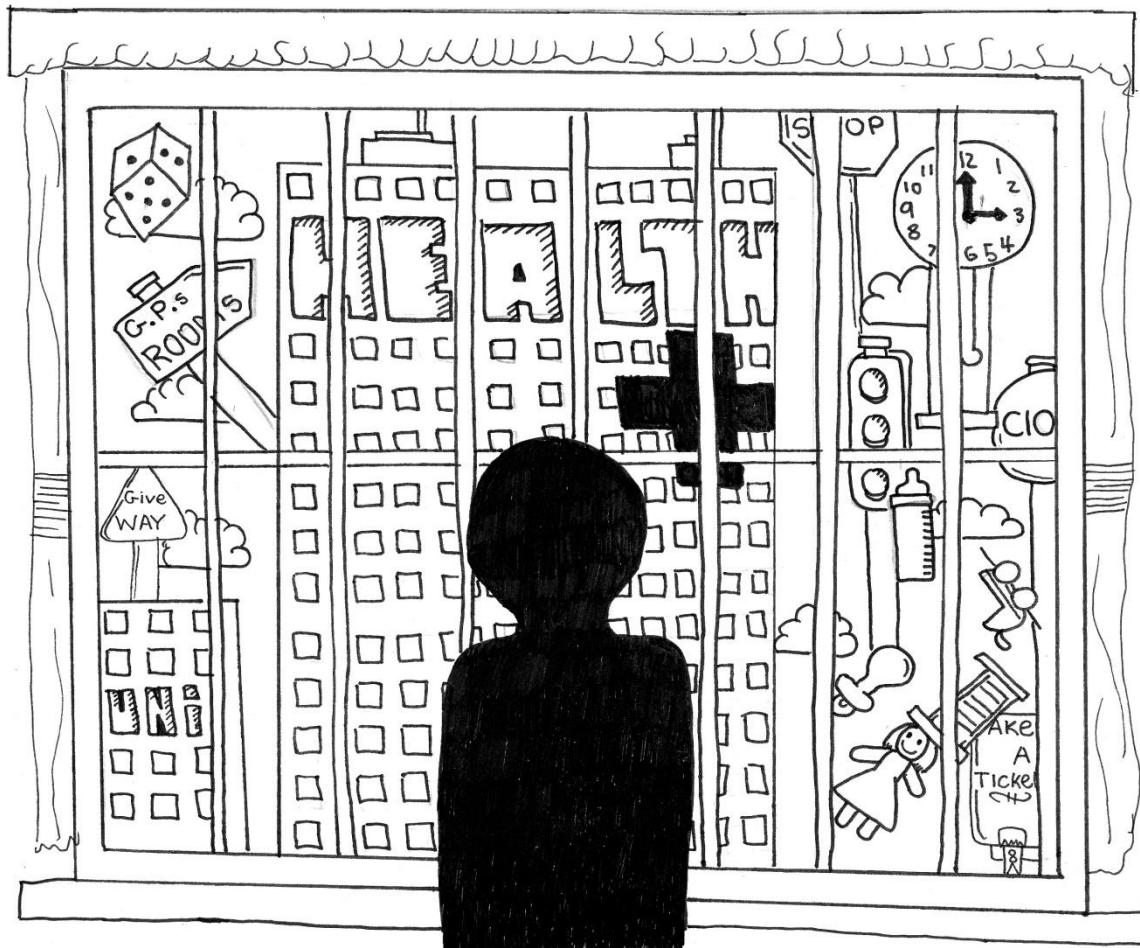


Figure 5-1 Sharon's view of woman-centred care

5.3 Exploring Sharon's story

Using the elements of woman-centred care, as discussed in chapter 3, to explore the maternity care experiences of socially disadvantaged women, there is little evidence that these women received woman-centred care during their maternity care encounters. Women express that they have little choice in relation to models of care or carer. *"It was never even mentioned, I did ask my doctor when I found out [I was pregnant]. I said, 'how do I go about seeing a midwife?' And he said, 'you don't.' I never had any option really with having a personal midwife."* Maternity care encounters following the initial visit to the woman's local General Practitioner (G.P.) are determined by the doctor, with the woman being directed to the local public hospital. This understanding is symbolised by the 'G.P.s' road sign pointing to the prominent health service building in Sharon's view of maternity care.

Women expressed that they had no sense of choice or **control** regarding their care and are not **valued** as an individual during maternity care encounters. In the following emerging themes table, Sharon conveys that socially disadvantaged women do not have a sense that they are the focus of maternity care. Sharon describes how women are made to feel that they are not part of decision-making processes, and do not feel safe to have a voice regarding their maternity care. Women do not ask for their needs to be met. Women may feel unsafe to seek greater control over their care because the health professionals are seen to “*get the baby*” for the women. The health professionals are in a position of power.

Socially disadvantaged women – emerging themes		
Original Transcript	Exploratory Comments	Emerging Themes
<p>Sharon: “if we [birthing women] were treated differently, like we were the centre of what's happening to us and our body, perhaps then we would feel a bit more in control to say, this is me and part of me and this is what I'd like. But, you feel that it's part of them, like you're having the baby but they'll get it for you”.</p>	<p><u>Precedence of woman's needs and Control</u></p> <p>Women understand that they are not valued; their needs are not viewed as important. They struggle to have a voice in the system. They do not feel safe to say this is what I want. The system and midwives are not available for the woman; the woman is an intruder in their domain.</p>	<p>Being safe Being available Being Valued</p>

Women see that midwives also lack control in the maternity care environment. When women understand that midwives have limited power and control in an environment that affords greater control to midwives than women, women understand they have even less prospect for control. Suzie recalls a doctor performing her perineal repair “*I could still feel It, I was crying and ...she [the midwife] didn't say anything, cause he'd jumped in and sa[id] 'I will do it.'*” When midwives have limited control in their practice, they have a reduced capacity to work autonomously and therefore guide or guard the woman. The midwife is unable to **be available** for the woman. The traffic lights depict Sharon’s awareness of midwives’ inability to have control in the maternity care environment.

Women expressed a strong sense of responsibility concerning the physical health and well-being of their baby. They follow directions or suggestions by

health care professionals to ensure the best outcomes for their baby. Women go to great lengths to make themselves available for the health professionals and local health district maternity services in meeting their obligations to ensure the best outcomes for their baby. Women do not feel safe to go against socially conditioned actions by seeking further information or questioning the authoritative knowledge of health care professionals. Health care professionals are seen as the experts in health related ***choices*** and decisions. In Sharon's view, the baby items illustrate a sense of ***responsibility*** for her baby and are placed purposefully under the road signs. The signs represent the imposed rules and regulations that drive her to conform to directives and advice proposed by health care professionals. In the following emerging themes table, Sharon explains that socially disadvantaged women are socially and culturally conditioned to conform to directives by health care professionals. In accepting responsibility for the physical health and well-being of their babies, they are "scared not to" do as instructed or advised by health care professionals in case a poor birth outcome results.

Socially disadvantaged women – emerging themes		
Original Transcript	Exploratory Comments	Emerging Themes
<p>Sharon: "it's just conditioned in us [women], especially like if it's you're first pregnancy [you] put all your faith in the carer that you've been given [and] you'd be scared not to [do what they tell you], cause it's all about you don't want to do the wrong thing by your child". "I think you do what they say because like, you're going to be a mother and you want to do everything the special people who are the professionals tell you to do because you don't want anything to happen to your baby and if that's what they need you to do, you jump through the hoops".</p>	<p><i>Choice</i> and <i>Responsibility</i></p> <p>Here Sharon is expressing that society expects women who are pregnant to act in a particular way that demonstrates they are doing the best for their baby/children. Particular ways of being are valued by society. Women acting in a responsible manner will conform to whatever the health professionals (the experts) deem necessary to ensure the physical well-being of their baby. The women make themselves available to the requests of the health professionals to demonstrate their acceptance of responsibility for the physical well-being of their baby, a behaviour valued by society – a good mother.</p>	<p>Being safe Being available Being Valued</p>

The majority of participating women voiced an inability to establish a relationship with a known midwife. Only one woman recalled having **continuity of carer** during her pregnancy and birth. She did not, however, recall how or why a continuity of midwifery carer model of maternity care was made available to her. Women saw their maternity care encounters as a game of chance. They never knew who they would see each visit or how that person might treat them. This is depicted by the rolling of the dice in Sharon's view. In the following emerging themes table, Sharon recounts that she was unable to establish a relationship with any one health care professional during her maternity care. It is acknowledged, by Sharon, that a relationship is necessary before trust can develop. The formation of a trusting ***relationship*** is required prior to the sharing of personal information by the woman. Women understand that midwives are less able to be available for women, when they are required to spend time each maternity care encounter re-covering issues addressed previously, or meeting the local health district's data collection requirements.

Socially disadvantaged women – emerging themes		
Original Transcript	Exploratory Comments	Emerging Themes
<p>Sharon: “[I] literally saw someone different every time. If you don't have constant care with the same carer, that relationship isn't there. Cause it takes time to build up the trust. You know what I mean? There's no attempt at continuity with who you see, I mean if you're having to see whoever you get when you go in, then there's no real chance for [getting to know anyone]”.</p>	<p><u>Continuity of care, Trust and Relationships</u></p> <p>Women understand that seeing someone different each visit (fragmented care models) reduces the ability to establish trust, which creates a safe space in which a relationship forms. Trust is required to maintain a relationship. This aligns with registered and student midwives' understandings. When there is no relationship, the midwife has little chance of being available as the midwife spends time familiarising themselves with all the medical details that need to be covered within the maternity care encounter. There is no time left for the woman to discuss issues relevant or sensitive that may take time.</p>	<p>Being safe Being available Being Valued</p>

Women voice that the consequence of non-continuity of carer models of care are maternity care encounters that focus on the midwife's need for data collection and task completion. Sharon recalls that midwives "*either didn't have the time or the inclination to find out anything other than what they need, what you were there for.*" Time allocated to discuss socially disadvantaged women's needs or to contextualise health information is insufficient. The format of health information is not suited to meet the needs of individual women. Sharon states that she "*was seeing midwives at the hospital, [and] they were like, 'this is what's going on'...and you've got all those pamphlets and that's it, that's all you got*". Furthermore, women describe how support from midwives diminishes with each subsequent birth following the first. Women want the same level of support with each childbirth experience and yet they felt that midwives prioritised first time mothers and largely ignored those who had birthed previously, regardless of their circumstances. Sharon explains, "*They assume with your second and your third child, you'll be okay, and they shouldn't 'cause it's all different... they ignore you and leave you alone*". Some women manage their desire for a relationship during their maternity care encounters, and the lack of support from midwives, by remaining under the care of their local doctor for as much of their maternity care as possible. Tina comments that "*if they've got to know who you are...it's just much more comfortable because you feel like you can trust...the person*"

Participating socially disadvantaged women expressed that **their needs did not take precedence** over those of the local health district. In the following emerging themes table, Sharon describes her maternity care encounters as similar to "*a factory*" processing plant. There is no individualising of maternity care encounters to meet a woman's needs. Sharon understands that similar actions and interactions occur during every woman's maternity care encounter in order to produce similar outcomes. The same information is provided to all women. The same procedures are performed within similar timeframes. There is no time allowed for women to seek information that is relevant to them as an individual. The midwives are unavailable to meet the woman's needs. The hospital is seen to function as an institution with childbearing women valued little more than goods being processed on a factory production line.

Socially disadvantaged women – emerging themes		
Original Transcript	Exploratory Comments	Emerging Themes
<p>Sharon: Midwives “either didn’t have the time or the inclination to find out anything other than what they need, what you were there for. It was very much, a little bit like a factory thing. Churn you in one end, churn you out the other. Give you an appointment card for the next appointment and off you go.”</p>	<p><u>Precedence of woman’s needs and Control</u></p> <p>Midwives perform tasks and do what is necessary as per hospital functioning. The woman’s individual needs are not considered here. The woman sees she is processed; her care is a production line that runs efficiently, meeting institutional needs without valuing her as a human being also with needs.</p>	<p>Being available Being Valued</p>

Women communicate a desire to have their maternity care from a midwife who can meet their individual needs, “*someone who is very helpful and tells you all the things that you actually want to know*”; a midwife who makes the time to be ‘with-woman’ and not “*someone just rushing you through*”. Women do not recall having a midwife who “*treated them as an individual*” and asks how they feel, or a midwife that listens and demonstrates an understanding of their needs. Women appreciate midwives who make time to “*talk to*” them. Midwives who make themselves available for women are viewed as “*heaps nice*.” Tina recalls that she “*had some really nice nurses [midwives]. As they’d end their shift, they’d come and say goodbye or as they’d start, they’d come in and say, ‘If you need anything, I’ll be looking after you for the night. Just press the button’.*” These “*heaps nice*” midwives worked in non-continuity of midwifery carer models of practice.

In the following emerging themes table, Sharon recalls being left alone without sufficient information to feel safe in the environment. The perceived busyness of the hospital environment is seen as preventing the midwife from being available for the woman. The woman understands she is not valued because other people, or tasks, take precedence over her needs. The comment “[that’s] just the way it is” indicates an acceptance of the conditions and care provided. Women lower their expectations of local maternity services because they understand that the needs of the overburdened local hospital and maternity

care staff must take precedence. Women do not feel valued sufficiently to speak up for what they need; their needs are not as important as 'others'.

Socially disadvantaged women – emerging themes		
Original Transcript	Exploratory Comments	Emerging Themes
<p>Sharon: "I was left alone and not told a lot and you know when I was told something was happening, well this is what's going to happen because you've got no choice and [that's] just the way it is". With "the sheer mayhem at the hospital no-one paid any attention to what was going on because they were all so run off their feet. You know they were running just to keep up with everything that was happening rather than being able to take time and care to see what was really going on with women".</p>	<p>Choice, Control and The Maternity Environment</p> <p>Sharon understands that she was alone and ignored in the hospital – no one was available for her. She was not valued as a person with individual needs and concerns. She was told what would be happening rather than presented with options and engaging in a collaborative discussion. The maternity care environment routine was blamed as the reason that no one knew what was going on with the woman. No one was available for the woman and she didn't feel safe to voice her concerns that she may have felt her physical well-being was compromised. Is this a safe environment for the woman?</p>	<p>Being safe Being available Being Valued</p>

Women express that the **maternity environment** impacts on all interactions between women and midwives, and is depicted by the large, centrally placed, building in Sharon's view. Maternity wards are not viewed as woman focused. The environment is isolating and the women are largely ignored by midwives during their hospital stay. Midwives are viewed as too busy to make themselves **available** for individual women. Workplace practices and hospital requirements take the midwives away from women, with no time to meet the needs of individual women. A clock is seen in Sharon's view representing the focus of time and busyness.

Women described the maternity ward as a prison. They feel they are in a gaol-like environment and largely do not "want to stay in hospital". Women also express a sense of powerlessness in relation to organisational policies. Rules are viewed as a means of controlling women. They spoke of midwives repeatedly referring to "...our rules and regulations" to enforce expected and accepted behaviours. Sharon's window has bars representing her sense of isolation and lack of power to control her conditions while in hospital. Although

women find the hospital environment isolating and unfriendly, they attempt to take control of their personal space by closing the curtains, further isolating women. Closure of the curtains creates a psychological barrier that keeps the intrusive and unfriendly midwives away. Suzie recounts “*I wanted my privacy...and to hide from that nurse [midwife]*”. Sharon’s window includes curtains that she may close to protect her from the view of midwives. One woman spoke, however, of the benefits of staying in the hospital environment. Sharon explains that “*if you've got other kids at home you stay in hospital, it's the only way of getting a rest*”. The hospital environment, while isolating and disempowering, can also be a haven for socially disadvantaged women who can have immense caring roles and responsibilities at home.

The fifth and final element of woman-centred care, **women's collaborative consultation regarding maternity service provision** was absent from the women's recounted experiences of their maternity care encounters. Thus it is difficult to comment on whether the women are aware that it is possible to be involved in the development and/or provision of local maternity services and whether there are processes at the local health district that enable socially disadvantaged women to be involved.

5.4 Conclusion

This chapter presented socially disadvantaged women's recounted descriptions of their maternity care encounters. Participating women's attempts at making sense of their experiences were shaped into a narrative. The narrative was then explored for understandings using a modified Interpretative Phenomenological Analysis process and the elements of woman-centred care as pre-determined themes. It became clear to me that the maternity care encounters of these women did not always incorporate the elements of woman-centred care. Participating women did not recall having choice, control, or continuity of care from a known midwife. Women did not recount instances where their needs took precedence over those of the local health district, or individual health care professional. They did not discuss being involved in the development and provision of health services. Participating women expressed that it was not safe

to have a voice regarding their maternity care. Furthermore, they described maternity care encounters in which no one was available to meet their needs. The needs of these women were not valued.

Table 5.1 *Recurrent themes: socially disadvantaged women*, demonstrates the recurrence of pre-determined and emerging themes across three groups of socially disadvantaged women. With the exception of one woman in one focus group, women participating in this study did not receive a continuity of midwifery carer model of maternity care. They did not have the opportunity, therefore, to establish a relationship with a known midwife. Only two women participating in focus group 1 spoke of having choice and control regarding their maternity care options. These experiences however, were discussed in relation to care from their local General Practitioner, not care received from midwives. As shown in the table, the remaining pre-determined and emerging themes were present in all focus groups.

The next chapter presents registered midwives' descriptions of midwifery and woman-centred care, maternity service environments and maternity care encounters in which socially disadvantaged women were the recipients of care.

Table 5-1 Recurrent themes: socially disadvantaged women

Identifying recurrent themes: socially disadvantaged women				
Pre-determined Themes	Emergent Themes	Focus Group 1	Focus Group 2	Focus Group 3
Choice: These women expressed they had <u>no choice</u> within their maternity care encounters	Being safe: These women lacked a sense of ' <i>being safe</i> ' in having choice or control	Yes No: n=2	Yes	Yes
Control: These women expressed they had <u>no control</u> within their maternity care encounters		Yes No: n=2	Yes	Yes
Continuity of care: These women described their maternity care as <u>lacking continuity</u> with a known midwife	Being available: These women lacked a sense that midwives were ' <i>being available</i> ' for them	Yes No: n=1	Yes	Yes
Women's needs take precedence: These women expressed that their <u>needs did not take precedence</u>	Being valued: These women lacked a sense of ' <i>being valued</i> ' within their maternity care encounters	Yes	Yes	Yes
Women involved in development and provision of maternity care services: These women described maternity care encounters that lacked <u>women's involvement</u> in development or provision of local maternity services		Yes	Yes	Yes

6 A discussion with Delvin: registered midwives' experiences

In this chapter a narrative has been created weaving direct quotes to reveal common experiences and episodes of difference as communicated by participants from every focus group, and interpreted by the researcher. Fictional characters have been designated either the voice of shared understandings or the voice of different or individual understandings, expressed by participants. In this chapter the researcher is present through the voice of 'Delvin, the midwifery educator'. My words are made obvious through differentiation of text styles (see table 4.3: key for understanding, p.S4-ii). Questions raised by Delvin are not necessarily those posed during focus groups. They are part of the creative process in bringing together participants' words and improve readability for the reader.

Following the narrative, an additional method of presenting participants' understandings of woman-centred care is provided through a visual representation of their view of maternity care encounters and woman-centred care. Finally, the second half of the chapter provides the reader with insight into the descriptive or exploratory process of analysis through the inclusion of extracts from my 'emerging themes' tables. In each extract the participant's words are displayed in the first column. My comments and thoughts are found in the second column along with the pre-determined and preliminary themes. Emerging themes are displayed in the third column. The colour coding demonstrates part of my engaged reasoning processes, that is, how I align participants' words, my thoughts and the final themes discussed chapter 9 – *New understandings*.

6.1 Introducing Delvin

Delvin, a midwifery educator, recently attended an international midwifery conference – Socially Disadvantaged Women, Health Inequities and Birthing. A key note speaker at the conference discussed the benefits of woman-centred care throughout the childbirth continuum, for the socially disadvantaged woman. Following the conference, Delvin facilitates a discussion group in her maternity unit to establish a midwifery dialogue around the provision of woman-centred

care in a fictitious maternity service. Delvin's colleagues attending the discussion group include Rosie, a recently graduated midwife. Rosie is one of nine midwives working in a Midwifery Group Practice, assigned to work specifically with socially disadvantaged women. Rosie's Midwifery Group Practice has been in operation for less than a year. Also attending is Margaret, the maternity unit manager; Carol, a community midwife team member; Helen, a hospital based-midwife working in the antenatal clinic; Olga, a midwife working in a more established Midwifery Group Practice; Wanda, a labour ward midwife; and Leesa, a lactation consultant. All midwives provide care for socially disadvantaged women.

6.2 A discussion with Delvin

Delvin: To what extent do we provide woman-centred care to socially disadvantaged women in this local health district?

Wanda: *"I'm not saying this is right or anything, I'm just saying this is when it gets to the point where they [midwives] are so busy that all those things [woman-centred care] go out the door. Like they are just too busy, they are being told, could you get her up as fast as possible, there's another one coming in. So there are lots of outside pressures out there. On a day to day basis, it's constant; they [midwives] very rarely have a break from it. I think labour wards are the same."*

Helen: *"I believe most of the midwives that work here, really do their best for each woman that they are caring for under the circumstances that they're working under."*

Rosie: *"We haven't got the midwives, enough child and health nurses to do it for everybody. We still need more staff."*

Margaret: *"If we had more staff, I think it would be easier, so that's what we are looking at."*

Helen: *"[But] the new graduates come into a culture where it's really medicalised".*

Olga: “Yeah, I do worry about some of the younger midwives, because they’re becoming more like obstetric nurses. Maybe it’s because they’re younger. Maybe eventually they’ll change.”

Delvin: What choice do socially disadvantaged women have regarding their maternity care options?

Olga: “I think once they access the model [Midwifery Group Practice], I think that they probably have as much control as any other woman. They get given the same information and support that every other woman does in terms of what choices are available as all of the other women on the program.”

Wanda: “Hmm, I think it would probably depend on the individual. I think again the midwives do have a lot more flexible approach to the mother, and I think it’s probably very, very variable. I mean the choice, the women can always refuse but I think sometimes it depends on how things are phrased. They obviously have the choice to refuse things. Like if they go overdue, some doctors like to bring them in and sometimes coerce the mother and I’ve heard some doctors say things like, ‘Oh you’re putting your baby at risk’, which maybe that’s not actually evidenced based, it’s just their opinion. I have heard one particular doctor will do that quite a lot, so it depends again on the doctors and who’s on at the time.”

Margaret: “They actually don’t. If they have experienced our care before and they’ve had a particular midwife, they can ask for that midwife again, and they will usually be allocated that midwife again if that’s what they want. They can also say they don’t want that midwife again. But that’s only in knowing because they know now what they want. If coming to us for the first time, they don’t really have a choice except I say to women as the manager, ‘If you don’t like a midwife or if you and she are having any sort of conflict and you’re not happy, you can come to me and I will do what I can to maybe change midwives, so they do have a choice.’”

Rosie: “I think you know, you’ve got a choice because you’ve had choice all your life and whereas if you haven’t had choice it’s a bit harder to step up and go okay I am going to make decisions here. Particularly if you’ve got multiple people that you have to see who are talking to them.”

Carol: “They do want choice but they just don’t want to think about until they have to make that decision.”

Olga: “I mean let’s face it, they are only 15 [years of age] and they haven’t had to think about any of that sort of stuff. If I was 15 I don’t think I could make those choices either.”

Delvin: How are maternity care options put to the socially disadvantaged woman so that she has control regarding decision-making?

Carol: “It’s a big bug bear with me, I don’t believe that women consent properly, um certainly not our women. They are just told go and get a test done. They have no idea what it is, what it means, you know.”

Rosie: “And then they feel compelled to sign that [the consent form] because you say this is what’s normal, and then they then complied, ‘well I want to be normal like everyone else, I’ll just do it’, rather than [the midwife] saying this is the general rule, but this is why we do it and you know you have a choice to do it or not to do it, it’s not something you have to do.”

Olga: “We don’t know because we’re not there. We don’t do that, we see them at 22 weeks, so all of that stuff is done to them before they get to us.”

Helen: “We discuss the immunisations with them postnatally, so we show them the schedule in the book and explain it.”

Olga: “You talk to them prior to when it’s due about this is what’s going to happen, so I explain to them, next visit, routinely we would do this. This is why we want to do it, it’s now up to you if you want to look up more information, go

to the Department of Health website, go to these websites, it's up to you to do that.”

Carol: “*Gradually, each time you see them just mention some stuff and [say] have a bit more thought about that, [it] makes them go oh okay. Then hopefully by the time they get to the labour or whatever if it's in regard to labour or in regards to breast feeding or in regards to cutting down smoking, hopefully by then it's sinking in a little bit more and they can have that confidence to make that decision.*”

Helen: “*I guess for most of those women, again they do as they are told. They are in the system. They don't butt the system, they go with the system. I think partly because they haven't got any other information, they don't know and they only get the information we give them so if we tell them it has to be done, then they do it.*”

Leesa: “*I give them the pros and cons but I have to always respect their decision. I think it is important that we do pull back and let the mums make their own choices. It is so important because we shouldn't ever pressure, it's their decision, it's all got to be their decision.*”

Olga: “*But they don't want to [make a decision] because it is too hard.*”

Leesa: “*I think every mother makes her decisions that are best for her in that time in their life and I don't think that ten years down the track they may have a different opinion and they may do things differently, but right there and then, they will make that choice that suits them.*”

Delvin: In order for a woman to have control of her maternity care options, she needs information. What access to health information do socially disadvantaged women have?

Olga: “*Because you've got them for a protracted length of time it is probably a major opportunity that we have with those women. You can do the smoking and the alcohol and the drug sort of education stuff and nutrition and yeah, so*

you've got them at a prime time and a time when they probably really want to think about it because everybody cares about their baby so if you can get them at a time when they are vulnerable to listening because they want the best for their baby, you can make big changes."

Carol: "They come to our care at a very captive time; primarily the baby is you know the number one thing, so there's opportunity there to tap into all the [health related] areas."

Helen: "We [also] have print outs and we will talk to them verbally about why we want to do tests, why not do the tests, why they would choose to do whichever one and the consequences of both; of doing it or not doing it, so they can make an informed choice."

Rosie: "I think women don't get a lot of unbiased objective written information to start with, [and] it probably will be subjective as to what they are told about what their options are. You know whether it's a routine test, or an optional, or where they make their decisions from that, so I think that comes across verbally. I don't know that there's a lot of objective written information that people get at that first visit so they can process it and make their decisions with their partner or their family in regard to what they take up. Then I don't know even if they make decisions, whether that will be adhered to [by the health care professionals]."

Carol: "But I find sometimes the disadvantaged girls, they're worried about, 'I don't want it because it hurts' and then you might get someone else that doesn't want it because it transfers to the baby [or] 'I don't want to have that, everything's all right. I don't need an injection after I've just given birth'."

Olga: "They'll often decline something with the fear of being hurt. 'I don't like injections.' It won't actually be that I've investigated it and ...

Helen: "It can be different reasons. Classic example is a 34 weeker I had with a very restricted growth baby from smoking. You know she was a heavy smoker and definitely didn't want anything put into her baby, like vitamin K. The nurse's saying, please can you ask for consent and she's saying no. The nurse

is telling her I think it's a good idea, the doctors say it's a good idea. So they are a bit mixed up I think. You know they [are] taking drugs and smoking but they're not going to do this because that might hurt the baby."

Olga: *And I'll betcha they've spoken to someone at play group about that. Or not play group, but just, you know, get together with their girl friends."*

Margaret: *"It's a hospital policy thing like everything these days. Everyone must get written information sheets, but I think where women really get the information is from their midwife in that one to one discussion about what is meaningful for this individual woman. I think a lot of it comes with continuity of care where you get to know the woman really well, and the woman has that relationship with her midwife. You can have those frank and fearless discussions if you need to. You can say stuff to women when you are having that one on one conversation that the handout doesn't say. An information sheet has to go through so many channels of bureaucratic red tape before we get the information sheet signed off that yes this is okay to give to women. It ends up being so limited because it has to say this and that. Half the time they [are] a waste of time because really the information on them is so generalised, and really doesn't encourage women to think that they have a choice. I believe that the information sheets are about telling women what we want them to know to make the choice that the system wants them to make. If they follow what's on the information sheet, they don't have choice, because it's all about making sure the woman's aware of what the risks are if she doesn't do what we are telling her to do. Whereas when you [are] having that discussion we can really individualise the information for that particular woman being mindful about what her own journey is and some women will want or ask or need more information to make a choice."*

Helen: *"Yeah but often it's so busy that the midwife [doesn't] get the chance to sit down and [discuss information with women]"*.

Wanda: *"I think people think, that they might explain things, but [if the woman] has limited understanding, [the] medicos and midwives often think that people understand, and they don't."*

Leesa: “I think it’s important to spend the time because if they want the information, they’ll seek it out, but they’ll often seek it out from a safe source. For instance a teenager might ask another teenager about contraception rather than ask a midwife who might be her mother’s age. They want the information, but [the woman thinks] how can I tell someone who’s so different to me that ‘I can’t read’. So they’ll seek it [information] from someone that they feel safe with, but they might not be getting good information.”

Delvin: Who is responsible, then, to ensure the woman is able to make an informed decision?

Olga: “I’m not responsible for their decision making. I say to the women, it’s up to you if you want to look up more information, go to the Department of Health website; it’s up to you to do that. I’m there to guide them in the right direction so they can make their decision, if they choose not to do that, that’s their choice, but I’ve given them the information. I can’t make their decisions for them which is what they want you to do. They want you to say, you should have this or you shouldn’t have this.”

Rosie: “[But] most of those women, they haven’t got any other information. They only get the information we give them so if we tell them it has to be done for this reason, then they do it. They haven’t had the ability to research it to make a really informed choice. But in saying that women that come to us, we give them all the information so they make a choice and we push them to make a choice.”

Delvin: Do socially disadvantaged women have choice regarding the model of maternity care they receive, or who their individual maternity carer is?

Helen: “No!”

Margaret: “I think it is predominately presented to them when they first book into the hospital, the types of models are explained to them and they are asked, ‘Which care would you like to have?’.”

Rosie: “But it can be fairly subjective depending on the midwife who interviews them, how the models of care are offered to them.”

Olga: “Yeah and that’s a little biased sometimes, because it depends on that midwife’s personal beliefs. They will influence the woman’s decision on what that midwife’s own beliefs are. If she thinks group practice is a great thing, she will push it, she will promote it to the woman and encourage her to go. But often, with young women, disadvantaged women or women having a first baby you often hear them say things like oh you know you might want an epidural dear so you shouldn’t go there. You just don’t know what labour is going to be like and you might want an epidural so you shouldn’t go there.”

Carol: “I think they often don’t know what choices are available to them. They are less likely to ask the right questions so they can get the information, and they are less likely to be assertive in asking for their needs to be met. They don’t know what their needs are because for lots of them I think, just getting through life day to day is difficult enough without them having the challenge of trying to find a model of care that meets your particular needs as well. They are less likely to know that they are pregnant as soon as they fall pregnant so, they are less likely to be able to get an immediate spot in the birth centre or with the continuity model. For most of them they don’t have a lot of choice about what model and the model of care sometimes determines their choice around where they birth and who they have with them for the birth as well. So for most of them I think they are really disadvantaged.”

Margaret: “[Name of hospital] takes basically anyone, they are quite welcome to come no matter where they come from and they can choose their midwife in such that if they met someone in a midwifery clinic and they weren’t happy with that person, they are likely to get a different one next week anyway. But they could ask not to see that midwife again if they chose, I mean the same with the doctors, if they are put into a team of doctors, it is difficult to get them changed,

but if they particularly don't like that doctor they can ask not to see that doctor again."

Rosie: *"They don't really have too much of a choice because we usually get allocated women. But if it is a problem we encourage them to voice if they are not happy and we can organise a swap."*

Carol: *"[But] if you have somebody that is socially disadvantaged and is not vocal, they might get missed."*

Olga: *"They can have a choice about where they can go or what's available. I just don't feel it's our role to make sure they organise appointments. I'll give them a number and say, 'You organise this appointment'. That's not my job to organise an appointment for you'."*

Leesa: *"I don't know. Women who have higher levels of education somehow learn what questions to ask about everything in life, not necessarily just around birth choices. Women with a higher level of education and that aren't in those really low socioeconomic groups maybe learn from other life experiences as well that you can have choice about a lot of things, and they will read and they have access to a broad range of information and different ways of getting that information, than perhaps less disadvantaged women. That makes a difference. They [socially disadvantaged women] are less likely to be well educated. They don't always have good access to primary health care, so they might not see their GP early in pregnancy. They are less likely to have had any pre-pregnancy discussion about preconception health, all of those different things. Lots of them when they do access primary health care, it's not with a known GP. It's drop in medical centres that you go to when you really have to and you go to the ones that will bulk bill you, so they often don't have that relationship with a primary health care professional prior to pregnancy."*

Rosie: *"In [a] continuity model we do try really hard to give women choices about who will be with them for their birth because it is so important. It has to always be about the woman and not about midwife's ego. But they have to get into the model first."*

Delvin: How does the socially disadvantaged woman access continuity of midwifery carer?

Rosie: “*They go through and see if they’re eligible for [Midwifery] Group Practice. They need to say yes, yes, yes, tick all the boxes, you can go to [Midwifery] Group Practice.*”

Olga: “[Like I said before,] it depends on the [booking-in] midwife’s personal beliefs. You know if she thinks [Midwifery] Group Practice is a great thing, she will push it. But you often hear them say things like you shouldn’t go there.”

Carol: “It’s hard to get into [name of Midwifery Group Practice].”

Rosie: “*There’s a stack waiting [to book into our Midwifery Group Practice] for March. And it’s really disappointing for the women. They’re in limbo because some of them are so committed to finding any way they can to get into group practice, they’ll hang on. So they’re probably not having the best pregnancy because they’re always feeling as though, they might get a chance.*”

Olga: “How many waiting for March?”

Margaret: “Thirty.”

Carol: “*Most women are still getting really fragmented care. I think if we could make sure that all of those women [had] continuity of care [that] would make a huge difference. But at the moment, most women from those groups don’t get any continuity.*”

Delvin: Can’t we get more staff in order to increase our continuity of midwifery carer options for women...?

Olga: “*No, we [are not] economically viable, you know, we’re an expensive model all that sort of stuff.*”

Rosie: “*I think it’s a bit of a control issue for entire management too, because they can’t control what you do and they can’t see what you do and what you do*

isn't visible and there's that sort of fear from higher management about that. So let's not put too many more in there because they've already got this many I can't control."

Delvin: To what extent does the socially disadvantaged woman have access to a known midwife for her maternity care?

Carol: *"It's a bit of a mixed bag, the ones who have the [team] midwives care [get a degree of continuity]. The midwives usually follow through and see them in the antenatal clinic, they hopefully see them round about the time of delivery, they probably won't be there for the delivery but they will see them, if they've got time, and they will follow them up after delivery, maybe give them a ring as well."*

Wanda: Yeah but, *"if they are going into hospital, and they are having a doctor's delivery, medical management, they get anybody, whoever the person is on at the time. The midwives manage their labour and they get any midwife and then if there's a problem whoever is on call at that time will come and deal with the issue."*

Helen: *"We do aim for some consistency."*

Margaret: *"We actually have a home birthing service now so hopefully those women will see their own midwife at home, but again you know it depends, if the midwife has been up for 24 hours the night before [the woman] might see somebody else that delivery. Hopefully she will be introduced to that person beforehand; they try and make sure that the people that might attend that birth are known to that person."*

Rosie: *"I think continuity of midwifery care needs to become the standard; expand the model of care for all women. At the moment we might be meeting [one] woman's care for continuity of midwifery but there's also another woman out there that hasn't been able to access [it]. We have the pressure of trying to meet the needs of the huge number of women that need continuity of midwifery care and there's no other model that offers that to them."*

Delvin: What are the benefits of continuity of midwifery carer models of maternity care for the woman?

Rosie: “*I guess the earlier we meet them in that sense we can influence their overall experience.*”

Olga: “*We’re really fortunate in that we have you know the capacity for one to one so you really do have an opportunity to develop a relationship with that woman and I guess we can influence the care that they receive.*”

Delvin: How early is early? When do you first meet women allocated to a Midwifery Group Practice?

Olga: “*We have a case file. Usually our booking forms are allocated to us around about the time they’d have their morphology ultrasound.*”

Rosie: “*Twenty-two weeks is our first appointment.*”

Olga: “*That’s where we’re really lucky in that we are involved for such a long amount of time, we do get to know the women and the families and can find out from them what’s helpful and facilitate that.*”

Helen: “[However, for us] a lot of the women that we look after, you can make some really good plans with them, but that can just all go right out the door when they walk in delivery suite.”

Carol: “*Because we provide community based care, you’re meeting families on their territory and so you often get a better response from them, a better picture of what their story is and what their needs are. They’re not as defensive in their own home as you find in the hospitals.*”

Rosie: “*We spend often, for those women, antenatally an hour at each visit with them, and similarly postnatally, because lots of those women won’t go to classes and things like that and in our care they probably don’t need to because we spend so long with them. You are educating while you are talking the whole time, so they don’t need to attend classes and they don’t need to go and sit*

there with other middle class white women when maybe they feel like they don't fit, so yeah."

Carol: *"I know in the clinic downstairs, they have 15 minute visits, what can you do in 15 minutes you know? The woman comes in, they see a different midwife every time, so you know she's [the midwife] only doing the physical stuff. She's not doing anything more than that and she doesn't know this woman and the woman doesn't want to tell every midwife she sees every month her story again, so she doesn't tell her story whereas continuity is what it's all about, it's the way you get the women to trust you, they will tell you stuff, you've got time to listen and you can do far more with them. They don't have to tell different people all the time and they know when they walk into the office, you know who they are."*

Rosie: *"I guess with us having the philosophy and the belief [aligning] that would be a better way to work. I totally understand that our colleagues have it really hard in the system and I know I cannot go back to the system."*

Olga: *"I love it, I found it challenging to start with because my kids were smaller, but I think if you are really passionate about something or if you really love it, then you just find ways to get around the challenges and the obstacles and I was lucky enough that I had really good support from my partner and family to work in that model. They could see that I loved it so much that I wouldn't be happy working in any other model, so you just sort of get over the obstacles and find ways around them, I really love it."*

Delvin: Are you saying that there are challenges for you when working in a continuity of midwifery carer model of practice?

Olga: *"For me it was huge, huge to not be a shift worker, for better or worse, just not being a shift worker after 23 years was really hard, and I still struggle a bit to let go. Managing your hours, managing your time, not feeling like, I'm not working if I'm not in a hospital, that has taken a while. And the women, I feel like I've had a few issues with being sick you know? Like sick leave, whereas if you were on shift work you'd ring up and say not coming in. You can't do that*

because if you don't see your women nobody is going to do it. If you put it off today, they've still got to be seen tomorrow. Not having the ability to have a sick day and things like that have been really challenging, so mainly just timing things."

Rosie: *"Initially I went into it [Midwifery Group Practice] to fit in with, three children and a very busy family lifestyle. It hasn't really fitted in that well, and it has been very stressful to the point I was about to have a breakdown, it was just that stressful. So many hours over each week and it just affects your whole family."*

Olga: *"I have to follow up procedures, and that's just added an extra workload. It's partly my fault because that's my nature, so I know a lot of it is my fault, 'cause I am a bit of a perfectionist so I have to make sure you know everything is done. I am trying to do that better, but it's hard. I went on holidays for two weeks, a woman who was on insulin previously, came back and high glucose, GTT extremely elevated, nothing done about it. I have to follow everything up, whereas I shouldn't really, it's been very [hard], in the same token it has been very rewarding."*

Rosie: *"I'm drowning because just the workload. You know workshop after workshop and you're going, well I've missed two days and I have to catch up here and then ...you never got your days off, you just don't get days off. It feels like sometimes you get one day off in about 12 days and then you might get a weekend off. It just feels like you are always working."*

Olga: *"The part I find challenging to my own personal profession because I would never put someone at risk [is when] you've got a medical team coming in. 'You're baby will die and you could as well if we don't hurry up and get this baby out' or something like that. [Or when] the woman [is] not wanting to do active management, so you have to be the person that negotiates between the two and I look at it as a win-win situation or a lose-lose situation. No-one's actually winning and no-one's actually losing but nobody's really getting what they want because either they cave in and go with the hospital's protocol or they say no and then the hospital is the one who's protocols aren't being followed."*

Delvin: How is it, negotiating between the needs of the woman and those of the hospital?

Olga: *"I don't actually have a problem with it as long as it's documented that that's what the woman wanted. But, I don't like the witch hunt society that the hospital creates. When a woman chooses not to follow their advice and it's not witch hunting the woman, it's witch hunting the midwife."*

Wanda: *"But the other thing, I was at this birth, it was a long day and we were supporting her as best we could and the doctor was just about to do an episiotomy and I thought, now hold on a minute, you need to tell her, you need to say look, I have to do this. I got into trouble for that, [doctors] they're used to calling the shots, 'it's my way or the highway' ..."*

Rosie: *"I've been questioned as to whether you gave the woman the right information, 'Did you make this decision, are you sure it was an informed decision, you gave her the appropriate information?' I've been there, done that. I've been disrespected by my colleagues for stepping out and doing home birthing, the same colleagues who are now doing home birthing in a public setting in a hospital. It can be really hard sometimes."*

Delvin: How would the rest of you describe your experiences of working with socially disadvantaged women?

Carol: *"It's tiring, challenging and emotional work".*

Rosie: *"I've had women that I've really worked really hard with but I know that I just can't meet all of their needs. Sometimes it's huge and in that one on one midwifery relationship, sometimes it's too much for one midwife."*

Olga: *"And the attitude from the women, you know the women we get, they are high risk ones, like [name of colleague] and I do Aboriginals, and Torres Strait Islanders, we'll pick up any dreg, anybody that is considered too hard goes to MGP [Midwifery Group Practice] and specifically us, you know, we get all the young ones, doesn't fit into any category, if it's a problem, if they are*

cantankerous, if they've got social problems they come to us. We don't get the nice normal young parents who've got a lovely supportive family, we get higher needs so we get the problems."

Margaret: "We had so many conflicts and unhappy stories, I still don't, I don't think I got to the bottom of how best to facilitate care for teenage mothers because they come in with all their teenage hang-ups and yet they're going through this life crisis of having a baby and it's very problematic at all sorts of levels. There were often barriers set up there, if the communications not there and it was really hard to facilitate good care for those teenage mothers plus facilitate staff interacting with these young mothers in a way that was positive. Maybe because they seem to have the greatest problems relating to our staff or visa versa."

Rosie: "I don't know, I feel that, you know, continuity of care is really, really good for women but some women have such huge needs that you have to share them because they are too much for one person to take on. If that was what life was like all the time, continuity of care as a midwife would burn you out really quickly. They are just so draining, does that make sense?"

Margaret: "Quite often with these women their outcomes are not what we would want for them. I mean it's probably a 50/50 chance that it's actually not going to be a good outcome and you can really take that on board and think, that was my fault, I didn't do enough, or I could have done this and why didn't I do that"

Rosie: "Sometimes I feel guilty because they are so deprived and I'm not and you know sometimes I feel like it's, you know condescending because I am so middle class and these families have so many more problems and are so disadvantaged."

Margaret: "[But Rosie,] on another level, if [you] can make this experience a really good one, one they can treasure and remember, when probably not much else in their life they can [treasure]."

Olga: "[However,] you need to know where your boundaries are and what you can do and what you can't do because there are some women, for instance

women who have a substance addiction who will continue on the path they choose and you might not be able to change that. And also know what you can promise and what you can't promise."

Helen: *"It can be very stressful and often I don't think that we have enough time to deal with these women to help them and put things in place for them, and hopefully we have a little bit of extended time. If they have a history of drug use for instance, they have an extended stay. We try and liaise with other organisations because drug addicts will tell you any story, so they will tell you what you want to hear in order to get what they want to, or what they think they need. So it's hard work and it's quite demanding work."*

Olga: *"I decided that a long time ago because I just think that you're just going to kill yourself. You can't help everybody, and you can't fix things for everyone, but what you can do is let them know that there is a different way of living, there are other options and I agree a little bit with ..."*

Rosie: *"You can't get emotionally involved, you become vulnerable to being hurt, it is too hard on you."*

Carol: *"And if we struggle with these situations imagine how those students feel. The students are being told day one a certain ideal of what they are going to come out with at the end of their training. I remember you know yay, I'm a midwife, I'm going to do this and it's like wow. And a brick wall goes up and you get hit in the face a few million times, have rhinoceros hide. My horns nearly flap. You know the students are being told something that in reality is never going to occur."*

Wanda: *"It can be pretty confronting for the student especially if sometimes they choose the path of least resistance for as long as they can. So they try and keep everything very normal and then when they are confronted for the first time with the labour that's got lots of intervention and complications, sometimes they virtually go into shock because they've got a really nice picture of how it should happen and it's like they've been abused. You know they reel back and you have to debrief with them as well on what your part has been in the whole picture."*

Olga: “I think students need to learn that. That’s an important thing and even you know sometimes you can empower students I believe.”

Helen: “[Again,] we have to try and be everything to everyone and it doesn’t work.”

Rosie: “[But it is also] enjoyable, it is life changing, yeah it is delightful.”

Carol: “[Yes,] it’s rewarding but can be emotional, it’s not just the girls, you meet the family and the family dynamics and sometimes that can put a lot of pressure on you.”

Leesa: “Never a dull moment, it’s always interesting and the thing is once you get to know these women, I really like the women. When you deal with them and I feel a lot of the times especially with the aboriginal women, I feel quite privileged that they will trust me now.”

Rosie: “We’re in this practice [Midwifery Group Practice] and we’ve all come out of different areas of the hospital. Some have been in the birth centre, some of us have done you know some community care. But now we can see that the women that we’re privileged to work with are also giving us satisfaction.”

Olga: “Some women just you know make it all worthwhile, not all of them, but some you just think this is why I am doing it, this is exactly why I am doing it, this is just fantastic.”

Rosie: “Because they are grateful, they are so appreciative. When you arrive in the labour room, it’s just that whole, oh [the midwife] she’s here and it’s just so rewarding to see them [go] ‘yep I can do this now’.”

Carol: “Yeah and these women have nothing. They are definitely disadvantaged. Not much social support, no financial and you know struggling and they really appreciate everything you’ve done for them.”

Rosie: “It really opened my eyes up to women that are socially disadvantaged, just digging that little bit deeper and gently because some of these women have got amazing stories to be told. But no one ever listens to them and I think that

lots of times they probably don't feel safe to share their own life journeys with anyone because they feel that they will be judged or that they won't be listened to or that it doesn't matter. And so for me as a midwife, that was a huge learning opportunity. Ever since then I've always done things differently with those women."

Olga: "For me it was such a learning curve because I realised I had been so judgmental."

Rosie: "Mostly the relationships are very rewarding for me as a midwife and I would hope really beneficial and positive for the women. I really enjoy sometimes the challenges that come with working with socially disadvantaged women because you certainly have to be creative in finding ways to help that woman have her needs met."

Delvin: To what extent are you able to develop collaborative relationships with socially disadvantaged women?

Carol: "Depends on the woman. Some distance themselves from you because they don't want you to know too much about their lives."

Rosie: "Yes that can be very threatening [for them]."

Olga: "When they find out, 'oh what you come and visit me at home, well how long for? I don't want you coming to my house, I don't want you seeing what goes on in my house', so they go through the other system or go through women's health clinic, go to labour ward and then they just go home. No-one's going to know what's going on, so some of those women don't want Group Practice."

Carol: "But also too, if you're in a domestic violence situation or you're homeless, or you're taking drugs and alcohol, do you really want to go to someone who you know is going to ask you the hard questions and you know really and possibly judge you and make a DOCS notification."

Olga: “Some people choose this [domestic violence]. I remember a woman coming in, I was working in labour and delivery, I was absolutely horrified, she had a broken nose [and] a boot print on her stomach. The police arrested him [the partner] he was dragged out, she delivered the baby [and] the next day I’m looking after her and he’s back, in the room and they’re all lovey dovey, they’re all over each other like a rash”...

Wanda: “It’s normal for them.”

Olga: “It’s not just disadvantaged women though; we’ve got lots of ethnic women here who are in abusive situations that we’ll never know about.”

Helen: “They come in and have their babies and go home and we know nothing about them really because you are seeing them in a hospital system when they are coming in to have a baby, you know so little about them.”

Margaret: “I just want to add that when [it] comes to working with the socially disadvantaged, I think there are [women] who often get a lot of negative feedback from [health care professionals] and it’s not just what’s said. It’s also in body language. They pick that up very quickly and it’s very important to establish a working relationship with these people. To start from a basis of mutual respect, treat them with respect and give them some positive feedback in whatever measure you can ‘cause once you start doing that you generally find they’ll open up a little bit more and they’ll be a bit more positive towards you. But if they suspect for one second that you’re judgmental or treating them with any less respect than you would with anybody else, then you’ve lost them.”

Leesa: “Coming into that relationship with a good attitude [for both parties] counts for a lot.”

Olga: “I say [to women] ‘I can only help you if we can develop some trust. I can understand that you didn’t [tell] me stuff when I seen you for your booking visit, because you had only just met me, so you’ve got no reason to trust me but I need [you] to be really honest with me’, so we just put our cards on the table at the first visit and both of us say what we need to say.”

Rosie: “I think for those women if she has continuity, the midwife is more able to identify with the woman what the particular issues are, and can work with the woman to refer her appropriately. That doesn’t happen when they are seeing different people all the time. Sometimes it can take most of the pregnancy to even figure out what half the problems are for a woman simply because it takes that long for the woman to open up and tell the midwife about half the stuff that’s going on with her in her life. So it’s about that establishment of trust that comes once that relationship is established.”

Delvin: When a woman-midwife relationship is formed, is there an emotional attachment?

Carol: “Yeah some of [the women] find it really hard because we keep seeing them up until six weeks [after birthing] and they love you coming to check their baby and make sure their breastfeeding is going well and that sort of stuff. Yeah some of them will find it really hard at the end, that you leave them and some of them you don’t leave. Like some of them will keep in contact and that’s okay too.”

Olga: “Yeah, especially I mean [with] some more than others of course. Sometimes it’s the experience that you’ve had with that person or it might be that personally you have really got to like and know them or just the whole depth of the experience that you’ve had with them that you find it hard to let go too, and [you] still ring them up a few months down the track just to see how they are going. Or the women will ring you up, or they drop in with their [baby], if they are in the area, they just drop in to the hospital and [ask] ‘I just wondered if so and so is here, I just want to show my baby’, so yeah.”

Rosie: “It [the emotional attachment] just consumes you because they have got so many problems, you’re their mother, and you’re just everything to them. You try to draw the line and you can draw that line 100 times but some of them just don’t get it and they become very attached because they have such a terrible life, and you can’t help but feel sorry for them and you know empathise with them and want to help them as much as you can.”

Delvin: As these women have complex needs, do their needs take precedence over the needs of the institution, in the provision of maternity care services in this local health district?

Carol: “[No.] for instance if you’re a single mother and you’ve got three children that are small and you live at [name of suburb] and you don’t have a car, it’s very difficult to get yourself to [name of hospital] for an antenatal clinic appointment. And you sit there for two hours and your kids are running around. It’s just not woman focused, so it takes a lot of, a real lot of, what’s the word I’m looking for, motivation to actually come in.”

Leesa: “They often get the referrals and things to happen easily enough for the stuff that is pregnancy related, but there seems to be a huge hole in how those women get referred to the other services that they probably need prior to pregnancy and are going to continue to need after they have their baby. We are not so good at referring women for all those things and helping the woman identify what it is that she needs.”

Carol: “But the services change so often. It’s very hard to keep up with what’s available for women. A person you do ring doesn’t answer the phone, you know they are at a desk and get a note and that note gets passed on.”

Rosie: “Yeah, the funding [gets] cut or they are really overworked. I’ve found [it] really frustrating. Just linking them into mental health is so difficult that you feel really bad for the woman because she’s asking for help and you’ve said I will organise all this for you and then you feel that you’ve let the woman down because through no fault of your own, you just couldn’t organise what the woman actually needed, simply because the services were so inadequate or so understaffed or underfunded. There is nothing we can do.”

Carol: “It’s pretty frustrating. When you ring Perinatal Mental Health, they say we can’t see the woman for ten weeks, and you’re thinking well what’s the point of even doing the EDS [Edinburgh Depression Scale]? If I can’t refer you to anyone because the service is so inadequate that by the time you get seen you’ll have a baby.”

Rosie: “I think when you’re looking at vulnerable women, when you bring them in to a hospital, you’re isolating them from their support groups and so they’re not going to stay. You know if you’ve got a teenager, she’s 14, she doesn’t want to be by herself in a hospital with no friends, you know.”

Helen: “[But,] others want to stay in hospital and be spoilt because it will be the only time that they will actually have a break.”

Rosie: “In general, a hospital ward is not family friendly. It’s not woman friendly. You’ve got four-bedded cubicles, we’re overcrowded, you know they pull their curtains around all the time ‘cause they want privacy and there’s no opportunity for partners to stay and help them.”

Leesa: “I agree absolutely because I did midwifery in [name of city] and I was accustomed to working with the mother surrounded by the family. We just did that all the time. When I came here, everyone’s focused on the visiting hours thing. You’re not just treating the patient, you’re treating the family and you don’t have a right to separate them but people are hell bent on, you know making sure that the mothers rest but they’re not recognizing that they’re also separating the women from their support structure and for the patient group that we’re talking about, the socially disadvantaged, the teenage mother, the women who have chaotic lives, their family group is absolutely vital to them. They’re completely enmeshed with them and I don’t believe they should be separated.”

Margaret: “Well last year the [Director of Services] and I were looking at the concepts of family friendly maternity units and what was available around the country. We found some organisations advertise themselves as family friendly but if you read through their advertisements, ‘this is our facility and this is what is provided as family friendly, oh and by the way visiting hours are strictly this’. We haven’t really got our heads around how to develop it further at [name of hospital] because we’re constrained by the geographical layout of the ward but we have actually looked at those issues. But it needs exploring further as to how we can facilitate it.”

Olga: “But, some of those women, if they hadn’t got pregnant and hadn’t come to a service like this; they never would have had that world opened up to them

and made that difference. If the pregnancy had never happened they would have just kept going on the way they were going on.”

Delvin: What can or does impact on your ability to meet the needs of the socially disadvantaged woman?

Olga: *“Sometimes socially disadvantaged women can be very difficult to manage, difficult to manage is not the right word, difficult to even talk to. Sometimes they will arch up and be quite aggressive when all you are trying to do is help and so again you have to back off and just let the woman calm down and try and be the placator and offer other services or offer other options.”*

Carol: *“Unfortunately the way hospital, the way it’s constructed sometimes, I think we’re all familiar with the concept of character assassination when you get handover and a certain patient may get a certain reputation and usually it’s related to, they have different values.”*

Margaret: *“[And] you get some staff who are openly biased because the patient is for instance 15 years old and pregnant and it’s her second baby or something along those lines.”*

Leesa: *“I don’t understand why but it definitely does happen and especially the ones that have all the problems really, they get judged before [they are admitted] you know.”*

Margaret: *“Because they’re using drugs and they’re having children and so there’s a lot of concern and anxiety over what these women are doing to themselves, to other members of their family. Also it’s patient’s behaviour, we have had patients who were very abusive, who have done extraordinary things like using drugs on the premises or selling drugs to other patients. We’ve had patients who have used sexually explicit behaviour in the wards. Patients who are argumentative, patients who are trying to obtain extraordinary levels of pain relief that they’re not entitled to and obviously, they have a dependency upon. That’s what people find challenging and I find a lot of the time it’s easier not to expect these women to behave like women of their chronological age.*

Generally they're emotionally immature and if you can recognise that and relate to them at that level, it's a lot easier because you don't have these unrealistic expectations of them from the outset."

Olga: "A lot of these women, their literacy skills aren't very good so they're not going to sit and read in hospital. Different if you've got a middle class, well educated woman. She'll sit and read stuff like that, but these women won't."

Leesa: "I think our assumption of literacy skills is so out of keeping with reality. Delivering [educational] programs that have a literacy based foundation for this group [with], so many actually illiterate. They don't have the ability for basic [reading] or they [are] a lower chronological age, they can't read. And I guess they get so good at faking it because they're a part of society where we're so, we've got forms everywhere and you know how it must impact on them in so many facets of their living that it becomes, I guess something that's hard to identify, that 'no I can't read that'. So I think that does really fall down a lot for the disadvantaged groups that you're talking about."

Rosie: "It's sad that they have to fake it, that they can't say 'I don't understand what's written'."

Leesa: "I think that's a defence mechanism that they've learnt and become quite skilled and honed at. A survival mechanism that they've adapted to."

Carol: "Yeah but, a lot of disadvantaged girls whilst they may get their vitamin K and their syntometrine mixed up, which one's which, they know it's out there. You'd be surprised of the kind of things they know because they often do talk all amongst each other and they mix with a lot of their friends [who] have already had two children. So I think that you'd be surprised, whilst they might not know some life skills, they seem to have a bit of an idea about what goes on."

Olga: "I pre-empt all my visits. I tell them routinely this is what you will do at the next visit. This is why we want to do it, the rationale rah, rah, rah. I then put the onus on them, go home and read about it. Most people have access to the internet; most socially disadvantaged people have more access [to the internet] than people [because they are] at home."

Rosie: “No, I think socially disadvantaged people will just say, well you’re the midwife so I’ll just take what you tell me. But the so called advantaged people will come in and say well I looked up this internet and I’m not having it because, dah, dah, dah, but the so called disadvantaged people ...”

Olga: “[Well,] I’ve given them the opportunity prior to the actual time when it was due to go and research. I’m not responsible for their choices. I don’t think they care the same way as the highly educated lawyer type people who want to know absolutely everything.”

Rosie: “You can’t say that about a whole group of people though because we’ve had disadvantaged women who seriously care.”

Margaret: “A lot of the women because their lives are so chaotic and they’ve got so much going on it’s kind of that Maslow’s Hierarchy of Needs, if you don’t have somewhere to live and you don’t have anything to eat, and you’re in a domestic violence. That takes priority so an unborn baby is really a concept for a lot of people. They can’t feel the baby moving or they don’t have any strong signs of pregnancy that can wait for a lot of women. What they need to do is get their lives together and so to go to a doctor or get an appointment it’s very difficult for a lot of women. To find a bulk billing practice and actually see a doctor, they just push it out the way until they get the other stuff sorted out.”

Olga: “And then there’s no petrol for the car or I can’t get that bus so things that we take for granted, every day is a challenge. And that education [about finances], well we’ve got \$150 and we’re going down to buy brand new baby gear and I think well there’s a really good second hand place and there are things that people can lend you but they have the perfect picture of having everything perfect and new for the baby if they can”....

Margaret: “Cause they’ve never really had that.”

Carol: “But we do find that socially disadvantaged young girls in particular, they have a lot of baby stuff, more than they probably need. Has anyone else found that? They feel like they have to, [to] be a good mother so they are not judged, they’ve got to make sure that they’ve got toys, they’ve got the pram, they’ve got

this and they've got that, and heaps of clothes and I say to them look you don't need all that stuff for a newborn baby. You only need a little bit of stuff and so I think they are doing that to compensate because they think people will judge them and say you're not a good mum, you haven't got a rocker or whatever. [I say] you don't need all those things, you know you could look in the Trading Post, 'oh no I am going to buy that new or I am going to lay-by it', so yeah some of them will do that."

Rosie: “[Also,] we just had one in yesterday who's had no antenatal care at all who's 36 weeks and you really worry about those women who get pregnant and go through months and months of pregnancy out there in the community without ever going near a health professional.”

Olga: “Sometimes [it] feels like ‘just don’t push me’ [like we are] interfering, yeah. And it can make them cranky. I don’t like that pressure that I’m getting, ‘are you telling me that I’ve gotta do this and this’, [and I say] ‘no I’m just giving you things that are available to you’. ‘Well I don’t have to do that’, ‘well no you don’t have to’. ‘What are you saying?’ You know you can feel that sort of, not anger in a certain way, but I sometimes feel like, alright this is available to you, now it’s up to you, and sometimes you have to stop there. You have to know when you’ve reached your limit.”

Carol: “[But,] when you actually get to know the women and you hear their story and you listen to what it’s been like for them and why their life is the way it is, you actually realise that most of the women want to be really good mothers. They want what’s best for their children. They’re just doing the best they can at the time and if you approach them in a non-judgmental fashion that you’re actually not there to judge them, you’re actually there to help them to actually find what their needs are and try to meet their needs and have a good outcome, most of them are quite willing to work with you.”

Delvin: So what is the role of the midwife in supporting the socially disadvantaged woman to have her needs met?

Carol: “We have a real sort of brokering role. We might continue with those women for maybe nine months, and I guess in that time we’re learning a lot more about what their needs are and what they would find helpful so we can be that link into the community services so that when they’re discharged from our service, if there is still ongoing needs, you know we’ve spent time talking to them about what’s out there and what they might like.”

Rosie: “As midwives we’d do a lot more to reduce social and health inequalities if more women had continuity of care, and more women could access midwifery models of care, but while most women are still getting really fragmented care, we don’t make that much difference at all.”

Olga: “[But,] it’s more than just a midwifery role. It’s a multi-disciplinary team role. It’s the hospital’s and the community’s responsibility. It’s not just midwifery.”

Helen: “It’s probably really limited. You only see them for a really short time and you’re not there to make major changes so you can support them through the pregnancy. Sometimes just being there is probably doing something for her. But yeah, I probably can’t do an awful lot for her.”

Margaret: “Some of them have just got so much, their day to day life for some of them is just so hard and if you can help that woman come in and have the most fantastic birth experience and she goes home on such a high because she had such a great time having a baby. She goes home happy and confident and you think well that baby has started off having the most lovely time and that woman started off her mothering journey in such a positive way that no matter what other life challenges get thrown at her in the next six months or six years or 50 years, when she talks to this baby and it grows up, she will say I remember the day that you were born and it will be really positive memories. I think that’s a big gift that we can give to those women, because we can’t fix all the other stuff that’s in their life, but we can help them to have a lovely and really exciting and joyous pregnancy and birth do you think?”

Carol: “And you think what does it do to their relationships too? Like often there’s lots of relationship stuff going on as well and you know by giving these

women such a powerful experience during their pregnancy and their birth, you know. These women can put their head up and stick up for themselves and be strong and believe in themselves and say well actually no, I don't have to have that or no I don't have to put up with that, and no I don't have to keep hanging out with my loser partner whose been beating me up for six years because I am strong and I gave birth to a baby and if I can do that really well, I can do anything. And you know some of them might change things about their lifestyle, probably lots of them don't, but I think the women know they can if they want to."

Rosie: "I also feel because we have them coming to the group practice quite a lot that they get really good care physically, emotionally and psychologically. I know they are getting great care and they are getting special care because they've got their own midwife allocated to them."

Delvin: How are you [midwives] supported when working with socially disadvantaged women?

Helen: "We have been using [name of program]. That literature helps guide the way we interact with those patients to try to establish some consistency with them, particularly patients who have the most challenging behaviour which is usually those with the personality disorders."

Leesa: "I think often the midwives will talk to the social workers at the hospital about a particular woman and the social worker will say oh have you thought about this or we could try that, or you could refer her here or this is who she could see. So I think we use a lot of allied health support, also I think we use the knowledge that we gain from each other, particularly with really complex women."

Rosie: "Midwives will come in and talk to their team mates and say I've seen [name of woman] today and this is happening and this is happening and I am really worried about her. I think it is just problem solving that midwives do with each other, and one midwife will then say to that midwife, 'Oh when I had [name

of different woman] earlier in the year, I referred her to Maternal and Child Health early and we organised a case review for her.' So I think a lot of it is very informal even just around the tea table."

Olga: *"You need [to] be a very self-reflecting practitioner and [like I said before] know where your boundaries are and what you can do and what you can't do because there are some women, for instance women who have a substance addiction who will continue on the path they choose and you might not be able to change that. There are a number of women that we look after whose babies are assumed into care by DOCS and that's something that we can't change so you need to really keep your professional boundaries. And also know what you can promise and what you can't promise, you know."*

Delvin: What would support you personally to better support socially disadvantaged women?

Margaret: *"I think it is so important for there to be a formal supervision [process] because you can't just develop that reflective capacity unless you've had some education in it and I think that's something that midwifery seems to have recognition of on paper but it doesn't seem to have filtered across into practice much."*

Delvin: How can midwifery, as a profession, better support socially disadvantaged women?

Carol: *"More education out in the community so that the community actually knows long, long, long before they get to birthing issues. A lot of women have no idea. They don't know their cycles, they don't know anything about their bodies, they become pregnant, they go down this path that sometimes is wonderful, sometimes not so wonderful, sometimes really bad."*

Helen: *"[The public] probably needs more recognition of what we actually do, I think, to be able to do that."*

Rosie: "I think at the end, women want someone to be kind and caring to them don't they? And that's what they remember. It's the kind words you said to them."

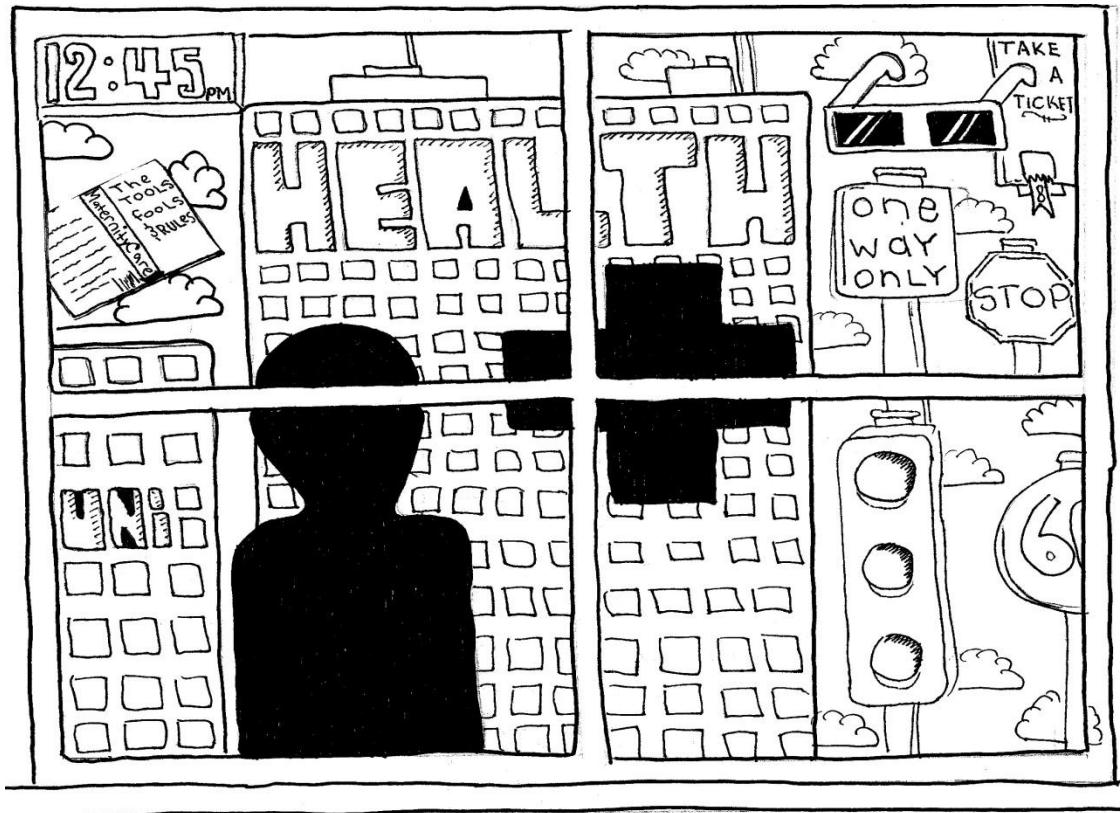


Figure 6-1 Delvin and colleagues' view of woman-centred care

6.3 Exploring Delvin's discussion

This chapter supports the findings from the previous chapter, that socially disadvantaged women are unlikely to receive woman-centred care during their maternity care encounters. There is little evidence that participating registered midwives, represented by Delvin and her colleagues, view socially disadvantaged women's maternity care encounters as incorporating the elements of woman-centred care.

Olga expresses that choice related to maternity care is difficult for socially disadvantaged women, "*they don't want to [make a decision] because it is too hard.*" She goes on to say that socially disadvantaged women do not care as much about health related choices or decision-making as non-disadvantaged

women. “I don’t think they care the same way as the highly educated lawyer type people who want to know absolutely everything.” When non-disadvantaged women question their maternity care options or make a decision which does not align with the midwife’s preferred option, their choice is viewed as an informed decision. Rosie reveals this understanding when she says “socially disadvantaged people will just say, well you’re the midwife so I’ll just take what you tell me. But the so called advantaged people will come in and say ‘Well I looked up this [on the] internet and I’m not having it because, dah, dah, dah....’” Rosie acknowledges, however, that choice may be difficult for women not experiencing control around decision-making prior to pregnancy. In the following emerging themes table, Rosie explains that it is difficult for midwives to understand how hard it is for socially disadvantaged women to accept the responsibility for decision-making when midwives have had greater opportunities for choice throughout their lives.

Registered midwives’ – emerging themes		
Original Transcript	Exploratory Comments	Emerging Themes
<p>Rosie: “I think you know, you’ve got a choice because you’ve had choice all your life and whereas if you haven’t had choice it’s a bit harder to step up and go okay I am going to make decisions here. Particularly if you’ve got multiple people that you have to see who are talking to them.”</p>	<p>Choice The midwife understands that the women may not be used to having control around choice; not used to their views being valued. When women are not used to their choices being valued, they are less likely to speak out and seek choice. How can midwives let women know that they are able to engage in choice? How can we create a safe environment for women to make choices? It is harder to create a safe environment when there is no continuity or carer – no relationship, no trust.</p>	<p>Being safe Being available Being Valued</p>

Non-continuity of care reduces the midwife’s ability to develop knowledge of the woman and her life circumstances, and to use that knowledge to develop a mutually respectful relationship. Without a trusting relationship the woman is not safe to exercise decision-making. Furthermore, when socially disadvantaged women do make a decision, their choice can be judged as inappropriate by midwives. Carol communicates, “sometimes the disadvantaged girls, they’re worried about, ‘I don’t want it because it hurts’ [or] ‘I don’t want to have that, everything’s all right.’” Even choices made by the women that are not related to

their maternity care are judged by midwives. Carol verbalises the inappropriateness of their financial choices. “*...they have a lot of baby stuff, more than they probably need... they've got to make sure that they've got toys, they've got the pram, they've got this and they've got that, and I say...you don't need all those things, you know you could look in the Trading Post...*”. Socially disadvantaged women may not feel **safe** to have a voice and choice in an environment in which their request for information is dismissed, and their choices are ignored or judged inappropriate.

Choice is made harder for socially disadvantaged women when health information is presented in a format that is difficult to understand. Rosie describes the format of health information as not meeting the needs of socially disadvantaged women. “*I think our assumption of literacy skills is so out of keeping with reality...They [socially disadvantaged women] don't have the ability for basic [reading] or they [are of] a lower chronological age, they can't read.*” Even when health information is provided verbally, during the maternity care encounter, understanding is not guaranteed. Wanda expresses, “*people think, [they] explain things, but [if the woman] has limited understanding, [the] medicos and midwives often think that people understand, and they don't.*” Although midwives acknowledge socially disadvantaged women may not understand health information provided, they do not make allowances to ensure the women have the knowledge or understanding required to engage in decision-making. Time restrictions and workloads are cited as the reasons midwives are unable to spend time explaining health information sufficiently to enable choice; “*it's so busy that the midwife [doesn't] get the chance to sit down and [discuss information with women]*”.

Control around decision-making and care preferences is restricted to options made available, and accepted, by the local health district and/or individual health care professional. Women are for the most part, “*told*” what “*choice the system wants them to make.*” This understanding is represented in the midwives’ window view by the textbook titled ‘The tools, fools and rules of maternity care’. Midwives are not able to support women to take control of their maternity care encounters because midwives do not have control within maternity care encounters when doctors become involved in decision-making.

In the following emerging themes table, Wanda describes how the doctor took control of the maternity care encounter. The midwife attempted to advocate for the woman. However, the woman was not considered and the midwife's professional knowledge was dismissed. The woman and midwife had no voice in decision-making.

Registered midwives' – emerging themes		
Original Transcript	Exploratory Comments	Emerging Themes
<p>Wanda: “I was at this birth, it was a long day and we were supporting her as best we could and the doctor was just about to do an episiotomy and I thought, now hold on a minute, you need to tell her, you need to say look, I have to do this. I got into trouble for that, [doctors] they’re used to calling the shots, it’s my way or the highway” ...</p>	<p>Control and Advocating for the Woman</p> <p>Doctors are viewed to have power over women and midwives. Doctors choices are valued more. Can women and or midwives feel safe enough to make a decision when their choices are so easily dismissed? Their choices are not valued. They understand that their choices are less valued, so shift responsibility of choice to the one who will make the final decision -the medical staff. Midwives are not safe to be available or advocate for the woman. They minimise their chance of being unsafe by positioning themselves with the local health district and/or individual medical personal during the maternity care encounter.</p>	<p>Being safe Being available Being Valued</p>

Helen articulates that the local health district, by controlling what information is provided, controls women's choices. “*I guess for most of those women, again they do as they are told. They are in the system. They don't butt the system...partly because they haven't got any other information, they don't know and they only get the information we give them so if we tell them it has to be done, then they do it.*” When women attempt to take control of their birth choices, there is no guarantee that health professionals will adhere to their decision. Non-continuity of midwifery carer models of maternity care reduce the ability for women to make decisions that will be adhered to. When decisions are made collaboratively between a woman and midwife during one maternity care encounter, follow-through of the decision-making process is unlikely to occur. A decision regarding labour care, made early in the pregnancy, that does not align with the preferred options of the midwife providing care for the woman during labour can be dismissed. Helen reveals this understanding when she explains, “*a lot of the women that we look after, you can make some really good plans*

with them, but that can just all go right out the door when they walk in delivery suite.”

Midwives describe how socially disadvantaged women are required to follow a predetermined set of procedures and practices when entering the maternity service. Health information is designed, formatted and presented in such a way as to persuade women to follow institutional requirements. Rosie portrays the provision of information as a means to control decision-making. “*I think women don't get a lot of unbiased objective written information...it will be subjective as to what they are told about their options...*” Women are informed by midwives of what is expected of them during their maternity care encounters. “*I explain to them, next visit, routinely we would do this, this is why we want to do it, it's now up to you if you want to look up more information, go to the Department of Health website, go to these websites, it's up to you to do that.*” Here Olga suggests that women need to engage in self-directed research if they want more information than is offered. This is despite the fact that earlier she acknowledges the poor literacy skills of socially disadvantaged women. The provision of written materials, accompanied by a brief explanation of the expected course of action, is considered to be sufficient information by Olga for women to make choices aligning with those of the midwife. The midwife has fulfilled their duty in providing information. Should the woman require more information than is routinely provided, the woman is expected to spend time and effort researching it. Asking a socially disadvantaged woman to engage in research activities to seek alternate options to those provided by the midwife discourages choice. The woman’s choices, therefore, are limited by the midwife’s preferred options. The woman is encouraged to conform to those options offered by the midwife.

Women’s choice regarding their preferred model of maternity care is restricted prior to commencement of their maternity care. Women’s access to the different models of maternity care and **continuity of carer** are dependent upon “*health care professionals’ bias*” towards those models of care, models of care available within the local health district, and the woman’s perceived suitability for a particular model of maternity care. Rosie describes how women must submit to a screening process to assess their suitability for a midwifery continuity

of carer model of maternity care. “*They go through and see if they’re eligible for [Midwifery] Group Practice. They need to say yes, yes, yes, tick all the boxes; you can go to [Midwifery] Group Practice.*” Many midwives express that the majority of socially disadvantaged women “*are still getting fragmented models of care*”, unable to establish a relationship with a known midwife. Midwives understand that women receiving non-continuity of midwifery carer models of maternity care are more likely to have their physical needs addressed only. In the following emerging themes table, Carol describes standard antenatal care in the clinics, and explains the benefits of continuity of midwifery carer in relation to meeting the woman’s needs. It is suggested time constraints that apply to standard antenatal visits prevent midwives from doing anything other than a physical assessment of the woman’s pregnancy. There is insufficient time to perform psychosocial assessments, provide emotional support or establish a relationship. The midwife does not have the time to establish a relationship with the woman. Again, the absence of an ongoing relationship prevents the development of trust between the woman and midwife and reduces the woman’s sense of being safe in sharing sensitive or personal information. The notion of fragmented care with women receiving care from different midwives each visit is depicted in the window view by the ticket dispenser, where women take a number and wait to see whoever presents on the day.

Registered midwives' – emerging themes		
Original Transcript	Exploratory Comments	Emerging Themes
<p>Carol: “I know in the clinic downstairs, they have 15 minute visits, what can you do in 15 minutes you know? The woman comes in they see a different midwife every time, so you know she's [the midwife] only doing the physical stuff she's not doing anything more than that and she doesn't know this woman and the woman doesn't want to tell every midwife she sees every month her story again, so she doesn't tell her story whereas continuity is what it's all about, it's the way you get the women to trust you, they will tell you stuff, you've got time to listen and you can do far more with them. They don't have to tell different people all the time and they know when they walk into the office, you know who they are.”</p>	<p>Continuity of carer</p> <p>If the midwife is not emotionally available for the women, the woman is not safe to disclose or freely discuss her needs or wants. With continuity of carer there is more opportunity for a trusting relationship to develop with the woman feeling safe to discuss issues relevant to her. There is more opportunity for a woman-midwife partnership to develop. It is harder to ignore the woman and attend to tasks (and tick boxes) when a relationship is developed. The midwife is more likely to align herself with the woman's needs rather than the local health district needs when a relationship exists.</p> <p>Under fragmented care models, the midwife has an ongoing relationship with the health service. The health service is valued over the woman</p> <p>N.B. this is also discussing hierarchy of midwifery models of practice and valuing the different models within midwifery.</p>	<p>Being safe</p> <p>Being available</p> <p>Being Valued</p>

Midwives acknowledge that the establishment of midwife-woman “relationships depends on what's verbally said to the” woman and the midwife's ability to value the woman as an individual. Carol conveys that “when you actually get to know the women and you listen to what it's been like for them...and approach them in a non-judgmental fashion, that you're actually there to help them, to actually find what their needs are and try to meet their needs, most of them are quite willing to work with you.” It is about listening to what the woman wants, hearing her story and being available. Only when the woman feels the midwife values her, will the woman feel safe enough to allow the midwife to be available for her. Margaret articulates that it is “continuity of care where you get to know the woman really well, the woman has that relationship with her midwife. You can have those frank and fearless discussions...really individualise the information for that particular woman being mindful about what her own journey is and some women will want or ask or need more information to make a choice.”

Rosie also verbalises that the establishment of a relationship between the woman and midwife enables the midwife to better support a woman's needs, and that a relationship develops only after trust is established. These midwives convey that the development of a trusting relationship is dependant upon "*What's verbally said to the woman*" and the midwife "*listening to the woman and approaching her in a non-judgemental fashion*". However, they did not acknowledge that these features can equally be applied in maternity care encounters not associated with continuity of midwifery carer models of practice. These features can be applied in every maternity care encounter, by every midwife, regardless of the midwifery context.

In the following emerging themes table, Rosie discusses the importance of mutually trusting midwife-woman relationships. While midwives communicate that continuity of midwifery carer is necessary for the establishment of a trusting, mutually respectful relationship, Rosie's quote that women just want "*someone to be kind and caring to them...*" reveals continuity of midwifery carer is not essential. When the midwife is available for the woman in the immediate maternity care encounter, the woman is more likely to understand she is valued and therefore experience a positive maternity care encounter.

Registered midwives' – emerging themes		
Original Transcript	Exploratory Comments	Emerging Themes
<p>Rosie: "I think for those women if she has continuity, the midwife is more able to identify with the woman what the particular issues are, and can work with the woman to refer her appropriately. That doesn't happen when they are seeing different people all the time. Sometimes it can take most of the pregnancy to even figure out what half the problems are for a woman simply because it takes that long for the woman to open up and tell the midwife about half the stuff that's going on with her in her life. So it's about that establishment of trust that comes once that relationship is established."</p>	<p><u>Continuity of care, trust and relationships</u></p> <p>It can take a while for the woman to feel safe enough to open up and take a chance at discussing her needs, to disclose sensitive issues to the midwife or to question the midwife. Feeling safe is also about trust. The woman has to feel she can trust the midwife and feel safe in opening up. The woman needs to understand her needs and input is valued by the midwife. That is more likely to be achieved when the midwife is available for the woman over a period of time. Therefore – being available allows the woman to feel valued and to trust that she is safe to engage in her maternity care encounters. This aligns with what students and women say about trust.</p>	<p>Being safe Being available Being Valued</p>

Midwives did not recount instances when the element **precedence of women's needs** over those of health care providers' needs, was observed during socially disadvantaged women's maternity care encounters. Carol talks of women attending the local health district environment for their maternity care encounters, regardless of their needs or commitments. In the following emerging themes table, Carol expresses her understanding of how hard it is for women living in difficult circumstances to attend their maternity care visits. The women who are able to attend their maternity care visits are seen as highly motivated. The understanding that it is difficult for socially disadvantaged women to access the hospital grounds is shared by other participant groups. Local health district management is seen as valuing efficiency and cost effective operational processes over meeting the needs of their customers.

Registered midwives' – emerging themes		
Original Transcript	Exploratory Comments	Emerging Themes
Carol: “for instance if you're a single mother and you've got three children that are small and you live at [name of suburb] and you don't have a car, it's very difficult to get yourself to [name of hospital] for an antenatal clinic appointment and you sit there for two hours and your kids are running around. It's just not woman focused, so it takes a lot of, a real lot of, what's the word I'm looking for, motivation to actually come in.”	<p><u>Precedence of women's needs</u></p> <p>The needs of the woman are not valued above the institution's needs. The women must come to the service, not the other way. The woman attends because she is responsible for the safety of her baby and so makes herself available for the service. Aligns with what women and students say.....</p>	<p>Being safe</p> <p>Being available</p> <p>Being Valued</p>

Midwives express that local health district management has control over what services and supports are available to women, and that the needs of socially disadvantaged woman do not appear to be taken into consideration. Midwives communicate that changes to services are not always in the best interests of local birthing women, with services varying in relation to funding and national health priorities. Rosie describes her frustration at the changes to services and the impact they have on her ability to support the socially disadvantaged woman. “The funding [gets] cut or they [the staff] are really overworked. I've found [it] really frustrating, just linking them into mental health is so difficult...she's asking for help and you've said I will organise all this for you and

then you feel that you've let the woman down because through no fault of your own, you just couldn't organise what the woman actually needed...". Midwives are positioned on the front line in the conflict between service users, the woman, and maternity service management. Midwives experience distress in not meeting the needs of women.

Local health district management decides what models of care are made available for women and the number of women able to access each model. Midwives articulate that access to continuity of midwifery carer models of maternity care is limited due to institutional needs taking precedence over those of women's, and management's fear of limited control over midwives' practice in those models of maternity care. Rosie voices her concern that socially disadvantaged women who want a continuity of midwifery carer model of maternity care are unable to have a position in their chosen model of care. *"There's a stack waiting [to book into our Midwifery Group Practice] for March. And it's really disappointing for the women.... it's a bit of a control issue for entire management too, because they can't control what you do... let's not put too many more [Midwifery Group Practice models] in there because they've already got this many I can't control."* Socially disadvantaged women cannot feel '**valued**' in a system that places greater importance on efficiency and cost effectiveness of services. Midwives can not feel '**valued**' in maternity services that prevent midwives from working in models of maternity care that align with their professional and personal ideologies. Midwives' inability to work autonomously or to their full scope of practice is represented in Delvin's view with a large centrally positioned local health district building.

The **maternity environment** is viewed, by midwives, as congested and "*isolating*" for women, with visiting hours hindering women's emotional support networks. The maternity environment is described by Rosie as "*not woman friendly. You've got four bedded cubicles, we're overcrowded, you know they pull their curtains around all the time 'cause they want privacy and there's no opportunity for partners to stay and help them.*" The "*geographical layout of the ward,*" lack of time and workload constraints are given as the reasons that midwives are unable to provide woman-centred care. In the following emerging themes table, Wanda expresses that time constraints and workload pressures

within the maternity care environment prevent midwives from providing woman-centred care. Midwives constantly struggle to keep up with workplace practices and procedures delegated as midwifery tasks. Completing tasks within designated time frames is valued over being available for the woman. The midwife is not safe to go against the dominant values of the workplace culture.

Registered midwives' – emerging themes		
Original Transcript	Exploratory Comments	Emerging Themes
<p>Wanda: “...when it gets to the point where they [midwives] are so busy that all those things [woman-centred care] go out the door. Like they are just too busy, they are being told, could you get her up as fast as possible, there's another one coming in. So there are lots of outside pressures out there. On a day to day basis, it's constant; they [midwives] very rarely have a break from it...”</p>	<p>Woman-centred care and maternity environment</p> <p>Being too busy equals not being available for the woman. Not valuing the woman's time or needs. The midwife needs to be safe; in order to be professionally safe the midwife aligns herself with local health district management specifications and expectations and the task-focused environment. The midwife demonstrates a valuing of workplace requirements and gains a sense of being valued by local health district management - a good worker. However, midwives acknowledge here that their professional ideologies (woman-centred care) are placed at risk as a result of providing task-centred care. The woman is not valued and the midwife understands midwifery professional ideologies and ways of practising are not valued. Therefore it is not safe to work in such a manner.</p>	<p>Being safe Being available Being Valued</p>

Midwives view the “*medicalisation*” of the maternity care environment and “*obstetric*” workplace culture as a hindrance to midwifery models of care being available for socially disadvantaged women. Midwives find it difficult to **position themselves within a midwifery culture** when workplace practices and management strategies do not value women, midwives or midwifery ways of working that support woman-centred care. Wanda describes the care of women not in a Midwifery Group Practice as “*having a doctor's delivery, medical management.*”

Midwives also understand that the maternity care environment and hospital policies fail to take into account a woman's needs when hospitalised. “*Everyone's focused on the visiting hours thing...people are hell bent on, you*

know making sure that the mothers rest but they're not recognising that they're also separating the women from their support structures...". Delvin's and her colleagues' views of woman-centred care depicts the woman standing off centre as she is not the focus of attention in their local health district. Although most midwives convey that the maternity care environment is not woman-focused, and that women might not want to be in hospital, some midwives voice that socially disadvantaged women prolong their hospital stay to gain respite from the caring responsibilities waiting for them at home. Helen declares "*others want to stay in hospital and be spoilt because it will be the only time that they will actually have a break.*"

The element **women's collaborative consultation regarding maternity service provision** was largely absent from the midwives' recounted experiences of maternity care encounters involving socially disadvantaged women. Midwives spoke of socially disadvantaged women as having "*reduced abilities*" and opportunities "*to be involved in their care*". Socially disadvantaged women were described as having limited prospects for participating in decision-making processes, at a personal or community level. Socially disadvantaged women's ability, therefore, to be involved in the development and provision of local birthing services may have been considered not feasible by midwives. Other issues discussed by registered midwives formed the basis for the following themes, which emerged during analysis.

Socially disadvantaged women are viewed, by participating midwives, as different from other childbearing women and midwives. These midwives express that socially disadvantaged women display "*challenging behaviours*", have "***different values***" to midwives and create emotional barriers that prevent effective communication between women and midwives. The 3-D glasses in Delvin's window represent midwives' view that socially disadvantaged women are different from other women and midwives. Carol describes how women prevent midwives from getting to close. "*Some distance themselves from you because they don't want you to know too much about their lives.*" Midwives understand that the women often distance themselves to protect against the surveillances of the public health servant, the midwife. While midwives previously discussed women's inability to choose models of care, here Olga

discusses how socially disadvantaged women choose standard care to reduce the likelihood of midwives' seeing the woman's life circumstances. "*I don't want you coming to my house, I don't want you seeing what goes on in my house*", so they go through the other system... go to labour ward and then they just go home....*some of those women don't want Group Practice.*"

Olga suggests that the difficulties in communicating with socially disadvantaged women are a result of their behaviour. "*Sometimes socially disadvantaged women can be very difficult to manage...difficult to even talk to, sometimes they will arch up and be quite aggressive when all you are trying to do is help...*". Margaret also describes how difference in understandings between midwives and socially disadvantaged women can result in difficulties within the maternity care encounter in the following emerging themes table.

Registered midwives' – emerging themes		
Original Transcript	Exploratory Comments	Emerging Themes
Margaret: "We had so many conflicts and unhappy stories, I still don't, I don't think I got to the bottom of how best to facilitate care for teenage mothers because they come in with all their teenage hang-ups and yet they're going through this life crisis of having a baby and it's very problematic at all sorts of levels. There were often barriers set up there, if the communications not there and it was really hard to facilitate good care for those teenage mothers plus facilitate staff interacting with these young mothers in a way that was positive. Maybe because they seem to have the greatest problems relating to our staff or visa versa."	<p>Difference</p> <p>Do women create a barrier as a safety precaution from midwives or do midwives create barriers (becoming less available) because of othering and value judgements?</p> <p>Socially disadvantaged women not worthy of care (see "waste of bed" comment). Women sense othering and judgement (this aligns with women's understandings). Socially disadvantaged women are too difficult to deal with. The tick-a-box and task completion way of working is more difficult when dealing with socially disadvantaged women.</p> <p>When midwives' self valuing is measured by completion of tasks, they may not see woman-centred care as valuable. If midwives understand they are unable to provide woman-centred care because they are unable to provide continuity of care, self preservation may cause midwives to shift their values; from 'being available' for women to being available for the maternity service.</p>	<p>Being safe</p> <p>Being available</p> <p>Being Valued</p>

These midwives understand that **midwives' attitudes** towards socially disadvantaged women, that are perceived to be judgemental and negative by others, are based on their concern for the welfare of the woman's baby and

family. “...*They’re using drugs and having children...so there’s a lot of concern and anxiety over what these women are doing.....*” Furthermore, some of these midwives understand that the socially disadvantaged woman will not behave or react in the same way as other childbearing women in relation to their health care needs and to advice provided. Margaret demonstrates this understanding when she comments, “*it’s easier not to expect these women to behave like women of their chronological age... because you don’t have these unrealistic expectations of them from the outset.*” Margaret sees the socially disadvantaged woman as different and is therefore able to justify the difference in care provided. When the midwife sees the woman’s behaviour or values as different to the midwife’s, the midwife may subconsciously become unavailable for the woman. This sense of difference maintains a barrier to the development of mutual respect between the woman and midwife. The development of a safe environment in which the woman can freely engage in her maternity care encounters is therefore hindered.

Carol, however, when she discusses character assassination, articulates that it is the workplace culture and practices that result in poor maternity care experiences for the socially disadvantaged woman. Carol describes how midwives pass on their judgments of a woman to other midwives about to commence a shift. “*I think we’re all familiar with the concept of character assassination when you get handover and a certain patient may get a certain reputation and usually it’s related to, they have different values.*” Here, commencing midwives are provided with a negative profile of the woman during handover, prior to meeting the woman. Although workplace practices are voiced as facilitating negative attitudes towards socially disadvantaged women, it is the midwives themselves who engage in and maintain the practices.

Working with socially disadvantaged women is described by midwives as “*hard, emotionally draining*” and “*demanding work*.” The work is also considered, to be “*life changing, rewarding*” with “*never a dull moment,*” with midwives understanding that given the context of local health district requirements and constraints, their colleagues are ***doing the best they can***. Helen articulates that “*most of the midwives that work here really do their best for each woman that they are caring for under the circumstances that they’re working under.*”

Rosie adds that midwives are struggling with the workload associated with working with socially disadvantaged women in continuity of midwifery carer models of practice and they attempt to provide support for each other. *"Midwives will come in and talk to their team mates...I think it is just problem solving that midwives do with each other...a lot of it is very informal even just around the tea table."* Midwives' attempt at limiting the emotional and physical impact of working with women with complex needs is depicted in the window by the speed limit signs.

While midwives struggle to provide what they consider best care for socially disadvantaged women, they express that woman-centred care is only possible through continuity of midwifery carer models of practice. Many of the midwives in this study elected to practice within Midwifery Group Practice models of care in an attempt to align their midwifery ideologies with work practices. However, working within a continuity of midwifery carer model of practice is described as stressful, with their workloads perceived to be heavier than non-continuity of carer models of maternity care. Rosie recounts her experiences of transitioning from rostered hospital based shift work to Midwifery Group Practice. *"It hasn't really fitted in that well, and it has been very stressful to the point I was about to have a breakdown...it just affects your whole family...I'm drowning because just the workload...It just feels like you are always working."* The stress expressed here is understood to be the result of the midwife's inability to align their midwifery philosophy and work practices. The workload associated with providing continuous woman-centred care is overwhelming.

Midwives also believe they need more support when working with socially disadvantaged women. Although midwives acknowledge their role in supporting socially disadvantaged women, seeing themselves as "*the link into the community services for*" them, supporting socially disadvantaged women is seen to be "*the community's responsibility*." Midwives understand that it is too much for individual midwives to take on the responsibility for supporting socially disadvantaged women. Society as a whole needs to support these women. Helen expresses that *"It can be very stressful and often I don't think that we have enough time to deal with these women to help them and put things in place for them...We try and liaise with other organisations...it's hard work and*

it's quite demanding work." Clinical supervision is recognised as a means of assisting midwives to maintain their emotional and professional wellbeing. Margaret, however, asserts that clinical supervision as present in theory but absent in practice. In the following emerging themes table, Margaret describes how the professional body promotes supervision and reflective practice. However the profession's ideologies do not match work practices. Resources and support strategies are not made available for midwives. Midwives are not supported to support socially disadvantaged women. The maternity care environment, in which these midwives work, is not viewed as valuing midwifery models of care or the needs of midwives.

Registered midwives' – emerging themes		
Original Transcript	Exploratory Comments	Emerging Themes
Margaret: <i>"I think it is so important for there to be a formal supervision [process] because you can't just develop that reflective capacity unless you've had some education in it and I think that's something that midwifery seems to have recognition of on paper but it doesn't seem to have filtered across into practice much."</i>	<p>Supporting midwives to support women</p> <p>When formal support is not available for midwives, they understand their work and the profession are not valued. Can the midwife continue to practice to their full scope of practice without support?</p> <p>Maternity service management is not available for the midwife → midwife not valued → does not value her own work practices and seeks recognition in meeting dominant values of institution → becomes task focused, with outcome measured and tick-a-box mentality. Women are not valued in that environment, with task completion and efficiency valued.</p> <p>When the midwife does not value their own practice, the culture of bullying in the workplace may be cultivated.</p>	Being Valued Being available

Midwives voice concern that if they are struggling with conflicting ideologies and competing demands between the midwifery and maternity environment cultures, "*how [will] students cope*" when **learning to be a midwife**. Wanda communicates that entry into the maternity environment can be confronting for students when there is such a difference between the theory and reality of midwifery practice. "*It can be pretty confronting for the student ... sometimes they virtually go into shock...it's like they've been abused*". Midwifery education is seen by these midwives to be failing students in not providing a curriculum

based on the reality of current maternity services. Carol voices her concern regarding the realities of midwifery practice in current maternity services. “...*You know the students are being told something that in reality is never going to occur.*” Midwives fail to value midwifery education and their professional ideologies when they say that students are learning unrealistic models of care and ways of working. These midwives are expressing concerns that woman-centred care is not achievable within current maternity care environments, and question why students need to learn the theory. There is no understanding that knowledge and awareness of a different way of doing midwifery needs to exist before change can occur. Midwives’ understanding that midwifery education does not match the current reality of the maternity care environment is depicted in Delvin’s window with the university building not corresponding in size to that of the local health district building.

Olga’s experience of newly graduated midwives contradicts the dominant view of participating midwives regarding midwifery education. Olga suggests new graduate midwives are entering the workplace ready to work within a medical framework. “*I do worry about some of the younger midwives, because they’re becoming more like obstetric nurses.*” Olga goes on to say that working within the current system over a period of time may alter new graduate midwives’ practice to more closely align with the midwifery concept and maternity care midwifery philosophy of woman-centred care. “*Maybe eventually they’ll change.*” However, it seems unlikely that new graduate midwives entering the workforce, who are viewed to align their practices with medical models of care, will shift their way of working when midwives also communicate that the maternity care environment is medically focused.

6.4 Conclusion

This chapter presented registered midwives’ recounted experiences, using direct quotes, of midwifery and maternity care encounters involving socially disadvantaged women. The midwives’ attempts at making sense of their experiences were followed by an exploration of their understandings. Registered midwives’ understandings of maternity care encounters involving socially disadvantaged women support the views of participating women in the

previous chapter, that there is little evidence of socially disadvantaged women's maternity care encounters incorporating the elements of woman-centred care.

As shown in - *Recurrent themes: registered midwives*, demonstrates the recurrence of pre-determined and emergent themes across three midwife focus groups and three individual midwife interviews. As shown in the table, participating midwives understand it is difficult for socially disadvantaged women to have choice within their maternity care encounters. Choice is limited by personal biases of individual health care professionals, including midwives, and by options of care made available through the individual local health district. Midwives expressed that socially disadvantaged women find it hard to take on the responsibility for their health care choices. With the exception of two midwives who articulated socially disadvantaged women have "*as much control as any woman*"; socially disadvantaged women are viewed as having no control within their maternity care encounters. These midwives understand that socially disadvantaged women are disadvantaged regarding continuity of care models of practice. The women are less likely to access their maternity service within a time frame that enables a position in a midwifery-led, continuity model of care. Socially disadvantaged women are also more likely to be classified high risk according to medicalised assessment parameters and assigned to a non-continuity of midwifery carer model of maternity care. Participating midwives associate the absence of continuity of midwifery carer with an inability to gain the woman's trust and establish a relationship. These midwives also express that socially disadvantaged women's needs do not take precedence over those of the local health district. Midwives did not recount instances of understanding that socially disadvantaged women could be involved in the development and provision of local maternity services.

The next chapter presents student midwives' descriptions of being a student in the maternity care environment. Their recounted observations of maternity care encounters in which socially disadvantaged women are the recipients of care and their experiences of learning and doing woman-centred are provided.

Table 6-1 Recurrent themes: registered midwives

Identifying recurrent themes: registered midwives								
Pre-determined Themes	Emergent Themes	Focus Group 1	Focus Group 2	Focus Group 3	Single midwife 1	Single midwife 2	Single midwife 3	
Choice: These midwives expressed that it is <u>difficult for socially disadvantaged women to have choice</u> within their maternity care encounters. Choice is limited by the individual health care professional, options of care available through local health district and institutional processes.	Being safe: Midwives lacked a sense of 'being safe' in offering choice and shifting control to women.	Yes	Yes	Yes	Yes	Yes	Yes	
Control: These midwives expressed that <u>socially disadvantaged women have no control</u> within their maternity care encounters.		Yes	Yes	Yes	No	Yes	Yes	
Continuity of care: These midwives expressed that <u>socially disadvantaged women may be disadvantaged regarding continuity of care</u> models of practice. The absence of continuity of care equates with an inability to establish trust and a relationship with a midwife.	Being available: Midwives lacked an understanding that they can 'be available' for women outside a continuity of care model of practice.							
Women's needs take precedence: These midwives expressed that <u>socially disadvantaged women's needs do not take precedence</u> over those of the local health district.	Being valued: Midwives lacked a sense that midwifery and woman-centred care are 'being valued' within maternity services.	Yes	Yes	Yes	Yes	Yes	Yes	
Women involved in maternity care development and provision: These midwives did not recount instances of understanding that socially disadvantaged women are, or can be, <u>involved in the development or provision of local maternity services</u> .		Yes	Yes	Yes	Yes	Yes	Yes	

7 Julie's journal: student midwives' experiences

In this chapter a narrative has been created weaving direct quotes to reveal common experiences and episodes of difference as communicated by participants from every focus group, and interpreted by the researcher. Fictional journal entries have been written to accommodate shared understandings or episodes of difference or unique understandings as voiced by participants. In this chapter the researcher is present through the voice of 'Julie, the student', who comments on and questions her experiences. My words are made obvious through differentiation of text styles (see table 4.3: key for understanding, p.S4-ii). Questions raised by Julie are not necessarily those posed during focus groups. They are part of the creative process in bringing together participants' words and improve readability for the reader.

Following the narrative, an additional method of presenting participants' understandings of woman-centred care is provided through a visual representation of their view of maternity care encounters and woman-centred care. Finally, the second half of the chapter provides the reader with insight into the descriptive or exploratory process of analysis through the inclusion of extracts from my 'emerging themes' tables. In each extract the participant's words are displayed in the first column. My comments and thoughts are found in the second column along with the pre-determined and preliminary themes. Emerging themes are displayed in the third column. The colour coding demonstrates part of my engaged reasoning processes, that is, how I align participants' words, my thoughts and the final themes discussed chapter 9 – *New understandings*.

7.1 Introducing Julie

Julie is a student midwife in the second year of a Graduate Diploma in Midwifery. She worked as a registered nurse for five years in a tertiary hospital prior to commencing the Graduate Diploma program. As a requirement for program completion and registration as a midwife, Julie is obliged to maintain records of her involvement with a number of Continuity of Care Experience women. Julie keeps a reflective journal detailing her interactions with the

women. The following journal entries have been created from the transcripts of participating student midwives. They disclose Julie's interactions with Sharon, Tina, Cath and Suzie (The women from chapter 5). Julie's entries also include her reflections on her interactions with midwives and other health care professionals within the maternity care environment, her experiences of being a student, and her observations of interactions between women and midwives.

7.2 Julie's Journal entries

Entry 1: Today I met my first continuity of care experience woman, Sharon. We met for coffee after her 18 week ultrasound. She told me she had not expected to pay for the ultrasound. I asked Sharon why she had the ultrasound and she replied "*You'd be scared not to, 'cause it's all about you don't want to do the wrong thing by your child*". I said to her, "*It's just a choice and you get to choose what you want to do...*". And she said to me, "*Do you get choices?*". I said, "*Yeah you do, it's your body, it's your baby*". Sharon "*didn't realise that she's got [choices]...I don't think women do realise that they have choices*". "*The midwives they're not woman centred it's – this is what we're going to do, this is how we're going to do it, is that okay with you and then she [the woman] says okay and then that's what they do. I think they need to teach the midwives the [woman] centred care*". Sharon told me "*[When] I see midwives at the hospital, they [are] like, 'This is what's going on'*".

Women receive information so that they can make a choice; however, "*we influence the decision. But as midwives, it's usually the right decision*". Although, a few weeks ago Tina, another continuity of care experience women, went "*to the clinics and it was like, I think she was about 32 weeks [at that] stage, and she [Had some risk factors for HIV] and hadn't had her HIV test done. I was with my educators and we said 'oh you'd better do it, have the thing done'. [The results] came back, and it came back positive. So there was this huge big rigmarole and we said 'Your test has come back positive for HIV'. And she said, 'What does that mean? Have I got AIDS?' And they said 'Yes.'*" So they shuffled her off to the sexual health [clinic] – they re-did the test and it cost her a couple of hundred dollars, which was huge out of her budget, she's on welfare payments. And it actually came back negative. And so they said,

'Well actually you don't have AIDS, you're fine, don't worry about it.' So this poor girl has been troubled, and then she was left with a \$230 bill and she said, 'I can't pay it' and she rang up and said 'I just don't have this money, I didn't even want the test' and they just said 'Too bad'. So I don't know. You sort of say have these tests, and then that classic example, this poor girl'.

Entry 2: Today *"I was working in the antenatal clinic, there was a woman who came in, obviously socially disadvantaged with income, housing, domestic violence, mental health issues and all of that kind of stuff. And it was really hard to offer her [continuity] of care, because straight away she couldn't go in a midwifery model. She's got to see a doctor because she had this health issue, but continuity would probably really be helpful for her". "It's the doctor, and the doctor's big, straight away on that medical regime and their [women's] choices are taken away, because they're not asked what they would like at the doctor's, they're told what's going to happen". You know, "lots of people ask for the one-on-one stuff [continuity of care(r)] and don't get it because they need to be shafted to this person or that person [for health issues]"*. Although at other times it is the timing that prevents socially disadvantaged women from obtaining continuity of midwifery carer. *"They turn up a bit later for their booking in visit. They present too late to be put into a midwifery model of care or whatever. They present at 28, 30 weeks". "So that automatically cancels them out [of Midwifery Group Practice] and they would benefit from that type of care, but they don't have it 'cause they've come too late, you only have to be like 12 weeks to miss out on getting on our good women-centred midwifery teams. You basically need to conceive and phone and get on the team". I don't understand "why aren't they presenting early? [Is it] lack of education, lack of knowledge"? Maybe it's "hard for them to get here - the transport?" Or "they're worried about the prejudiced midwives". I remember Suzie telling me last visit that, "until something about the whole system's done I don't think you're going to get that extra attention and care that you'll get from your GP".*

Entry 3: Today, *"one of the things I saw that worked really, really well and I saw it happen about three times in this one day, was when the midwife actually said, 'Here's my card and here's my mobile number. If you need to talk to me about anything, you give me a ring.' And just, you see each single woman, you could*

just see there was a little flicker of hope in her eyes and she went ‘Wow, this person really cares about what I’m doing, what I’m going through’. And that’s one of the things we seem to miss in the antenatal [student clinic] because we’re looking at our, even as students, we’re looking at our [women], just going ‘I’ve got 30 minutes to connect with this woman and make her feel like she’s supported, then I’ve got to go and grab the next one.’” “I don’t know how we [could] incorporate that [relationship building] into a bigger practice” for all women and students “because we don’t have that continued [relationship with women] and continuity of care. We don’t get that [and disadvantaged women] would probably benefit the most from that care, having that relationship. Like I know our clinics, they can see a different midwife every visit”. “They certainly don’t get the continuity of care or [same] midwife each visit. They just see whoever’s there on the day, who looks after you is whoever’s on, that day.

Entry 4: This is my last day in the clinic for this placement and “*I find in the clinics, doing my booking in, all the women were like, ‘Well what are my choices?’ They had absolutely no idea. And on my last clinic day, there was one woman. So that’s one woman probably out of 10 that actually was aware of her options. So, like, women do not research into this. They probably put more effort into what pram to buy than they do to look into what care they are entitled to or what is out there*”. Although, “*I think what’s interesting with women is giving them permission to know. Like, they’re so used to coming in and being told what they’ve got to do, it’s okay for you to go home and look up this. Or you can make choices about your delivery and your care and how you birth your baby. And they sort of go ‘Oh really?’ They just don’t know that’s available*”. “*Sometimes you’ve got to maybe give them a bit more credit too. I mean ultimately it has to be their choice what they do*”.

Entry 5: Sharon had her baby yesterday afternoon. I was at the birth and when I asked Sharon about her wishes regarding the Vitamin K and Hep B injections. “*She said ‘What’s that?’ She goes, ‘I don’t know, what do you think?’ They say ‘You know best’. So they try to get us to tell them what to do*”. “*And she’s on the table, being sutured back up. And I wasn’t happy to give it. I said, ‘If you*

haven't' done any reading and you don't know about it, I'm not happy to give this to your baby until you have read about it.' "It's very easy to say 'Oh well, everyone else's baby has vitamin K and Hep B'. Like I could have said all that, and I know she would have said 'Yes', I know that. But I wasn't comfortable 'cause she said 'I don't know what that is'."

Infant feeding is another situation involving the woman making a decision. *"This lady at our student clinic, she can't read or write and she's quite young, in her early 20s. She's choosing to bottle feed because it's easier for her mum to help her look after the baby, yeah and sometimes that is an informed choice, and it might be the right choice, too".* On the other hand, Tina a continuity of care experience woman I met who chose not to breast feed, told me that when she was in hospital, *"every time [she] had her [baby] on the bottle there was this one midwife kept coming in, 'Aren't you going to try her on the boob? She needs to go on the boob. Better for her'. Yet, "we had a couple, she was Down Syndrome and he was undiagnosed developmentally delayed, they spent I think, four weeks on our ward. She ended up having a premi baby. They [the midwives] decided that it was too much for her to breastfeed and to keep [up] her supply, so it was better just to cut off the breastfeeding altogether, even though she just wanted to desperately breastfeed this baby. So they just cut the breastfeeding bit out and said 'Alright you can bottle feed your baby' and she wasn't really happy with that. Apparently her mother wanted her to breastfeed and so there was all these kind of issues and the mother was saying, 'You know there's a lot of family history of asthma and allergies and all sorts of things and can we please try and at least breastfeed because we know that breastfeeding would be better for this baby'. But the health professionals decided that it was better for her to bottle feed the baby. And you know, on the last couple of last days, they were deciding as to whether they [would have] DOCS involvement and like, well she's not going to be able to look after this child when she gets home".*

"I don't know whether all the options were presented to them at all. I kind of think the health professionals were making decisions for her and saying 'Well we think that this is going to be the best model of care for you to go home with'. I think a lot of choice was taken away from that couple. I actually know of that

lady in general society as such, and she let herself be institutionalised, but that's her mentality. She's quite a clever, very independent woman in society, and I believe firmly that a lot of her choices were taken away from her by health professionals for whatever that reason they thought. Antenatally, that lady had a number of teams looking after her, and none of them provided any postnatal education in her antenatal care, which I just thought was appalling. And it was only just before her birth that she, that the actual, the breastfeed family education, whatever you call it...the antenatal education classes, the lady that sort of organises those had come and seen her and said 'What's going on?' She was covered by, you name it, she had everyone come and write that they were providing ongoing support. Yet outside of the room, they all made judgments and no one actually helped her".

Entry 6: I am doing my first rotation to labour ward. I know it's "only some of them" but you "get slapped, like your hand slapped or roused on". "You get I'm stupid". "In front of people you get told to shut your mouth. You're not allowed to ask questions, it's just what you do". Then, "you're told take control of the situation by other midwives and the doctor [is] yelling at the woman, or they [the midwives] walk in the door and virtually push you out of the road and take over". I told the educator, who "said she would take the matter to management. I think taking it to management is a waste of time". "I think the people [midwives] in the delivery suite need to know how they're treating us because some of them might just go, 'Oh my God I can't believe that that's how they're [the students are] feeling' or that that's what they're taking on and some of them might not realise that that's what they're doing. Because I do believe that they're not all deliberately nasty and that they might stop then and rethink". "I lost more confidence being there in that environment and walked out feeling like I don't know why I was doing this. You're treated as nothing".

"It's almost like you're drowning because it's very hard to swim because you're taught to swim like this [at university]. When you get there [to the clinical environment] they take a different stroke, you can't do it and you drown, there's no support". "It's hard. Yeah. It's kind of you take two steps forward and four steps backwards. Like you think – oh cool, I can do this and the woman respects me and then someone walks in the door and says one little wrong

thing because we are students and haven't learnt and – in a new environment and then you know nothing, and so it just feels – they make you feel so stupid that you just end up thinking that you're stupid and you stand in the background because you don't get a chance". "But I think those skills will improve once we've got experience and more knowledge and more confidence. And I don't think that's something the uni can teach".

Entry 7: Every day is interesting in the labour ward. Today, "*I had an Aboriginal lady who just came in to have a baby and everyone was, you know, putting her down for that reason. But apparently what we were told by the Aboriginal Liaison Officer was that they don't like to come into hospitals because that's where their babies are removed*". "*So they have their cultural reasons, but I suppose we need to educate them to understand that that's not always the case. But I suppose sometimes we do [remove their infants], don't we?*" However, not everyone wants our support, "*sometimes the lower socioeconomic [women] or even the Aboriginal people or [women from] different cultures or whatever don't [want support]. One lady I think was Aboriginal and I said to her 'would you like some support?' and she was adamant that she didn't want [any]. And I think it's because of [their] preconceived [ideas], or the judgment that she thought people were judging her 'cause she's Aboriginal*". But *then...that's their mentality, that's how they take it on, that not necessarily that we've judged them negatively, but that's their mentality sometimes to think that because so many people do judge them, that opposed to helping them [they think we are] being nosy and stuff as opposed to offering it as a positive outcome*". Like, yesterday "*I looked after an Aboriginal woman and she had three or four family members there, rather than the [recommended] two, but they were supportive so that was fine. So we got her in and we did her admission CTG, and the mother and aunty said, 'Shall we take her for a walk now?' And we went 'Yep, good'. Like, take her for a walk that was their culture. When you're labouring, you go for a walk and get everything going*".

"But it's interesting, the cultural [differences]." "The other day we had [some] Sudanese women [and] they've got a different cultural way of life. So this Sudanese lady's having a baby. She had a caeser. And it's just so, why did she have a caeser, you wonder, after three natural births [in her own country].

And I asked her how she laboured in her other country and she said they weren't allowed to sit down, they had to walk around the whole time and had lots of black tea. And that makes sense...and in here, she's like epidural, lying on the bed". "How [do] they, in their own country [birth] naturally, and then come here and end up having lots of complications?"

Any cultural difference appears to me to impact negatively on the woman's care. *"I know a lot of Polynesians just tell you what they think you should hear. It's really hard to build up a relationship unless you're in a continuity environment where you can actually talk to the woman and get an honest response. Because they [are] very quick to please and just like to say yes to everything and think that they're doing the right thing to make your job easy. And that's a very social thing and within the[ir] culture it's normal, but when it's in our society it doesn't always work to the best advantage [for the woman]".* This morning *"we had a Chinese girl and another one was a Muslim girl. And they had caesars"*.

Entry 8: Back in the clinics, and the *"midwives pretend, under the umbrella of being a midwife clinic, but it's actually medicalised, most of it is obstetric based, like they [the women] just come to the hospital clinic"*. Women are *"limited to public services, they're not really going to be able to look at private obstetrician care. 'Cause I mean you're offering choices, they haven't actually got. Cost is a determinant"*. *"Women don't make choices; the doctors make them for them"*. However, *"I find the women that probably speak out more are the ones that have been in the system longer. So they know, 'No I don't want that', 'Yes I'll have that'. The ones that are just shoved through and take what's given don't say 'I won't [or] I will'. They don't seek out [choice]."* It is even harder for women from diverse cultural backgrounds. *"I do wonder about their antenatal [care], what [culturally appropriate support] they're getting, where they're going, what information they have, why they're not bringing their history with them..."*

Entry 9: I met a new continuity of care woman today, Suzie, and *"one of the things I've found with these socially disadvantaged women is the fact that they fall pregnant and where do they go next? Who do they turn to? They go to their GP and it's usually referral to the antenatal clinic"*. At least with *"a student*

[clinic, she is] probably getting the most continuity of care than all the women [who go] through the cattle run, actually run through the hospital". Suzie said when she went to the other antenatal clinic for her last pregnancy, "every time she was seeing someone, she was going through the emotional exhaustion of having to explain her situation. And to some, unfortunately, to some residents, they really didn't give a, they didn't have that paradigm of thinking that we [midwives] have that it's not just a thing on the bed".

Later I accompanied Suzie for her maternity ward orientation. The women were shown the birthing room in delivery suite. In there, "they've got a room and it's got a spa and got a little lounge and a nice bed and a CD player in it and a bigger bathroom and all the rest of it. And all the women that come through for the orientation visit or you know the walk through, they see this room. And it's 'Yeah, this is your birthing suite, blah blah blah', and...and then when they [women not in Midwifery Group Practice] come in to birth, they get placed in one of the normal rooms that don't have a bath, got a smaller bathroom, and no lounge, it's got a hard plastic chair in it, because the birthing suite or whatever it's called is kept for the MGPs, the Midwifery Group Practice ladies". "I've never ever seen a socially disadvantaged woman being looked after by the MGPs". It is "all upper class, who are quite educated, who know about this secret midwifery practice that exists. And they have that one on one contact, they have the mobile phone of that midwife. Whereas the obstetric, run of the mill, cattle class people, and disadvantaged, are put through the obstetrics system, you know, if you've got any problems just ring the hospital. So they have no one on one connection with anyone". "With our midwifery models of care, we should still be able to provide them [socially disadvantaged women] one on one midwifery care or team or whatever, and just pull in those people when we need them, allied health care, and all their GPs, you know"?

Entry 10: I am finding that relationships between midwives and socially disadvantaged women are "good and bad, overall bad. Generally, [I'm] not inspired at all". Midwives can be "judgmental [and] categorise [women]". It is like they say, "I don't want to deal with these issues [women], get em in, get em out... get em out today". "It's not really about social disadvantage [either]. This woman, she came in for VBAC [Vaginal Birth After Caesarean] she'd had two

previous caesareans at the private hospital, her first was an emergency because of fetal distress. The second one was just an elective. She didn't get the choice of VBAC. It was just 'You're having a caesarean', that was it. And she came through the midwifery antenatal clinics wanting a VBAC, wanting everything natural, skin to skin, just everything natural...Unless [you] really had a very strong opinion, which not too many people would say something? You don't have too much choice and it takes you a while to get to know them [the midwives]. But you don't know [anybody], so how do you say something when you haven't got a relationship with anybody anyway?"

[I understand] it is hard work, "like sometimes you'll meet a woman. They don't want you to get close. And they've got this protective [shield up against us] so they get managed that way. But if you just get a little chink that actually you might be able to change something, well then you've got a chance. But it has to be a partnership [in which the woman is willing to participate] I guess". I try and "get as much support as we can [for the women]. But then other times I'm kind of going, 'well why are we helping...?' You can only do so much for them, and maybe they've been down this road before and they just have to get to rock bottom and then [help themselves]". I remember one woman, "she portrayed to the staff that she wanted to do the right thing. But her actions were a little bit different and it's hard to sort of differentiate between [what she said and what she did]. 'Cause she did say all the positive stuff, but her actions weren't exactly positive. So it's yeah interesting. But she understood that she had to do things, to make more responsible choices, to have better outcomes". But then again, one of my continuity of care "ladies who came in was dyslexic, couldn't read, she was low socioeconomic, and you know, [I would say,] 'What [do] you want? What are your choices?' And she goes, 'I don't know, what do you think?'"

Entry 11: It is so busy "on the wards, [how] do we address all their needs? It's so much easier to focus on what they need physically, her blood pressure 'cause they've got pregnancy hypertension, they need this and this and this done for them to keep the pregnancy healthy. But how much can you support them, there's not enough time sometimes. I was "looking after [one woman, she] was a real challenge, because she was fitting in the low socioeconomic group, no housing, previous child removed, history of drug abuse, and like, it

was really hard to work, just talking to her about finding housing, it was like an impossibility. And I don't think this woman's ever going to find a place to live, because she couldn't go back to her mum's because her mum was taking custody of the baby and she wasn't allowed to be near it. And I just thought, the only way you're going to get housing is to go back out and live with these people that are in the drug use circle, are in the prostitute circle. And she has to go to court, and she'd driven without a licence, so she's likely to end up in gaol. It's just like it gets...its huge". Its "hard, [it's] emotional, I think we sometimes forget that we have our own lives as well".

Entry 12: “*On the ward [today] I looked after a woman [who had been there] for about four weeks. She had housing issues, we think it may have been domestic violence, but the attitude that a lot of the staff [midwives] had was that it was basically she was just taking a bed. There was nothing medically wrong so she should go home. And I basically stuck up for that woman and said “well actually midwifery is holistic and her mental health wellbeing is part of this,” so I didn’t agree with the view that she was just taking up a bed. I couldn’t say how many times I heard them say, ‘She’s a waste of a bed’. There was a lot of social work involvement, a lot of additional support, that it almost meant that the midwives on the ward could just have a hands off approach. ‘Well that’s been dealt with, we don’t have to [do anything]’, like it’s always someone else’s job to [take on the responsibility for the woman]” No one saw that she wasn’t “just a thing on the bed, it’s actually a person who’s very, very complex. And very vulnerable at the same time. Yeah, I don’t know how we fix that”. Change “needs to come from the organisation, doesn’t it”?*

For any woman who requires additional support or who has complex needs, “*I’ve found that, in handover the nurses [midwives] would go, ‘Oh, I don’t know if she’ll be able to cope when she gets home’ but they weren’t offering her actual support, the thing coming out of that handover was that there was no support given to her. But she was very slow to do things, like it took her a long time to actually process the whole thing. I think what she actually needed was somebody to be with her the whole time and do that process over and over again so she would understand it when she got home, but they weren’t prepared to do that. ‘Oh we don’t have time to be able to spend time with her.’”*

"The only time I've ever seen women-centred care [was] with the Midwifery Group Practice midwives. They're amazing, you know? [When they are in the labour ward], they pretend like there's nothing outside the door and they stay in that room and they're with that woman and they birth that woman". However "that's a real problem [for delivery suite midwives because] they [the Midwifery Group Practice midwives, do not] consult the other core birthing suite midwives who tend to get the doctor. Doc comes in, ventouse. You know, it's not like 'okay, let's maybe try something else'. They [delivery suite midwives] just jump right to the obstetric way of having a baby".

Entry 13: On the ward still and "*it's just...I don't know, it's hard.*" How do the midwives do it? "*Midwives don't get any clinical supervision or anything*". "*Like we all just want to get in there and try and help them all*". "*It's a sinking system*". "*It's a sinking ship*". There are "*Lots of policies to help keep the consistency with it, so that there's [no] choice on how much information they get at the time and the disadvantaged...it's not like we as students can make decisions,... that goes above too [with the doctors and management deciding], because the protocol that we have to work under anyway*". "*And with disjointed care, you know, I know we've got checklists, but they're not always ticked [and] you don't know who's spoken about what*". "*Yeah, it's just like a tick box, have you done this, have you done that, have you done something else?*"? I think "*the staffing needs to be appropriate [with] time allocated to do these things*". "*We don't have time to do this*". "*We don't, [provide time for informed consent] we will give them a form for consent, because you know, she's delivered, and she's being fired with questions and it can be quite an inappropriate time to get really true, informed consent off people. There needs to be time and space available*".

Entry 14: This week I am working in the "*high risk antenatal ward, and it's not midwifery model of care. I think the only time I see midwifery model of care is grief and loss. It's the only time I can honestly say I've seen that, as much as I try, it is for me, nursing. I have a list of things to do, and you put your head down and you go. And even though, like every morning, every shift I get in there and I fight with it, not too much but I do, you know, go up to the doctors and say, 'Why are we doing this? Daily CTGs?' I really get in there and have*

my opinion. I'm not normally like that, but you know, why are we doing these things to women that are so medical and make them so anxious”?

“There’s no correlation between what you get taught [in the university] and what you are practising in the hospitals”. I hear from the midwives, “I know this [is] how you do it at uni but this is how we do it here. I know this isn’t what you’re taught. They don’t – they don’t acknowledge [what we learn] – that’s the best practice I guess. They just say this is the way we do it, this is what we’re going to do”. It is not just students either, “there are younger ones [new graduate midwives] that feel exactly the same as we do and they’re not allowed to practise the way they want to practise the birth centre theory, model, whatever is just thrown out the door because everything’s intervention, intervention, intervention”. “The midwives can even be nasty to some of the junior doctors”. The midwives are “stamped with the information that, this is how you do it in a complex situation and that’s it”.

Even at the university “we got taught one normal, and how to support women with normal births and then after that we got taught this is what can go wrong, but there was no ‘This is what can go wrong and this is how you can help the woman’. There was no bridging from normal and – and woman-centred to – to complicated [and] woman-centred. There’s no complicated and woman centred, it’s just complicated or normal [and] woman centred”. Perhaps, “employ[ing] some [educators] – not – you know the hospital employs educators in the hospital to help us, [but if] the university can employ people to be in the hospital to help us, they would teach different. I need more examples of those positive mentors and their view. I don’t think educators there [in the hospital] necessarily give us a very good experience either because you can work with one [and a different] one the next day, the same ward, similar woman, and they’ll both do different things different ways and you’ve just got no idea what you’re doing”. “There’s greatly contrasting people in educating. I think it needs – like continuity in the education”. We need to learn how to interact with each other in the clinical environment. “You could do it [have scenarios] for any – any problem that may come up and it was involving the doctors and how the doctors could rely on the midwives and how the midwives could rely on the doctors”. “I think doctors and midwives need to work together to make it more woman

focused". " [Also,] I think if [the midwives] had that sort of thing [clinical role plays about] what we learn at uni... [we could work together with] the midwives that we're working with, something like that, so they know where we're coming from and we know what they expect, that would be a lot easier for everybody".

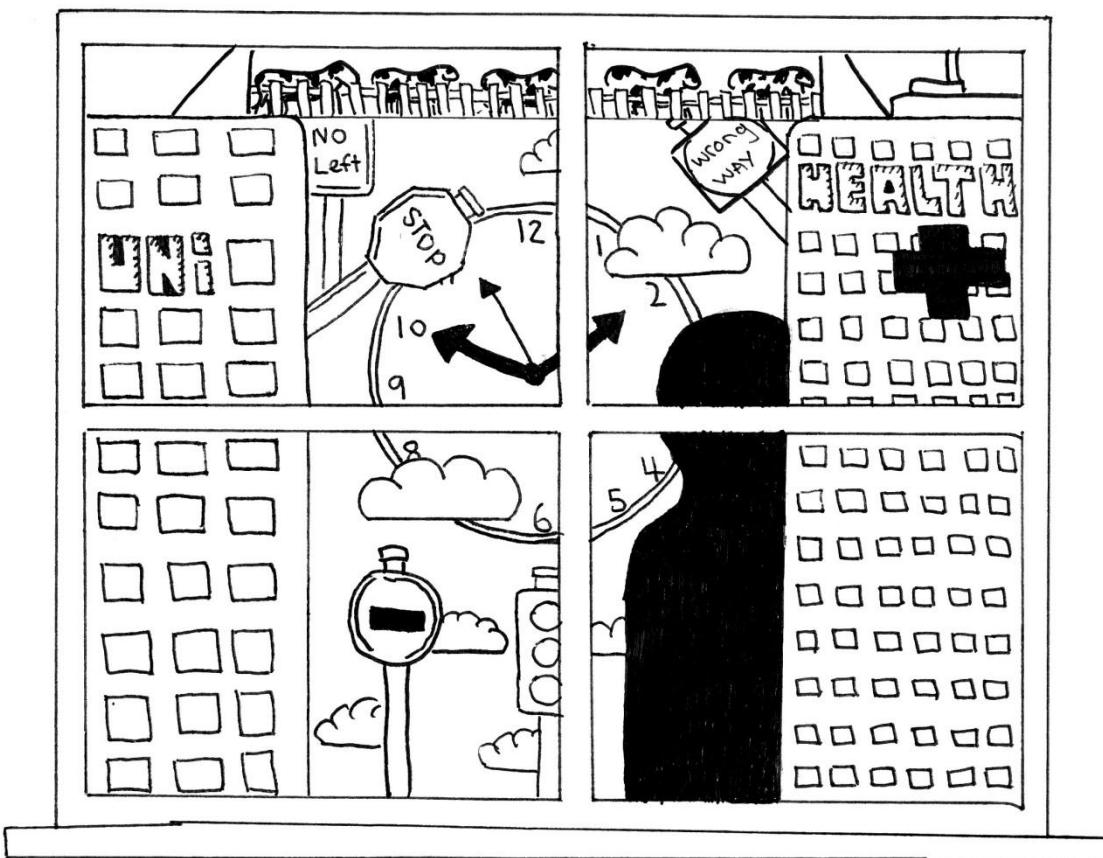


Figure 7-1 Julie's view of woman-centred care

7.3 Exploring Julie's journal

Julie's understandings of observed maternity care encounters involving socially disadvantaged women supports the findings from both the women's and registered midwives chapters. That is, socially disadvantaged women are unlikely to receive woman-centred care during their maternity care encounters. The lack of woman-centred care is illustrated in Julie's drawing with the woman positioned off centre. There is little evidence that participating student midwives, represented through Julie's journal entries, view socially disadvantaged women's maternity care encounters as incorporating the elements of woman-

centred care. That is, the woman has choice, control, and continuity of carer, she is involved in the development and provision of maternity services, with her needs taking precedence over those of the local health district.

Participating students view **choice** as either permitted or not, with health professionals having the power to allow or deny women choice. There are written and unwritten rules about what choices women are allowed. This view is depicted, in Julie's drawing, by the road traffic authority signs. Students articulate that women are usually told what is going to happen to them. This understanding is shared by the women and registered midwives in the previous two chapters. In the following emerging themes table, Julie discusses how choice is restricted through the midwives failing to make choices known or influencing the woman's decisions.

Student midwives – emerging themes		
Original Transcript	Exploratory Comments	Emerging Themes
<p>Journal entry 1:</p> <p><i>"The midwives they're not woman centred it's – this is what we're going to do, this is how we're going to do it, is that okay with you and then she [the woman] says okay and then that's what they do."</i> [Women receive information however,] <i>"We influence the decision. But as midwives, It's usually the right decision".</i></p>	<p><u>Choice</u> and <u>Precedence of women's needs</u></p> <p>Students see that midwives do not provide choice and control around decision-making processes. Midwives tell women what to do. Therefore they do not provide woman-centred care. This aligns with what women say about their ability to have choice. Midwives don't value women's input or needs; they follow hospital protocols and policies to ensure public health and institutional needs are met. Midwives are aligned with the hospital not the woman. When the woman does not feel valued, she does not feel safe enough to make a choice different to that proposed by the midwife. The woman may not feel safe to voice her concerns; the cycle of non-engagement in decision-making is maintained. Women are afraid to go against "the special people" due to their sense of responsibility for the baby. The woman agrees to follow directions and suggestions by the midwife. Students do not value the woman's ability to make decisions regarding her health care options when saying usually it is the right decision – right for whom?</p>	<p>Being available</p> <p>Being safe</p> <p>Being Valued</p>

Students express that the capacity for choice is further reduced for women who present with medical or psychosocial problems. Entry 2 reveals that doctors are deemed to be in control of decision-making processes when women are identified to have a pregnancy complication. The woman's permitted

involvement in care options is withdrawn. “...*She’s got to see a doctor because she had this health issue...and the doctor’s big, straight away on that medical regime and choices are taken away...they’re told what’s going to happen.*” The doctor’s judgement and input are valued over the woman’s, with the woman advised that optimal birth outcomes depend upon decisions made. The doctor is portrayed as the expert; women therefore are encouraged to follow medical orders to ensure the physical health and well-being of baby and self.

Students describe how socially disadvantaged women appear to be programmed to conform to health care professionals’ advice. Students speak of women as being “*so used to coming in and being told what they’ve got to do*” by health care professionals that they actively seek advice regarding their maternity care choices from the midwives. Students convey that the women appear to avoid making decisions, referring to the midwife for a recommended choice. Julie writes in entry 5, the woman, “*she goes, ‘I don’t know, what do you think?... You know best’*”. Students appear unwilling to take on the responsibility of decision-making for women and redirected responsibility for choice back to the women. As seen in entry 5, students want women to have ownership of choice. “*I said, ‘If you haven’t done any reading and you don’t know about it, I’m not happy to give this to your baby until you have read about it’*”. When women do make choices, however, students can consider their decision-making processes to be inappropriate. In entry 4 Julie comments, “*I find...the women ... probably put more effort into what pram to buy than...what care they are entitled to....*”.

When women conform in their decision-making, following the directives of health care professionals unquestioningly, they are held accountable by students for the poor care received. Julie speaks of a woman in entry 5 who “*let herself be institutionalised, but that’s her mentality.*” However, students recognise it can be hard for socially disadvantaged women to have a voice or choice in a maternity care environment without the supportive guidance of a known midwife. This understanding is demonstrated in journal entry 10, when Julie writes, “*...you don’t have too much choice, and it takes you a while to get to know them [the midwives]. But you don’t know [anybody], so how do you say something when you haven’t got a relationship with anybody anyway*”. Equally,

women seen as not engaging in decision-making processes with health professionals are held accountable for the care they receive. In entry 10, Julie writes *"it is hard work, like sometimes you'll meet a woman. They don't want you to get close. And they've got this protective [barrier] so they get managed that way...But it has to be a partnership... You can only do so much for them..."*. Students view the barrier erected by women as a defence mechanism against potentially unsafe maternity care encounters. The barrier, however, is also seen to reduce the midwife's ability to be available for the woman. It diminishes midwives' ability to support women in making maternity care choices. Midwives, in the previous chapter, also spoke of women erecting barriers that affect the midwife-woman interaction.

Students view socially disadvantaged women as having no **control** over their maternity care encounters. Women are seen as powerless against the authority of health professionals. This view is similar to those of participating women and registered midwives. Socially disadvantaged women are not **safe** to have a voice or choice within the maternity care encounters. The multiple road signs in Julie's drawing depict the authority that health professionals have within maternity care encounters to prevent women from having control. In the following emerging themes table, Julie describes how midwives have control over women's ability to make choices. In this journal entry midwives have made a decision concerning infant feeding without involving the woman in decision-making processes. The woman's needs were dismissed; the woman's needs were not valued by the midwives. Care was infant-centred, and decision-making was midwife-centred.

Student midwives – emerging themes		
Original Transcript	Exploratory Comments	Emerging Themes
<p>Journal entry 5:</p> <p><i>"They [the midwives] decided that it was too much for her to breastfeed and to keep [up] her supply, so it was better just to cut off the breastfeeding altogether, even though she just wanted to desperately breastfeed this baby. So they just cut the breastfeeding bit out and said "alright you can bottle feed your baby" and she wasn't really happy with that.... But the health professionals decided that it was better for her to bottle feed the baby."</i></p>	<p><u>Choice, Control</u> and <u>power over</u></p> <p>Midwives and other health care professionals made decisions about, and not with, the woman as to how her baby should be fed. Perceived benefits for the baby was the stated reason for choices made. The woman's input was not valued. This aligns with the women's comment "<i>they get the baby for you</i>". Women are the outsiders in the maternity environment. Staff made judgements about the woman's ability to care for her baby at home. They questioned, was the baby safe with the woman? However, the woman was not safe in the hospital to have a voice and choice. She was completely disregarded. No one was available for this woman. No one was her advocate, no midwife supported the woman.</p> <p>Continuity of carer or an established relationship with a known midwife may have prevented this situation.</p>	<p>Being safe</p> <p>Being available</p> <p>Being Valued</p>

Any woman from a culturally or linguistically diverse background is viewed by these students to have less choice or control during their maternity care encounters than women from the culturally dominant population of childbearing women. In entry 7, Julie speaks of women from diverse backgrounds and how their cultural differences impact negatively on maternity care. *"I know a lot of Polynesians just tell you what they think you should hear...but when it's in our society it doesn't always work to the best advantage...the culture...they had caesars".* While students express that women from culturally diverse backgrounds are less likely to have their cultural birth practices acknowledged, the women can be held accountable for the difficulties in meeting their needs. *"...I said to her, 'Would you like some support?' and she was adamant that she didn't want to".* Students did not demonstrate awareness, through their discussions, that the support offered may be culturally inappropriate. These students understand that a woman's decision to refuse support is based on ignorance, and that midwives "*need to educate them to understand*" the importance of maternity care.

Students express that it is difficult to establish a relationship with women through **continuity of carer** in a hospital environment largely absent of continuity of midwifery carer models of maternity care. In the following emerging themes table, Julie describes how midwives work within the maternity care environment.

Student midwives – emerging themes		
Original Transcript	Exploratory Comments	Emerging Themes
<p>Journal entry 14:</p> <p><i>"I think the only time I see midwifery model of care is grief and loss. It's the only time I can honestly say I've seen that, as much as I try, it is for me, nursing. I have a list of things to do, and you put your head down and you go"</i></p>	<p><i>workplace culture and models of care</i></p> <p>The hospital environment promotes task focused models of care. Institutional needs and completion of tasks are valued over being available for the women. These students (who worked prior to their midwifery program as nurses) do not see any difference between midwifery and nursing within the hospital environment. Midwives work as nurses within the maternity care environment - a medical model of care. They are available for the local health district. The student talks here of putting their head down. This has a number of meanings. Firstly the busyness, just running without looking to get to the finish line. Secondly, keeping the head down prevents the student from 'seeing the woman' and her needs. Finally, the student is not safe to have their head up and to question where they are going and what they are seeing. When everyone has their head down no one can see what is occurring for the woman.</p>	<p>Being Valued</p> <p>Being available</p> <p>Being safe</p>

When students do observe a midwife-woman interaction where the midwife is available for the woman, the woman is viewed by students as being optimistic of her future maternity care encounters. “*You could just see there was a little flicker of hope in her eyes and she went, ‘Wow, this person really cares about what I’m doing, what I’m going through’*”. Here the student expresses that when the midwife informed the woman that she was available for her, the woman understood that the midwife valued her as an individual; being available for the woman demonstrates that her needs are valued.

Students express that a hierarchy of maternity care models exist within the maternity care environments in which they observe and learn midwifery ways of working. At the top of the models of care hierarchy is the Midwifery Group Practice model. At the bottom is the obstetric based, non-continuity of midwifery carer model of practice. Students communicate equally that they and socially

disadvantaged women would value a Midwifery Group Practice model of maternity care over the obstetric based model. In the following emerging themes table, Julie discusses labour and birthing care as provided by midwives working in a Midwifery Group Practice. She indicates that the only time she witnesses care that aligns with the philosophical principles of woman-centred care is when she observes care provided by midwives who work in a Midwifery Group Practice model of practice.

Student midwives – emerging themes		
Original Transcript	Exploratory Comments	Emerging Themes
Journal entry 12: “ <i>The only time I've ever seen women centred care [was] with the Midwifery Group Practice midwives. They're amazing, you know? They pretend like there's nothing outside the door and they stay in that room and they're with that woman and they birth that woman</i> ”.	<u>Woman-centred care</u> Students express that Midwifery Group Practice is a superior model of maternity care compared to hospital-based maternity care. They see that midwives who provide continuity of carer models of practice, such as those in a Midwifery group Practice, value their women and create a safe space in which to birth, free from unnecessary interventions. The midwives, by staying in the room, show they value the woman's needs by being available.	Being Valued Being safe Being available

Students communicate that socially disadvantaged women are more likely to receive the obstetric based model of maternity care. “*I've never ever seen a socially disadvantaged woman being looked after by the MGPs*”. It is “*all upper class, who are quite educated, who know this secret midwifery practice exists...they have that one-on-one contact...Whereas the obstetric, run of the mill, cattle class people ...they have no one-on-one connection with anyone*”.

The hospital system and medicalised models of maternity care are seen to function as a processing plant, with women processed like cattle in a factory. This understanding is supported by similar comments from participating socially disadvantaged women and is demonstrated in Julie's drawing by the cows lining up for processing.

Students did not recount instances when a **precedence of women's needs** over those of health care providers' needs was observed during socially disadvantaged women's maternity care encounters. Students express that

women are required to follow the hospital's operational processes. The woman is not a valued part of the system, but a visitor. This view is depicted in Julie's drawing with the woman's silhouette backgrounded. Students suggest that socially disadvantaged women's life circumstances can make it hard for them to meet the needs of the local health district. Socially disadvantaged women can experience difficulties attending maternity care visits where and when local health district management determines. In entry 2, Julie states failure to comply with expected behaviours concerning maternity care visits can be a consequence of a lack of transport, limited understanding of the importance of maternity care visits, or fear on the part of the woman of being judged by health care professionals. Regardless of the reason, women who fail to comply with hospital processes are penalised with the removal of choice regarding models of care. The consequences for the woman of presenting later in pregnancy for her maternity care is that "*they present too late to be put into a midwifery model of care...that automatically cancels them out.*" Participating midwives share this understanding with similar wordings in the previous chapter. While both students and midwives share an understanding that women presenting later in their pregnancy are penalised in the models of care available to them, participating women did not discuss this issue. Neither students nor midwives described instances when they informed women of the importance of presenting early in pregnancy for maternity care, or the consequences of presenting late. Women, therefore, may be unaware they are being disadvantaged by presenting late for their maternity care.

Students express that women's maternity care is medically focused and institutionally based. Julie describes, in entry 8, how women must physically attend the hospital for their care and that the care received is not woman-centred. These students question whether midwives are aware of, but choose to ignore, the incongruities between the philosophical underpinnings of midwifery and care provided. "*Midwives pretend, under the umbrella of being a midwife clinic, but it's actually medicalised, like they [the women] just come to the hospital clinic*". Students discuss that they are powerless to change the system and view management as responsible for changing the medicalised, task orientated **maternity environment**. It "*needs to come from the organisation,*

doesn't it?" Julie's drawing reveals a scene where buildings are cast in concrete, fences exist and rules are in place. A change in the scenery is thought to be almost impossible.

Time constraints are identified as a barrier for midwives in meeting women's emotional and physical needs. Students communicate that it is difficult to build and maintain relationships with women when working in a task orientated environment. The focus of time limitations or constraints is depicted in Julie's drawing by the prominent position of the clock in her drawing. A clear view of the clock is not possible, as Julie has conflicting views on time and its use in midwifery. Julie writes in entry 11, "*on the wards, [how] do we address all their needs? It's so much easier to focus on what they need physically...they need this and this done for them to keep the pregnancy healthy. But how much can you support them, there's not enough time sometimes.*" Here the student articulates that while midwives might want to support women with complex psychosocial needs, the maternity care environment values efficient task completion.

Time is not allocated for midwives to be available for the woman. It is easier for midwives to attend to the physical needs of women and complete tasks. Students state that more time needs to be allocated to provide midwifery models of care because psychosocial needs are more complex and take longer to resolve. The woman with psychosocial needs requires the midwife to be available to meet her needs for a longer period. Students express that the individual psychosocial needs of women are not considered by midwives to be worthy of hospital resources or midwives' time. In journal 12 Julie reflects on midwives' attitudes towards a woman who is hospitalised for non-physical reasons. "*I couldn't say how many times I heard them say, 'She's a waste of a bed'. No one saw that she wasn't just a thing on the bed.*"

In the following emerging themes table, Julie talks of workplace practices and time constraints that prevent the formation of a midwife-woman relationship. Students express concern that the inability to establish relationships reduces the opportunity for trust to develop between the midwife and woman. The

woman cannot feel valued with this model of care and the student does not feel safe to speak out against the dominant cultural values of the workplace.

Student midwives – emerging themes		
Original Transcript	Exploratory Comments	Emerging Themes
Journal entry 3: <i>"I've got 30 minutes to connect with this woman and make her feel like she's supported, then I've got to go and grab the next one".</i>	<p>Maternity environment and relationships</p> <p>The student voices that current non-continuity of midwifery carer models of maternity care do not allow midwives (or students) to be available for women. Current models of care demonstrate that management and institutional needs take precedence over women's needs and that women's needs and midwifery work are not valued. Students indicate that they "have to" go and grab the next one. They are not safe to go against the dominate workplace culture and be 'with-woman'. Students are not safe to question workplace practices. Time dictates work practices not the woman.</p>	<p>Being available</p> <p>Being Valued</p> <p>Being safe</p>

The final element of woman-centred care, **women's involvement in health service provision**, was absent from the students' recounted midwifery experiences and maternity care encounters involving socially disadvantaged women. Other issues discussed by students are the basis for the following themes, which emerged during analysis.

Students describe their experiences of ***learning to be a midwife*** as difficult. They spoke of incongruities between midwifery philosophy, education and practice. Julie's drawing demonstrates a theory/practice gap with the educational and local health district buildings positioned on opposite sides of the window. Students express that the theory of woman-centred care is not contextualised or integrated throughout all courses within their midwifery program. Julie describes in entry 14 how midwifery education is largely focused on complications and management of the antenatal, labour and birthing, and postnatal periods. Woman-centred care and normal birth is covered during the first teaching period and is largely absent from the remainder of the midwifery program. '*We got taught one normal, and how to support woman with normal births and then after that we got taught this is what can go wrong... There's no complicated and woman centred, it's just complicated or normal.*'

Students also communicate that clinical placements fail to support their experiential learning of woman-centred care. Julie discusses, in entry 3, her concerns regarding the ability to achieve and maintain woman-midwife relationships through continuity of midwifery carer models of practice once she is registered. “*That’s one of the things we seem to miss...even as students...how we incorporate that [relationship building] into a bigger practice because we don’t have that...continuity of care. We don’t get that.*” Then, in journal 14, Julie comments on midwives’ failure to support student learning and implementation of evidenced based midwifery practices. “*They don’t acknowledge [what we learn] – that’s the best practice I guess. They just say this is the way we do it, this is what we’re going to do.*” In the following emerging themes table, Julie describes how her expectations, based on learning within the university environment, and experiences of midwifery practice in the clinical environment were so different that she found it difficult to position herself professionally as a midwife.

Student midwives – emerging themes		
Original Transcript	Exploratory Comments	Emerging Themes
<p>Journal entry 6:</p> <p>“It’s almost like your drowning; it’s very hard to swim because you’re taught to swim like this [at university]. When you get there [to the clinical environment] they take a different stroke, you can’t do it and you drown, there’s no support”. “It’s hard. Yeah..They make you feel so stupid... you don’t get a chance”.</p>	<p>Learning to be a midwife</p> <p>The students do not see their learning environment as safe. When no one is available to support the student, the student understands they are not valued, learning is not valued and the midwifery profession does not value itself. The midwifery learning environment therefore is unsafe. Students are unable to learn to be woman-centred midwives with the support of midwives, educators and management.</p> <p>The students are drowning when they attempt to implement theory into practice. Why is the workplace such that students can not transfer theory into practice? What prevents woman-centred care from occurring? In this environment the student learns to be unavailable, who and what to value, and what practices are safe to demonstrate or support.</p>	<p>Being available</p> <p>Being Valued</p> <p>Being safe</p>

Students also discuss the **bullying culture** within the maternity environment. In entry 6, Julie reflects on her experiences of working with midwives in the delivery suite. It is “only some of them” but you “get your hand slapped or

roused on. You get I'm stupid in front of people. You get told to 'shut your mouth'... I lost more confidence being there in that environment and walked out feeling like I don't know why I was doing this. You're treated as nothing". Students report it is not only students who are bullied by midwives. New staff, newly graduated midwives and junior medical officers are victims of bullying. Students express, however, that midwives may be unaware their behaviour is bullying. "Some of them might just go, oh my God I can't believe that that's how they're [the students] feeling...some of them might not realise that that's what they're doing. Because I do believe that they're not all deliberately nasty..." Students defend midwives' behaviour because they see midwives are under multiple pressures within the maternity care environment.

Students describe **midwives' attitudes** as generally negative towards meeting the needs of socially disadvantaged women. Midwives are viewed by students as judgemental and generally not interested in working with women with complex psychosocial needs. In the following emerging themes table, Julie recalls the attitude of midwives towards socially disadvantaged women who are inpatients.

Student midwives – emerging themes		
Original Transcript	Exploratory Comments	Emerging Themes
Journal entry 10: <p>"Good and bad, overall bad. Generally, [I'm] not inspired at all". Midwives can be "Judgmental [and] categorise" women. It is like they say, "I don't want to deal with these issues [women], get em in, get em out. Ask them when they're going home. Try and get them out today".</p>	<p>Midwives attitudes</p> <p>Students understand that midwives make value judgements about socially disadvantaged women and do not value the needs of women with complex needs. Midwives do not make themselves available for socially disadvantaged women with complex psychosocial needs.</p> <p>They can not 'DO' midwifery. Is this because midwives do not feel they can meet the woman's needs, and therefore can not achieve an outcome for the day? The only way to achieve job satisfaction and be valued in an environment that is medically orientated and outcomes focused is to adopt similar values and practices. Is this about being safe in your work environment???</p> <p>Being available is not measurable, and therefore not valued. When this is the workplace culture, to be accepted you must take on the dominant values.</p>	<p>Being available</p> <p>Being Valued</p> <p>Being safe????</p>

Students, however, demonstrate an understanding of why midwives might find it challenging to work with socially disadvantaged women. In entry 11, Julie describes the emotional challenges of working with women who have complex needs. “*It’s just like, it gets...it’s huge*”. It’s “*hard, [it’s] emotional, I think we sometimes forget that we have our own lives as well.*” Students convey that midwives want to support the needs of socially disadvantaged women. Local health district management however, does not support midwives to do so. All three participant groups spoke of workplace practices and workload issues preventing midwives from providing care that is focused on the woman’s needs. In entry 13, Julie describes how management fails to support midwives in their role of providing support for socially disadvantaged women “*Midwives don’t get any clinical supervision or anything. Like we all just want to get in there and try and help them all. It’s a sinking system, it’s a sinking ship.*” Julie also talks of the challenge that midwives face, in providing care that focuses on the needs of the individual woman, in the maternity ward environment. “*...With disjointed care, you know we’ve got checklists, but they’re not always ticked, you don’t know who’s spoken about what...it’s just like a tick box, have you done this, have you done that, have you done something else? The staffing needs to be appropriate [with] time allocated to do these things ...There needs to be time and space available*”. Students express an understanding that ***being available*** for socially disadvantaged women is difficult for midwives under current maternity service practices and work models.

7.4 Conclusion

This chapter presented student midwives’ recounted experiences, using direct quotes, of midwifery and maternity care encounters involving socially disadvantaged women. The students’ attempts at making sense of their experiences were followed by an exploration of their understandings. Student midwives’ understandings of observed maternity care encounters involving socially disadvantaged women supports the views of both participating women and registered midwives in the previous two chapters; there is little evidence that socially disadvantaged women’s maternity care encounters incorporate the elements of woman-centred care.

Table 7.1 - *Recurrent themes*: student midwives, demonstrates the recurrence of pre-determined and emerging themes for two groups of student midwives. As shown in the table, participating student midwives, similar to their registered midwife colleagues, understand it is difficult for socially disadvantaged women to have choice within maternity care encounters. Again, it was voiced that choice is limited through personal biases, the exercise of authoritative power by individual health care professionals and reduced options of care offered by local health districts. Students articulated that socially disadvantaged women find it hard to accept responsibility for health care choices. However, the women were viewed by students as having no control within their maternity care encounters; choice is difficult without control over decision-making. Similar to the views of registered midwives, students expressed that socially disadvantaged women are deprived of continuity of care models of practice. Socially disadvantaged women were described as unlikely to access maternity services within a time frame that enabled a position in midwifery-led, continuity of care models of practice. Student midwives, like registered midwives, see continuity of carer models of practice as the model of care that provides conditions conducive to woman-centred care. Students expressed that socially disadvantaged women's needs do not take precedence over those of the local health district or individual health care professional. Students did not recount instances of understanding that socially disadvantaged women are collaboratively involved in the development or provision of local maternity services.

The next section of the thesis - *New understandings*, integrates findings from participants and literature. Using the final steps in the Interpretative Phenomenological Analysis process, new understandings around woman-centred care are presented.

Table 7-1 Recurrent themes: student midwives

Identifying recurrent themes: student midwives			
Pre-determined Themes	Emergent Themes	Focus Group 1	Focus Group 2
Choice: These students expressed that it is <u>difficult for socially disadvantaged women to have choice</u> within their maternity care encounters. Choice is limited by the individual health care professional, options of care available through the local health district and institutional processes	Being safe: Student midwives lacked a sense that they can 'be safe' in offering choice and shifting control to women	Yes	Yes
Control: These students expressed that <u>socially disadvantaged women have no control</u> within their maternity care encounters. Individual health care professionals have control and power over women		Yes	Yes
{ 7-211 Continuity of care: These students expressed that <u>continuity of carer models of practice are largely absent for socially disadvantaged women</u> . The absence of continuity of care equates with an inability to establish trust and a relationship with a midwife	Being available: Student midwives lacked an understanding that they can 'be available' for women outside a continuity of care model of practice	Yes	Yes
Women's needs take precedence: These students expressed that <u>socially disadvantaged women's needs do not take precedence</u> over those of the local health district	Being valued: Student midwives lacked a sense that midwifery and woman-centred care are 'being valued' in theory or practice	Yes	Yes
Women involved collaboratively in maternity care development and provision: These students did not recount instances of understanding that socially disadvantaged women are, or can be, <u>involved collaboratively in the development or provision of local maternity services</u>		Yes	Yes

Section 5: New understandings

In this section the findings from all three participant groups are integrated and the research question “How do socially disadvantaged childbearing women, registered midwives and student midwives understand woman-centred care?” addressed. The first chapter in this section - Chapter 8 - *Collective findings: a summary of understandings*, provides the reader with a synopsis of the themes explored within the study. Where appropriate, the understandings of women, registered midwives and student midwives are integrated within each theme. Chapter 9 - *New understandings*, presents my understandings of maternity care encounters in which socially disadvantaged women are the recipients of care. Through the interpretative process three super-ordinate themes were found to be common to all three participant groups. The three themes ‘feeling safe’, ‘feeling valued’, and ‘being available’ are offered as discussion topics. It is in this chapter that I incorporate current literature to position my understandings within the wider context of maternity service provision for socially disadvantaged women. In accordance with my midwifery philosophical stance and the focus of this research, woman-centred care, women are positioned as the focus of discussions. Registered midwives’ and student midwives’ understandings provide social and contextual information in relation to maternity care encounters for socially disadvantaged women. Chapter 10 - *Reflecting on new understandings: implications for midwifery practice, education and research*, addresses the follow-up question presented to participants, “How might maternity care encounters be more woman-centred for socially disadvantaged women?” Possible implications for midwifery and maternity care, midwifery education and future midwifery research opportunities are discussed in relation to understandings gained from this study. It is also in this final chapter where I reflect on and evaluate my research processes. Limitations and possible improvements in the research process are discussed.

8 Collective findings: a summary of understandings

Findings presented in the last three chapters show that maternity care encounters are likely to disempower socially disadvantaged women. Women participating in this study did not receive maternity care that could be described as woman-centred. Women² recounted maternity care encounters in which they had no choice, control or continuity of care from a known midwife. Their needs did not take precedence and they had no choice regarding location, environment or timing of their maternity care encounters. They had no control over the model of care allocated or the health care professional present for each maternity care encounter.

8.1 Choice

Women expressed it is unsafe to have choice within maternity care encounters. Fear around choice appeared to result from inadequate contextualised information being provided to them by health care professionals; the woman's sense of responsibility for the health of her baby and the actions and reactions of midwives when seeking choice and control. Socially disadvantaged women did not appear to receive sufficient individualised information to be involved in their maternity care, given there was no discussion around evidence or the rationale for routine health care practice. Options or alternatives to routine health care practices were not discussed. When health care information was offered it was presented in a format unacceptable to women. Health information leaflets were compared to tourist brochures with lots of generalised irrelevant information. It appeared that information that was not perceived as relevant to the individual woman was ignored and that socially disadvantaged women did not read health information leaflets. Midwives did not take time to discuss information in the leaflets.

² Throughout this chapter the terms 'socially disadvantaged women', 'registered midwives' and 'student midwives' are used. However, the findings and the terms used, refer only to participants of this study. There is no attempt to generalise these findings to all socially disadvantaged women, registered midwives or student midwives.

Midwives articulated that socially disadvantaged women's low health literacy levels are the reason for poor participation and engagement in health related decisions. Midwives did not, however, translate this awareness into an understanding that they need to take responsibility for providing women with evidenced based information that facilitates involvement in maternity care encounters. During maternity care encounters midwives were reported to provide a corporate dialogue and to disseminate information leaflets that met public health agenda. These health information leaflets were described, by midwives, as the means to coerce women into complying with expected health care practices. Responsibility for contextualising health information for the individual woman was not accepted by all midwives. While some midwives spoke of the emotional and physical exhaustion that can result from attempting to meet every woman's needs, other midwives said that it is beyond their role and responsibility to provide additional time and information for women. These midwives report that when women seek additional information, or ask questions arising from the midwife's dialogue, the woman is advised to seek information from other sources. This action is inconsistent with other midwives' understanding that socially disadvantaged women have low health literacy levels which can prevent access to reliable sources of information.

The socially disadvantaged women in this study wanted to be involved in, and informed of, health related choices. It is suggested that limited health care knowledge and inadequate provision of contextualised information from midwives results in socially disadvantaged women conforming, mostly without question, to instructions from the midwife. This action of acceptance is a consequence of the woman accepting responsibility for the health and well being of her baby. Without adequate information to make an informed decision, the woman delegates control and responsibility for choice to the health care professional to ensure the best outcome for her baby. In contrast, registered midwives and student midwives in this study did not recognise that women make a considered decision to shift control and responsibility for their health related choices. These women were viewed as passively conforming without engaging in conscious decision-making, and were judged as neglectful of their baby's health. The midwives perceived that socially disadvantaged

women do not have the same capacity to care about, or accept responsibility for choice within their maternity care encounters as non-disadvantaged women. In summary, the findings suggest that women and midwives have different understandings of what constitutes involvement and active decision-making within maternity care encounters.

8.2 Control

There is a hierarchy of control within the maternity care environment. All three participant groups appeared to understand that midwives have limited power or control within the maternity care environment. Doctors were seen to have more authoritative control over clinical decision-making than midwives, and midwives were seen to have greater control than women. Students and midwives also communicated that local health district management has control over midwifery practice including workplace policies and models of care provided.

Student midwives recounted instances where midwives manipulated women's choices. Women who engage in decision-making but make a choice that is considered unsuitable or inappropriate by the midwife are harassed and bullied. Midwives attempt to change the woman's decision. When the woman upholds her decision, she is made to feel that she is a "bad" mother; ignorant of the possible health consequences for her baby. While these midwives said that women need to take on the responsibility for decision-making and accept the consequences for their choices, midwives' actions, according to participating women and students, did not align with this understanding. Midwives fail to provide the conditions in which women can have control.

Socially disadvantaged women spoke of their choices being ignored within maternity care encounters. These women understood that they were outsiders to the maternity care system with no sense of medical belongingness, and therefore no authority within maternity care encounters. Women said that they had no control regarding maternity care options made available to them. Local health district management was seen to control what maternity services are available for women and models of maternity care offered. Eligibility criteria to gain access to the models of care available and the number of positions

available in each model of care are also controlled by local health district management. These women expressed acceptance of their powerlessness as a reality of their social and financial positioning.

Women's choices, regardless of the decision-making process, are not valued by health care professionals, with the rationale behind their decisions being questioned. When women question health care professionals' directions, they are seen to be aggressive and ignorant of the health consequences for self and baby. Equally, when they conform unquestioningly, they are seen to lack concern regarding the consequences for their baby. When women are judged as unable or unwilling to be involved in the decision-making process, the midwife assumes a greater degree of control within the maternity care encounter. Women see pregnancy as a physically and emotionally vulnerable time in their life. They attempt to avoid conflict with health professionals during their maternity care for fear of care being affected, allowing the midwife to take on a greater degree of control. These women, however, also communicated that to have their needs met and choices accepted, they needed to be assertive – like a "Bolshy cow". Socially disadvantaged women, who resist pressure from midwives to conform to preferred choices, are viewed by midwives and students as ignorant and aggressive. Conversely, participating midwives articulated that when a woman chooses not to conform to policies and local health district protocols, the midwife's clinical competence and professional accountability is questioned. Responsibility for poor birth outcomes, regardless of decision-making processes is often positioned with the midwife.

8.3 Continuity of carer

Midwives who worked in continuity of carer models of practice said they are more able to provide woman-centred care than midwives working in non-continuity of midwifery carer models of practice because of their ability to establish ongoing relationships with women. Midwives working in non-continuity models of practice also spoke of their inability to provide woman-centred care, due to their inability to provide continuous midwifery care. Student midwives, in observing midwives in the clinical environment, reported

concern about their prospective abilities to provide or maintain care that is focused on the woman, through the provision of continuity of midwifery carer models of practice. These students appeared to recognise that woman-centred care is largely absent in the clinical environment, reporting only a small number of instances where the midwife was able to make themselves available for the woman. These instances of ‘being available’ were always associated with continuity of midwifery carer models of practice. While continuity of carer constitutes one element of woman-centred care, the absence of it allows registered and student midwives to blame ‘the system’ for not providing the other elements of woman-centred care.

Midwives and students value midwifery-led continuity of carer models of practice above other models of midwifery care. Midwives and student midwives understand continuity of care models of midwifery practice are of superior quality and that Midwifery Group Practice midwives are the “good” midwives. However, women in this study describe a good midwife as one who says hello and goodbye during the maternity care encounter, takes the time to be available and listen to the woman, provides information relevant to her needs, and keeps the woman informed of what is occurring regarding her health as well as the health of her baby. Furthermore, women describe their maternity care encounters as a game of chance; they may or may not encounter a “good” midwife. While most women express a desire for continuity of carer, some women express a preference for non-continuity of midwifery carer models of maternity care. These women spoke of the relief when the “*horrible ones*” left at the end of a shift. Women preferring non-continuity of carer models of maternity care are concerned continuity could result in continuous care from a “*horrible one*”. It is recognised that these women did not experience continuity of midwifery carer.

8.4 Precedence of the socially disadvantaged woman’s needs

All participants expressed that the needs of the local health district and/or individual health care professional are valued over those of the socially disadvantaged woman’s: efficient running of the local health district takes precedence. Midwives speak of maternity services and support for socially

disadvantaged women that shift in focus according to funding and national health priorities, not according to the needs of local birthing women. Socially disadvantaged women attend their maternity care encounters at a venue and time that meets the requirements of the local health district. Hospital rules and regulations deny women's emotional needs, and the physical environment fails to meet women's physical or emotional needs. Women express empathy for midwives, acknowledging their inability to meet the demands of the maternity care environment. Women talk about how midwives prioritise their daily tasks and that women with physical needs take precedence over those with psychosocial or emotional needs. Ward routines, institutional requirements and workplace culture prevent/inhibit midwives from meeting the more complex needs of socially disadvantaged women. The needs of socially disadvantaged women are not valued within a maternity care environment that values task completion. Socially disadvantaged women require more time than that allocated to a task focused model of care.

Maternity wards are described by students and midwives as meeting the needs of the institution rather than women and their families. At the same time socially disadvantaged women describe the in-patient experience as isolating and lonely. They compare the maternity ward to being in gaol with enforced rules and visiting hours, lack of privacy and a sense of abandonment. Women are largely ignored by midwives and other health care professionals. Women can not recall the names or roles of the health care professionals they encountered during hospitalisation. There is no attempt by maternity staff to establish relationships with women. All participants said that fragmented models of practice, workplace culture, busyness and the physical environment limited midwives' ability to provide care focused on the needs of individual women. The blame for midwives' inability to be available for the woman is positioned with local health district management, rather than individual midwives.

8.5 Collaborative consultation of socially disadvantaged women in maternity service provision

Dialogue around socially disadvantaged women's involvement in maternity service provision is lacking in all three participant groups. Women did not talk of being consulted about maternity service provision and student midwives did not speak of socially disadvantaged women being involved in the development and provision of local maternity services. Midwives, while not directly discussing socially disadvantaged women's involvement in maternity service provision, spoke of their "reduced abilities" and opportunities "to be involved in their care" at the individual level. Midwives understand that limited prospects for participation in decision-making processes prior to pregnancy, at both personal and community levels may hinder socially disadvantaged women's understanding that they can be involved in their care. Midwives talk of constant changes to maternity services which impact on their ability to support women with complex needs. They express frustration that neither they nor women are consulted or involved in the changes.

8.6 Conclusion: an understanding of woman-centred care

It is evident from all three participant groups that one or more of the elements of woman-centre care, as defined by the Royal College of Midwives (Royal College of Midwives, 2001), are absent within the maternity care encounters of socially disadvantaged women. In relation to the primary research question, "*How do socially disadvantaged childbearing women, registered midwives and student midwives understand woman-centred care?*" participating women had a different understanding of the midwifery concept and maternity care philosophy of woman-centred care than participating midwives and students. While participating women spoke of the actions and interactions within individual maternity care encounters as being either woman-focused or not, midwives and students spoke of the models of care that support or hinder woman-centred care.

Findings from this study suggest that socially disadvantaged women experience instances of maternity care that they describe to be woman-centred. Care that focuses on the individual woman is understood to be

woman-centred regardless of the model of care or midwifery context. Participating women describe care as woman-focused when:

- The midwife acknowledges the woman's presence at the commencement of each maternity care encounter by saying 'hello';
- The midwife asks the woman what she wants to know during the maternity care encounter;
- The midwife allows sufficient time for the woman to voice her needs and concerns;
- The midwife listens to the woman;
- The midwife follows through on what they say they will do; and
- The midwife concludes the maternity care encounter by saying 'good bye'.

When the midwife provides instances of care that incorporate these actions, the woman understands that she is the focus of care. The maternity care encounter is interpreted to be a positive experience and the woman understands she is valued as a partner in her maternity care.

Although women spoke positively of continuity of carer, this understanding was based on continuous care from their local doctor. While continuity of carer can facilitate the conditions in which woman-centred care is achievable, care episodes described by participating women as woman-centred were based on their experiences of single maternity care encounters with midwives and other maternity care health professionals.

Participating registered and student midwives however, understand that continuity of midwifery carer is the critical element in the provision of woman-centred care, and the absence of continuity of midwifery carer models of practice prevent the woman receiving care that is woman-centred. In addition, all participating midwives, including those working in continuity of carer models of practice, understand that woman-centred care, or care that focuses on the woman, is not achievable when workplace practices require institutional needs take precedence. These midwives and students speak of restrictive workloads, limited midwifery resources and support process, and medical domination of the maternity care environment as preventing the implementation of woman-

centred care practices. Participating registered and student midwives describe woman-centred care as:

- Non-existent for socially disadvantaged women in the absence of a continuity of midwifery carer model of maternity care;
- Not possible in maternity care environments in which workplace practices require that institutional needs take precedence; and
- Not achievable in the presence of medically dominated workplace environments.

When the midwife understands woman-centred care is not possible outside a continuity of midwifery carer model of practice, this understanding can be conveyed to student midwives, new staff and the recipients of care – the woman. The status quo is maintained and woman-centred care as understood by midwives and students is not possible.

No one element can define woman-centred care, and no person but the woman can determine if she has been a recipient of woman-centred care. It is time for midwives, and other health professionals working in the maternity care environment, to consider how care described by the woman as woman-centred can be implemented within every maternity care encounter. The following chapter presents new understandings of maternity care encounters co-constructed through the interpretative processes of participants and myself.

9 New understandings

In this chapter I talk about maternity care encounters involving socially disadvantaged women throughout their childbirth continuum, current midwifery practice and maternity care environments, and student midwife learning experiences. I will highlight current literature that focuses on these issues in relation to the three themes of significance in this study - '*feeling safe*', '*feeling valued*' and '*being available*' that were found to be common for all three participant groups. These themes, offered as discussion topics, form the remainder of this chapter.³

I now understand that in order for a woman to have choice and a sense of control within her maternity care encounters, she needs to feel safe to have a voice. As well, the midwife needs to feel safe enough to release control and to share responsibility for choice with the woman. In order for students to learn to become woman-centred midwives they must feel safe to explore, question and be with midwives able to work to their full potential within any model of care or midwifery context. Both the woman and midwife need to feel valued in their roles in the childbearing process. The woman, as the centre of decision-making processes, needs to feel that she is heard and that her needs are important. The midwife, as the link between the woman and her local health district, needs the midwifery role of guide and guardian to be seen as important and respected by colleagues, local health district management and other health professionals. Students also need midwifery to be valued by management and others so they can maintain their desire to work within a midwifery framework. In order for the woman to feel her needs take precedence, the midwife needs to be available for the woman during maternity care encounters. It is difficult, however, for the midwife to be available for the woman, or student midwife, when support and resources for midwives are not available within current maternity services.

³ While discussions presented in this chapter reveal similarities that may lead the reader to conclude participants were involved in and recounting the same maternity care encounter, participants from the different groups did not interact with each other during their recounted maternity care encounters

9.1 Feeling safe

Within midwifery literature, the terms safe and safety are primarily used to discuss the physical health of the woman and/or her baby. The context for application of these terms is most often in relation to birthing outcomes or the birthing environment. There is minimal literature using the term 'feeling safe' in relation to the psychological well-being of childbearing women throughout the entire childbirth continuum. However, this concept is visible in the literature pertaining to mental health issues and pregnancy (Austin, 2004; Eagle Williams, 2011; Marks, McConnell & Baker, 2005). While there is a growing body of literature around emotions in midwifery (B. Hunter, 2004, 2005, 2006, 2009) and the psychological stress of midwifery work (Copp, 2010; Klein, 2009), studies tend to focus on a particular midwifery context, such as continuity of midwifery care models of practice (Gu, Zhang & Ding, 2011; Stevens & McCourt, 2002), the labour and birthing event (John & Parsons, 2006; Leinweber & Rowe, 2010), or workplace practices and environment (Birch, 2001; Knezevic et al., 2011). I was unable to locate any literature using the term 'feeling safe' in relation to the experiences of either socially disadvantaged women, registered midwives or student midwives and which covered the entire childbirth continuum and multiple midwifery contexts.

I use the term 'feeling safe' with a new midwifery understanding. Feeling safe within the maternity care encounter describes a state in which the woman and midwife can interact without fear of perceived or actual psychological (or physical) harm. The woman is guarded and guided by the midwife to experience maternity care encounters in a manner she chooses, free from controversy. The midwife offers the woman a sense of being protected against emotional or psychological harm during maternity care encounters. Feeling safe in the context of socially disadvantaged women and maternity care is comparable with the concept - cultural safety, which requires health care professionals to create conditions that enable the less powerful to comment with safety. The aim of cultural safety is to benefit those that nurses and midwives serve, with the potential to ultimately improve humanity (Ramsden, 1992). Similarly, the midwife needs to be guided and guarded by maternity service management to work autonomously to the midwife's full potential

within the model of care in which they practice. This understanding of feeling safe can be accommodated for student midwife learning as well, with the student guided and guarded, by the midwife, to learn to be a woman-centred midwife. When students are not guarded and guided by their registered colleagues, students do not feel safe to engage in learning to be woman-centred within the clinical context (Begley, 2002). I define the midwifery term ‘feeling safe’ as - *being without fear of perceived or actual psychological (and physical) harm; being guided and guarded to seek and experience maternity care encounters free from unnecessary controversy*.

9.1.1 Feeling safe within maternity care encounters

Women in this study did not feel safe to engage in decision-making processes, to have a voice or have choice within maternity care encounters because:

- Their strong sense of responsibility for the physical health and well-being of their baby endorsed conformity with suggestions and decisions made by midwives; women chose not to make a decision outside their scope of knowledge because midwives know best;
- Their self-acknowledged poor health literacy levels, coupled with an understanding that midwives were unlikely to provide information that would enable participation in decision-making processes; and
- Any attempt to have control over decision-making processes was largely ignored, dismissed or judged disapprovingly by midwives.

Responsibilities: “they know best”

These women were responsible for the physical health and well-being of their unborn baby and viewed midwives as having the knowledge and decision-making capabilities that would ensure the best outcome for self and baby. They largely conformed to instructions and directives from midwives “*because they know best*”. Women participating in this study wanted to be seen as responsible and, therefore, good mothers, by making decisions accepted by health care professionals. They transferred responsibility for decision-making to the midwife for fear a wrong decision would result in being judged as irresponsible or a bad mother. Jomeen (2006) interviewed 10 pregnant women

in early pregnancy to explore the rationale behind their choices for maternity care. Although Jomeen did not specifically look at socially disadvantaged women and her study examined women's choice around models of maternity care, responsibility for the physical health and well-being of the baby was a major finding. According to Jomeen, the continuing presence of medical discourse along with the undercurrent that childbirth is risky reinforces women's understanding that they are unqualified to make the 'risky' decisions associated with childbearing. Women in Jomeen's study voiced the same understandings as women in the current study - they wanted to be seen as responsible mothers and make the right choices for their baby. The right decision was seen as handing control for maternity care choices over to the person/s qualified to make such important decisions, the health care professionals.

Women participating in the current study trusted their midwife to provide the information and guidance that would result in optimal maternity care outcomes. Any desire to question the midwife, however, was minimised when the midwife, viewed as the expert, advised a course of action with an authoritative presence; portraying the course of action as best practice. Although women in this study articulated that midwives failed to guide them in their choices, the women understood that midwives had a greater body of knowledge and that midwives' knowledge was superior in relation to childbearing than their own. These women persisted, therefore, in transferring responsibility for maternity care decisions to the midwife, even when the midwife ignored their need for information. This finding is supported by Blix-Lindström, Christensson and Johansson (2004) who also found that decisions made by midwives were accepted by women regardless of the level of information or guidance provided. In this study the researchers did not specifically explore socially disadvantaged women's experiences and the context for women's decision-making processes was augmentation in labour. However, both the women in the current study and those in the Blix-Linström et al. study refrained from decision-making when they considered their knowledge to be poor on the subject. When the midwife fails to guide the woman in her choices by withholding information or providing insufficient

information that is relevant, timely and contextualised, the woman is effectively silenced. The midwife prevents the woman from engaging in maternity care choices.

Midwives participating in the current study did not fully acknowledge they were instrumental in limiting socially disadvantaged women's choices. They voiced a degree of choice was provided. These midwives conformed to the dominant workplace culture and did not offer choices outside the accepted and expected options; they implemented a professional protective mechanism to maintain their sense of 'feeling safe' within their workplace culture. In addition, when women sought care choices that went against the accepted and expected options offered by the midwife, midwives voiced that blame could be more easily positioned with the woman. This understanding around blame and personal responsibility was shared by participating women, thus promoting compliance to the maternity care customs of that maternity service. These socially disadvantaged women did not want the responsibility for maternity care choices because they were aware of their lack of medical knowledge in determining possible health outcomes. The need to 'feel safe' in decision-making overruled the woman's need for control and the midwife's desire for autonomy of practice.

Findings from the current study would suggest that differing decisions by a midwife and socially disadvantaged woman can transpire early within a maternity care encounter without the other's knowledge. While these socially disadvantaged women transferred responsibility for maternity care decisions to the midwife, the midwives and students sought to allocate or re-locate responsibility to women. Neither player in the encounter seemed aware transference of responsibility had occurred. Furthermore, women participating in this study transferred the responsibility for maternity care decisions to health care professionals during the first maternity care encounter, with responsibility for maternity care decision-making not fully reclaimed until discharge from the maternity service, after giving birth.

Women in the current study were of the understanding that midwives and other health care professionals retained responsibility for maternity care

decisions throughout the entire childbirth continuum, while midwives understood that responsibilities shifted throughout the childbirth continuum. These midwives voiced that women have greater control over maternity care choices during pregnancy and the postnatal periods, with a shift in control and responsibility for choice to the midwife during labour and birthing. Some midwives in this study communicated that an acceptance of increased responsibility for decisions made during labour and birth by midwives was due to the consequences of choice being more immediate, observable and measurable. These midwives expressed that their midwifery colleagues as well as other health professionals placed the responsibility for variations from normal progress in labour and birthing as well as poor birth outcomes with the midwife, not with the woman. Positioning of blame with the midwife was seen to occur regardless of the decision-making processes.

Participating midwives articulated that women have a large degree of control and responsibility for choice following the birth of their baby, specifically in their role as a mother. This understanding suggests that these midwives permitted socially disadvantaged women to have a greater level of choice when choices did not directly impact on the midwife's professional reputation or practice. However, the midwives' voiced transferring of responsibility back to women was contradictory to participating women's recounted experiences. Women in the current study understood that they were not involved in postnatal decision-making processes anymore than their antenatal or intrapartum choices. In the period following birth, when these women expressed a sense of vulnerability, they communicated that midwives bullied them to conform to infant feeding methods championed as best practice.

Providing maternity care information: we know best

Midwives participating in this study voiced that socially disadvantaged women have a reduced capacity to be involved in maternity care decisions. These midwives articulated that difficult life circumstances associated with social disadvantage reduces a woman's capacity to engage in her maternity care encounters. Socially disadvantaged women were viewed, by these midwives, as either not caring about their maternity care to the same degree as women who are educated and non-disadvantaged, or having inadequate health

knowledge to participate in decision-making. There seemed to be no understanding by these midwives that the woman's perceived inaction during maternity care encounters is not subsequent to her reduced capacity to care about herself or baby. Rather, socio-cultural controls and life circumstances reduce the socially disadvantaged woman's ability to take affirmative action when a health care issue presents.

Midwives in the current study communicated that they did not spend time discussing issues that were not specifically raised by socially disadvantaged women because of the women's lower levels of understanding and reduced capacity to care about or engage in their health care as much as more educated women. There was little acknowledgement by these midwives that midwifery time needs to be allocated to providing relevant information to socially disadvantaged women in order to enable engagement in decision-making. Furthermore, participating women voiced that midwives did not take the time to listen to their needs, allow questions or explain maternity care information. These women understood that midwives were too busy for their questions.

These findings resonate with those of Kirkham, Stapleton, Curtis and Thomas (2002a) who found socially disadvantaged women were treated differently by midwives, compared to non-disadvantaged women. The study by Kirkham and colleagues was part of a much larger, multi-centred study involving 15 maternity units and hundreds of women, midwives and other health care professionals in England and Wales between the years 1979-1999. This phase of Kirkham and colleagues study reports on findings from observed midwifery antenatal care visits in relation to the inverse care law. The inverse care law, first described by Hart (1971), proposes that those with the greatest need for health care support are the least likely to receive it. The midwives observed in the study by Kirkham and colleagues used non-verbal communication techniques that informed women of the midwives' busyness. The maternity care encounter was completed without the woman asking questions. The midwife's routine question to the woman, "any questions?" was communicated in a way designed to suppress questions and inform the woman that the encounter was drawing to a close. This finding from Kirkham

and colleagues is explored further in this chapter under the heading - *Unavailable: not seeing the midwives*, where I describe and discuss the midwives' mumble.

Midwives participating in my study articulated that they were more likely to take control, albeit unwillingly, over decision-making when they understood the woman to have insufficient knowledge, or inclination to participate in decision-making processes. However participating students communicated that midwives seized a greater level of control around decision-making in the maternity care encounters of socially disadvantaged women, because this group of women were culturally programmed to be submissive to the authoritative power of midwives. This understanding is supported by Habibis and Walter (2009) who state that social disadvantage creates a sense of distance between groups, with value judgements identifying one group as inferior to the other. This in turn creates a cultural reality of domination and subordination. Socially disadvantaged women in the current study may have learnt to be submissive in their participatory role through encounters with various health and welfare departments prior to their maternity care encounters. When midwives assume control over choice within the socially disadvantaged woman's maternity care encounter without negotiation, the action can reinforce the woman's understanding that midwives have authoritative control. The woman is silenced and the midwife can perform their midwifery tasks in a more efficient manner while maintaining the institutionalised maternity care encounter.

Although participating midwives and students voiced that socially disadvantaged women needed to accept responsibility for maternity care decisions, they also communicated an understanding that socially disadvantaged women have low health literacy levels and complex life situations that make it difficult to focus on maternity care issues. Both registered and student midwives in this study conveyed that socially disadvantaged women want midwives to tell them what to do. "*They say "you know best."*" The woman's attempt to transfer responsibility for health related choices to the health care professional was described, by midwives and students, as a negative action on the woman's behalf. Bluff and Holloway

(1994) however, suggest it is reasonable for women to hand over responsibility for decisions for which they are made to feel they have insufficient understanding to make. Eleven women were interviewed by Bluff and Holloway in the early postnatal period. Women were asked to recall their midwifery care experiences during labour and birth. While this study focused on the birthing context and did not specifically target socially disadvantaged women, the authors concluded that information provided by midwives encouraged women to hand over responsibility. A midwife's communication practices can both position and maintain the midwife as the expert within the midwife-woman relationship.

Although registered and student midwives participating in the current study voiced that socially disadvantaged women need to be responsible for researching information necessary to make informed choices, this understanding was in contrast to other voiced concerns that socially disadvantaged women can be inept at accessing and absorbing health knowledge due to their life circumstances and educational deficits. While Bluff and Holloway's study (1994) was undertaken sixteen years prior to the current study, the recounted experiences of women in this study would suggest communication patterns involving midwives and socially disadvantaged women have not shifted in accordance with the principles of woman-centred care introduced in 1993 (Department of Health, 1993). Student midwives in the current study communicated similar understandings to the women in Bluff and Holloway's study when they spoke of midwives influencing women's decisions through the permitting or denying of choice and the creation and preservation of an environment, by midwives, that ensured that women conformed to preferred options.

Student midwives in the current study had contradictory understandings regarding socially disadvantaged women's attempts to release responsibility and control over choice. While students expressed that it is wrong for women to hand over responsibility for choice to the midwife, they also acknowledged that midwives often create and maintain the conditions that ensure women transfer responsibility. This contradiction in understandings is similar to those of participating midwives. Students' understandings may have been influenced

by the midwife role models they were exposed to during clinical placements. These students may have been enculturated to the dominant views of their professional colleagues prior to graduation. The term enculturation refers to a person's acquisition of accepted behaviours, beliefs and actions that belong to a socially constructed group or culture, in an attempt to be recognised as a member of that group (Glover, Longson, Hutton & De Bellis, 2001). In contrast to a plethora of literature on the enculturation of nursing students into the workforce environment post graduation, there is minimal literature that focuses on the enculturation of midwifery students prior to completion of their midwifery education program. While exploring the experiences of student midwives who had previously completed a nursing degree, Bluff and Holloway (2008) examined the influence of midwife role models on student midwife experiential learning. The authors reported that student midwives copy behaviours of midwives with whom they work; therefore all midwives are role models. Student midwives can learn to be woman-centred and autonomous in their practice, or institutionally-focused and subservient to the medical profession, depending on the midwife role models and midwifery context in which they are enculturated.

While participating midwives also spoke of socially disadvantaged women needing to accept responsibility for their choices, they did not acknowledge that they were responsible for providing the women with the conditions to enable control and allow choice. These midwives also failed to understand that the woman was likely to have made a choice. The only choice over which she truly had control; to delegate responsibility for health related decisions to the midwife, and maintain control over her non-health related maternity decisions. These women acted in a similar manner to health professionals. They made a referral regarding their maternity care to a more qualified person when decisions were outside their scope of knowledge or practice, as a woman. Registered and student midwives in this study did not appear to understand a considered and responsible choice had been made by the woman.

The women communicated that it was difficult to have choice when information needed to make a decision was either not provided, or presented in a format that inhibited choice. They described health information leaflets as like tourist

brochures on display in motels, with a generalised one-size-fits-all document that lessened their desire to read the leaflets. They also communicated that midwives did not follow-up the distribution of leaflets with a discussion about content. There was no individualising or contextualising the content for these women. Findings from the current study echo those of Stapleton, Kirkham, Curtis and Thomas (2002) who found that women's perception of leaflets were that they made little difference to their ability to exercise informed choice. Furthermore, while midwives provided women with information during antenatal care visits, they rarely checked if women needed or understood the information. Interestingly, midwives in the current study supported participating women's views regarding the power of information leaflets to facilitate informed choice. These midwives described health information leaflets as documents outlining the risks in not conforming to the expected and accepted behaviours of their maternity service. Health information leaflets were seen as encouraging women to conform to public health strategies, routine screening procedures, and behaviours sanctioned by the local health district. While midwifery discourse refers to midwifery actions and conditions that empower women, the provision of health information leaflets without contextualising content reduces choice and control. This allows the local health district and individual midwife to maintain that information has been provided to enable the woman to make an informed choice, while effectively implementing a risk minimisation strategy.

All participants voiced that the absence of continuity of carer was the reason midwives failed to provide contextualised health information, with the woman required to provide the same, and at times, sensitive information to different health professionals numerous times. Midwives, regardless of the model of maternity care in which they worked, spoke of the difficulties and personal costs in meeting expectations to provide follow-up to test results, planned care arrangements and individualised information. Participating women however, communicated that there was never an attempt to enquire as to what health information they required during maternity care encounters. Furthermore, these women voiced a concern that time was often wasted during maternity care encounters trying to follow-up results from prior visits and re-asking

questions previously answered. The women recognised that this time could have been spent inviting them to speak of their concerns or needs. These women wanted more information that focused specifically on their needs, rather than information they perceived the midwives wanted to impart. The re-doing of tasks reduces the time that midwives can be available for the woman; to meet the woman's needs and provide relevant information to facilitate decision-making processes.

Women participating in the current study shared similar experiences to women in a study by McCourt in 2006. McCourt examined communication patterns between women and midwives in three different models of maternity care; conventional, community midwifery and caseload midwifery. It was found that women receiving conventional maternity care, that is, a non-continuity of midwifery carer model of maternity care provided in a hospital environment, asked fewer questions and the midwife lead the conversation. Midwives in conventional care models, when compared with community midwifery or caseload midwifery, were also more likely to offer women standard information without enquiring as to what women wanted to know (McCourt, 2006). Furthermore, a study by Blix-Lindström and colleagues (2004) found that women wanted more information than was offered by midwives and more information than was indicated by their observed decision-making behaviour. Women valued sense of control over choice more than the act of choosing (Blix-Lindström et al., 2004). Hence, while women may choose to transfer responsibility for decision-making to the midwife, they continue to want the information and to have choice regarding their level of involvement. Continuity of midwifery carer models of practice are best suited to reducing the duplication of tasks and to facilitating midwife-woman interactions in which the woman is more able to seek contextualised information and feel in control.

Every which way but choose: “they make you feel so bad”

Participating women did not feel safe to have choice or a voice in their maternity care encounters. These women understood that their choices could be ignored or judged inappropriate by midwives. Despite midwifery claims that women have a body of personal knowledge and are the experts of their own

body, these women understood that their decision-making processes were not valued. Women participating in this study voiced that they wanted their needs heard when giving birth and to be protected from health care professionals who bullied them. These women wanted someone to advocate for them, to guard their choices; they did not want to fight to have their needs met during their maternity care encounters. Fahy and Hastie (2008) discuss the term guardianship in relation to a midwife working with a woman during the labour and birthing process. The midwife guardian preserves the boundaries of the woman's birthing environment to ensure the woman's wishes are upheld, with the woman empowered regardless of the birthing outcomes (Fahy & Hastie, 2008). Although the concept of guardianship is discussed in relation to the birthing environment, women in the current study voiced that they want midwives to be their guardians throughout the childbirth continuum.

Socially disadvantaged women participating in this study spoke of midwives bullying and harassing them when choices made were in opposition to midwives' preferences. These women communicated that their choices were often viewed by midwives as inappropriate or irresponsible with the midwife attempting to coerce the woman to make what they considered the correct health choice. Women participating in this study conveyed that choice, control and precedence of the woman's needs were absent from discussions with midwives around infant feeding. Women in this study who chose not to breastfeed, without a midwife-determined 'valid' reason such as a sick infant, described how they were made to feel that they were bad mothers. "They make you feel so bad". Although much literature has been published regarding bullying and midwives (Bluff & Holloway, 2008; Commisso, 2005; Curtis, Ball & Kirkham, 2006; Hastie, 2006), the literature usually focuses on interdisciplinary or intra-disciplinary workplace bullying. Almost no literature was available on midwives bullying women. One article published in 2010 by Dietsch and colleagues explored women's experiences of leaving their communities in remote and rural regions of Australia for maternity care in larger centres (Dietsch, Shackleton, Davies, McLeod & Alston, 2010). The authors report that these women experienced what could be described as bullying behaviours by midwives (Dietsch et al., 2010). Although the bullying by midwives was not

limited to Aboriginal women, encounters involving bullying behaviours were more common amongst the recounted experiences of Aboriginal women, who are often socially disadvantaged. Women in the current study recounted instances of bullying behaviours by midwives. These women were socially disadvantaged, a marginalised sub-group of childbearing women. Participating student midwives recounted similar observations of bullying behaviours, by midwives, towards socially disadvantaged women. It may be that women from marginalised and disadvantaged minority groups are more at risk of bullying behaviours from midwives.

Registered and student midwives in this study viewed women who did not conform to a course of action recommended by the midwife as arrogant and ignorant of the possible health consequences for their baby. Women who questioned information presented by the midwife, seeking additional information, were described by midwives as aggressive and irresponsible regarding the possible health consequences for their baby. However, women who conformed unquestioningly were also considered to be lacking concern regarding the health outcomes for their baby. When socially disadvantaged women make a non-verbalised decision to follow the midwife's advice they are viewed as non-engaging; ignorantly conforming. All decisions by socially disadvantaged women therefore, whether they are verbalised or not, can be viewed as inappropriate by the midwife, with socially disadvantaged women positioned in a no-win situation. The possibility that the woman has made a well thought out choice was not considered by students or midwives.

Responsibility around choice needs to be equally shared by the woman and midwife. Although these midwives voiced that socially disadvantaged women's low health literacy levels contributed to their poor engagement in health related decisions, they did not translate this awareness into an understanding that it is midwives who need to take responsibility for providing socially disadvantaged women with the relevant information. It is midwives who need to allow additional time to explain and contextualise maternity care information so the woman can be involved in her maternity care decisions. Without sufficient understanding, the ability to have choice is reduced and the woman is more likely to conform to the options provided by the midwife. Participating

students conveyed that socially disadvantaged women were coerced to follow directives from midwives under the banner of making responsible choices for their babies.

Responsible decision-making by a socially disadvantaged woman appeared to entail listening to options presented by the midwife, engaging in minimal and affirming discussion around proposed options, verbally selecting an option deemed appropriate by the midwife, and then seeking confirmation the correct decision was made. When the woman made a verbally announced choice that aligned with the midwife's view, it was considered a responsible and therefore correct choice. Interestingly, McCourt (2006) reported that women's knowledge and understanding of information required to make a maternity care decision was not questioned when they conformed to the health care professional's desired course of action. However, women who selected a course of action deemed inappropriate by the health care professional were questioned as to their understanding of the information and possible consequences of their choice.

Furthermore, participating midwives acknowledged that even choices, by women, deemed appropriate can be disregarded by health care professionals, including midwifery colleagues. These midwives spoke of decisions made collaboratively with the woman, prior to entering the labour and birthing environments, being dismissed by labour ward midwives. Midwives working in birthing suites were seen by other midwives to use their position to change pre-determined labour and birthing care choices made during pregnancy. These midwives understood it was the absence of continuity of midwife carer that allowed the woman's choice to be ignored in later maternity care encounters. When the relationship is ongoing a decision made collaboratively between a woman and midwife is more difficult to ignore or vary without further negotiation between both parties. While continuity of midwifery carer does not guarantee that equal input from both parties will ensue, or that the decision will be upheld, the relationship that develops between a woman and midwife within a continuity of midwifery carer model of practice creates the conditions for a more inclusive decision-making process. It is easier for midwives working in continuity of carer models of practice to assist and support women's choices.

Non-continuity of midwifery carer models of practice make it more difficult to preserve a woman's decisions in future maternity care encounters.

Participating midwives and students also voiced their concerns that socially disadvantaged women's choices were not always beneficial to the health and well-being of the woman, her baby or family. When midwives and students made negative comments about socially disadvantaged women's non-health related maternity choices, it reinforced their judgements that women's maternity care choices were likely to be inappropriate. This action and reaction justified the dismissal of socially disadvantaged women's maternity care choices. Furthermore, participants from all three groups articulated that permission to engage in decision-making processes must first be granted by the health care professional/s involved in each maternity care encounter. The degree of authoritative power midwives demonstrated directly affected the level of control these women understood they were able to achieve within their maternity care encounters. The midwife therefore, must be willing to give up their position of power in order for the woman to have greater control and choice. Jomeen (2010) comments that midwives need to be aware of how they influence childbearing women's decisions within the maternity care encounter. In asserting their own professional power, as a maternity care expert, midwives limit women's control over choice.

Midwives may be unwilling to furnish control to the woman when they see their ability to have control within maternity care encounters is already limited. Midwives in this study did not feel safe to allow the woman to have control over choice. They did not feel safe to work with the woman to their full scope of professional practice, placing control for decision-making with the socially disadvantaged woman, when decisions were seen to directly affect their professional standing within the maternity environment. Midwives participating in this study spoke of the "*witch-hunt*" culture with midwifery colleagues, medical staff and management scrutinising every aspect of the midwife's actions and decisions when care outcomes were less than ideal. Maintaining ignorance around choice, therefore, positions a greater degree of control with the midwife, affording a measure of protection from professional and personal persecution within the maternity care environment. These midwives

understood they were shielded to some extent against blame when they maintained control around decision-making. Being shielded from shame or blame was dependent upon the level of control and choice they allowed the woman and degree of adherence to the health service's preferred directives of care. Figure 9.1 reveals the shame and blame decision-making framework that promotes the midwife's need to maintain control over decision-making within maternity care encounters.

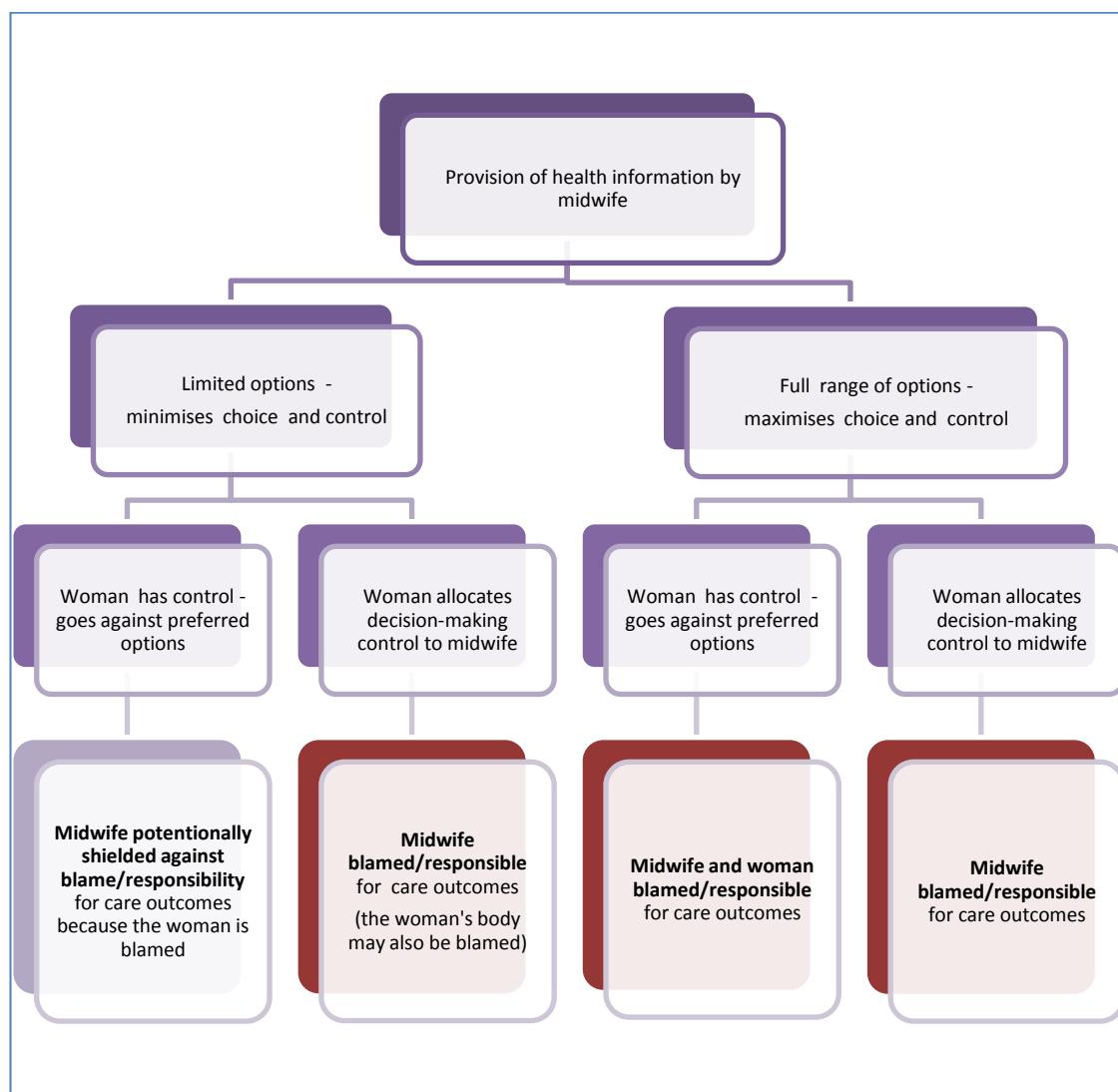


Figure 9-1 Shame and blame decision-making framework

All participants in this study understood that a woman's maternity care choices were less likely to be taken into consideration when the woman was socially disadvantaged. While socially disadvantaged women were described by some midwives as having the same capacity for choice and control within their maternity care encounters as any woman, these midwives also recognised the capacity for choice and control was greater for women in continuity of midwifery carer models of maternity care. All participating midwives voiced that socially disadvantaged women were less likely to receive continuity of midwifery carer models of maternity care, with their care options limited from their first maternity care encounter.

Participants in all three groups communicated that the local GP dictated which local health district the socially disadvantaged women were to attend for maternity care. Although participating women understood their local GP restricted their maternity care options, they did not recognise that the booking-in midwife at their local hospital equally influenced the model of maternity care they would receive. Participating midwives, however, did recognise the potential gate-keeping qualities of the booking-in midwife. Participating midwives spoke of the booking-in midwife allocating models of maternity care to socially disadvantaged women based on the midwife's personal biases and agendas. Students and midwives in this study understood that a woman faces a similar situation, when encountering the booking-in midwife, to that which took place during her initial visit with the local GP. The venue and model of maternity care is allocated by the booking-in midwife with little or no discussion. The woman is not involved in care option decisions.

The process of allocating models of care to women without discussion or collaborative decision-making processes continues because of women's continuing trust in the experts (Bluff & Holloway, 1994; Jomeen, 2006, 2010). Women participating in the current study did not recall being involved in discussions around which local health district they would attend for maternity care or which model of care would best meet their needs. These women accepted the maternity care model allocated by the midwife (who they perceived as the maternity care expert), as the midwife knew what was available and would best suit their needs. Interestingly, when a socially

disadvantaged woman is allocated a medicalised, non-continuity of midwifery carer model of practice, where higher rates of medical intervention are likely to occur, the consequences of intervention can result in the need for further medical involvement. The documented maternity care outcomes then reinforce the booking-in midwife's understanding that a decision to position the socially disadvantaged woman in the medicalised and non-continuity of midwifery carer model of practice was justified. Her reality is validated and subjective gate-keeping maintained.

A midwife's understanding that socially disadvantaged women need to be allocated to a medicalised model of maternity care can be understood when one considers the birth outcomes of socially disadvantaged women. A systematic review of socioeconomic disparities and adverse birth outcomes, published in 2010, clearly demonstrated social disadvantage was consistently associated with an increased risk in adverse birth outcomes including babies born premature, low birth weight or small for gestational age. The review included 106 studies published between the years 2000 and 2007 from similar countries, as determined by membership of the Organization for Economic Cooperation and Development (OECD) (Blumenshine, Egerter, Barclay, Cubbin & Braveman, 2010). However, other methods of measuring birth outcomes reveal discrepancies in outcomes even for well women with no identified risk markers. Tracy, Sullivan, Wang, Black and Tracy (2007) examined the association between medical interventions during labour and birth and mode of birth, over a three year period in Australia. The study involved 363,794 women, identified as low risk. While the authors disclosed their definition of the term low risk and the proportion of primiparous and multiparous participants, they did not make known demographics related to social disadvantage. Tracy and colleagues reported that the adjusted odds ratio for low risk primiparous labouring women receiving a combined intervention of augmentation of labour and epidural anaesthesia was 8.07 times greater for an instrumental birth and 52.18 times higher for a surgical birth. For low risk multiparous women, the same combination of medical interventions resulted in an adjusted odds ratio for an instrumental birth 12.32 times greater and 30.63 times greater for a surgical birth (Tracy et al., 2007).

In light of these findings, the allocation of socially disadvantaged women to a medicalised model of maternity care further disadvantages this group of childbearing women by increasing their odds of instrumental or surgical births.

All participant groups spoke of medical staff having the highest degree of control in relation to socially disadvantaged women's maternity care choices. Decisions made prior to a doctor entering the maternity care encounter were often seen to be dismissed in favour of the doctor's preferred course of action. Participating women recognised that midwives were silenced by doctors, and they, as outsiders with no medical belongingness, articulated that they had even less power to take control or have a voice. These women understood that they were lower in the decision-making hierarchy than the midwife or doctor. A woman is not the centre of care, but the object of care. These women communicated that midwives were unable to guard them against medical interventions, ward routines or rules that were contrary to care actions that focused on their needs. Midwives were viewed by these women as incapable of guarding the woman so that she could 'feel safe' within her maternity care encounter because the midwife was equally powerless when a doctor entered the decision-making equation. In addition, women in this study understood that midwives often supported medical interventions, ward routines and rules that women wanted to be guarded against. Midwives were seen to enforce the rules regardless of the woman's needs or the midwife's voiced philosophy of care. This understanding is supported by Porter, Crozier, Sinclair and Kernohan (2007) who observed the decision-making strategies of 16 midwives working in antenatal, birthing and postnatal wards, in two maternity units in England. The maternity units provided both midwifery-led and physician-led maternity care. While the authors did not make explicit whether the midwifery-led model of care provided continuity of carer, participating midwives understood their working environments to be medically dominated. Porter and colleagues (2007) observed midwives working in these units employed one of three models of decision-making within their maternity care encounters. The first model involved a collaborative process or partnership between the woman and midwife. The second model involved unilateral decision-making by the midwife, based on the midwife's perceived

expertise or professional knowledge. The third and most common model of decision-making involved a bureaucratic decision-making process, with adherence to the policies and procedures of their workplace environment. The partnership model of decision-making was the least likely strategy to be used (S. Porter et al., 2007). While the authors did not disclose if socially disadvantaged women were the recipients of care in their study, similar justifications were offered by midwives for not involving women in decision-making processes as were offered by midwives in the current study. Firstly, that midwives are more likely to take control over decision-making processes and maternity care choices when women are deemed not interested in or incapable of participating in decision-making process. Secondly, medical dominance within the workplace environment supports institutionally focused decision-making strategies rather than woman-centred processes.

When the woman's and midwife's maternity care decisions can so easily be disregarded within maternity care encounters, midwives may withhold information and choices that they understand can be ignored or dismissed by doctors or maternity service management. This behaviour is a protective mechanism for the midwife. Midwives need to 'feel safe' in offering their body of knowledge and working to their full potential. Maternity care encounters need to occur within an environment in which the woman 'feels safe' to take control and participate in decision-making, and midwives 'feel safe' to release control, guiding and guarding the woman in her choices. Conditions that can facilitate both the woman and midwife in 'feeling safe' within maternity care encounters are discussed further in the next chapter – *Reflecting on new understandings: implications for midwifery practice, education and research.*

9.2 Feeling valued

In order for a socially disadvantaged woman to feel safe enough to have a voice and choice within her maternity care encounters, she needs to understand her needs are valued; the woman needs to '*feel valued*'. I define '*feeling valued*' within the midwifery context as - *being highly regarded; considered with respect or importance through the actions and reactions of the maternity care culture*. For the socially disadvantaged woman to feel valued, she needs to understand her needs will take precedence over those of the local health district and her voice within maternity care encounters is respectfully considered. For the midwife to feel valued within the maternity care environment, their professional identity and ways of working with-woman need to be respected by midwifery colleagues, maternity service management and other health professionals. Equally, for the student midwife to feel valued, their need to learn and their future midwifery voice needs to be respectfully considered within the maternity care environment.

9.2.1 Valuing socially disadvantaged women: “*treated like a number*”

Socially disadvantaged women participating in this study did not believe that they were the centre of their maternity care. These women described the impersonal nature of their maternity care experiences and felt that they were treated as an intruder or outsider in the system; a burden that needed to be dealt with in the most efficient manner. These women communicated that there was no evidence that their individual needs were to take precedence, or that they were valued as a partner in their maternity care encounters. Participating student midwives supported this perspective when they described maternity care encounters in which care decisions were made without input from the woman. Decision-making processes were seen to be based on the individual health professional's beliefs regarding the woman's personal situation, physical condition, or the needs of her baby. Socially disadvantaged women's contributions in decision-making processes were observed, by students, to be discounted. When midwives failed to include women in collaborative decision-making processes, these students understood that the socially disadvantaged woman viewed the midwife as an

expert. The midwife's decision-making processes were valued over the woman's; the woman was silenced within maternity care encounters.

Students and midwives in this study communicated that socially disadvantaged women were required to meet the needs of the maternity service, rather than the service meeting the needs of the individual woman. Furthermore, participating women described being "*treated like a number*" in a system designed to be efficient in meeting the institution's needs. All participants articulated that socially disadvantaged women's life circumstances or needs were not considered when arranging maternity care activities and services. There was no collaboration or partnership, involving women, regarding maternity care choices. Government departments and local health district management were viewed as responsible for determining options of care and choices available at a broad level, that is, at the maternity care services level. Individual health care professionals make decisions for socially disadvantaged women at the local level, that is, during maternity care encounters.

Participating women expressed an acceptance that their care was understood to be of inferior quality compared to the care received by women able to pay for maternity services. The perceived inferior quality of care experienced by these women was understood to be a direct consequence of their financial positioning - poor people receive poor quality maternity care. Student midwives voiced similar understandings to those of participating women in relation to an acceptance of the status quo. These students described a sense of helplessness in their ability to change a maternity care service that they understood to perpetuate discrepancies and inequalities in the provision of health services to socially disadvantaged women. Participating students understood that socially disadvantaged women's needs were not valued and that local health district management needed to take responsibility for changing the efficiency-focused medically dominated maternity care environment. These students verbalised that altering the status quo and changing maternity services to more closely align with the needs of women was beyond the power of midwives or student midwives. This understanding is strongly supported by previous research around obedience, compliance and

the maintenance of the status quo within maternity care environments (Hollins Martin & Bull, 2006; Kirkham, 1999; Pollard, 2010).

Hollins Martin and Bull (2006) interviewed midwives with varying years of experience, to assess the rationale behind conforming to routine practices within maternity care environments and Pollard (2010) explored how midwives' discursive practices related to the status quo of their maternity care environments. Midwives in Hollins Martin and Bull's study understood hospital policies were an "agent of domination", developed and maintained by the dominate group to disempower subordinate groups. The midwife's ability to practise autonomously was diminished and any attempt to deviate from the expected and accepted practices of the unit was quietened. Midwives rarely challenged the status quo of their workplace or deviated in their practices to provide woman-centred care. Pollard expanded on the issue, concluding that midwives' clinical practice generally reflects the midwifery context in which they provide care. Midwives working within a hospital based, and medically dominated, maternity care environment largely followed the policies and rules of the environment. Compliance by midwives to accepted practices was maintained through fear of conflict with senior colleagues and staff (Hollins Martin & Bull, 2006). This understanding is explored further under the chapter heading - *Valuing midwifery: it's my way or the highway*. Midwives in Hollins Martin and Bull's study also feared the possibility of an abnormal birth outcome and spoke of the "war crimes court" that would transpire should an abnormal birth outcome result, with colleagues and other staff scrutinising their practice (2006). These findings illuminated why midwives in the current study may have expressed feeling unsafe in guiding and guarding women in their full range of choice. Midwives in this study also spoke of having their practice scrutinised with the term "witch-hunt culture" used to describe the processes that follow a poor birth outcome.

While concerned with the negative aspects of current maternity service operations, women participating in this study also understood decisions made by their local hospital when they acknowledged the limitations in public funding and health resources. They conceded that the public health system needed to be efficient in meeting the needs of a large number of people, and not the

individual woman. These women understood that little can change for them; their needs were not valued as highly as others. For these women “others” included childbearing women perceived to be physically unwell, women with an infant that was unwell, doctors, busy midwives and their colleagues requiring assistance, management and administrative staff; that is everyone else. When the needs of everyone else are considered to be more important, the woman’s understanding, that her needs are valued less, are reinforced. Participating women understood that because health resources need to be allocated to those with greater need, the quality and provision of their own maternity care was unlikely to change. *“It’s just the public system is the way it is with the hospital”*. The understanding by women this study, that the public health system uses its resources in the best possible manner, echoes those of women in a study by Porter and Macintyre over a quarter of a century ago (1984). Women in this study largely accepted the status quo of maternity care and were satisfied with the care they received. Their satisfaction was based on the assumption that the model of care received, information provided and decisions made for them, were well thought out and therefore the best available to suit their needs. The women understood that health care professionals and health service management were the experts in maternity service provision. Being experts they would act in the best interests of service users (M. Porter & Macintyre, 1984). While women in the current study acknowledged that the public health system needs to use resources in the best possible manner to meet the demands of many, they were not satisfied with the care they received. Twenty six years ago women spoke of the “production-line atmosphere” (M. Porter & Macintyre, 1984). Socially disadvantaged women in the current study still speak of the “factory processes”. Perhaps the biggest shift in the status quo for socially disadvantaged women’s maternity care is, that while the women in this study accepted the care they received to be a consequence of their socioeconomic positioning, they also recognised the care received and conditions under which care was provided was not the best available. Women in this study wanted a relationship with their maternity carer, regardless of the carer’s profession. They understood that maternity care could be better for socially disadvantaged women.

Valuing difference: “cattle class people”

Student midwives in this study voiced that the public health care system appears to have two levels of care; one for socially disadvantaged women and one for non-disadvantaged women. The better quality midwifery care or “*secret midwifery practice*” with continuity of midwifery carer was seen as more often available for non-disadvantaged women. Students expressed that socially disadvantaged women were more often allocated to non-continuity of midwifery carer models of maternity care, with both students and women in this study speaking of standard hospital based models of maternity care as similar to processing plants. Furthermore, women viewed midwives working in the maternity ward as factory workers, constantly processing people and tasks. Student midwives described socially disadvantaged women as being treated like “*cattle class people*” with their maternity care encounters compared to the processing of cattle in a milking plant. Student midwives understood that these women were viewed by midwives and the maternity service as different and therefore treated differently. The concept of seeing those not belonging to one’s own socially constructed group as different has been in the literature for many years and has been discussed under the terms discrimination (Bowler, 1993), stereotyping (Kirkham, Stapleton, Curtis & Thomas, 2002b), and othering (J. Johnson, Bottoorff & Browne, 2004). Johnson and colleagues describe othering as the “process that identifies those that are thought to be different from one’s self or mainstream and it can reinforce or reproduce positions of domination and subordination” (2004, p. 253). All three participant groups in this study understood that care options and maternity care services for socially disadvantaged women were inferior to the options of care and services available for other childbearing women. However participating students and midwives frequently voiced stereotypical comments and understandings concerning socially disadvantaged women. Green (1990) points out that the stereotyping of service users supports the establishment and maintenance of perceived needs and therefore existing processes. However, Green also suggests that stereotyping can be lessened when health care professionals are able to establish relationships with service users. When the midwife does not know the woman it is easier to stereotype

by appearance and communication patterns (1990). Interestingly, most of the midwives in the current study worked in a continuity of midwifery carer model of practice and the students were involved in Continuity of Care Experience relationships. Both groups of participants were in positions that facilitated the formation of relationships with the women of whom they spoke. The voicing of stereotypical comments regarding socially disadvantaged women's lifestyle and health care choices by these midwives and students, demonstrates that the capacity to build relationships does not guarantee stereotyping can be abolished. There are other factors that maintain stereotyping within the maternity care environment.

While the focus of this study was the maternity care experiences of socially disadvantaged women with no specific cultural demographic selected, students voiced that there were groups of socially disadvantaged women, who were least likely to have their needs valued. Student midwives communicated that women who differed in racial, ethnic and cultural backgrounds to those of the maternity care environment were even less likely to have their needs met in comparison to other socially disadvantaged women. Women with obvious differences in views, values and practices to those belonging in the maternity care environment have greater difficulty in making emotional connections with health care professionals. As discussed previously, midwives can find it more difficult to form relationships with women with whom they are unable to identify. Socio-cultural differences, therefore, place an additional layer of complexity over the socially constructed context of choice, power and relationships within maternity care encounters (Cheung, 2002).

Socially disadvantaged women were viewed by participating registered and student midwives as having different personal value systems to the remainder of society. These midwives and student midwives understood socially disadvantaged women were more likely to make poor lifestyle choices that contributed to their life circumstances. The difference in personal values between those of midwives and socially disadvantaged women were also seen to result in the challenging behaviours exhibited by socially disadvantaged women towards midwives. However, these midwives also spoke of "*character assassination*", collectively understood to mean condemnation of the woman's

character. Midwives communicated that character assassination usually takes place during shift handover, between midwives ending their shift and midwives commencing the next shift. When midwives use character assassination techniques during shift handover a collectively negative attitude towards the woman is developed and maintained, with midwives commencing maternity care encounters with pre-determined and culturally sanctioned attitudes of difference towards the woman.

Furthermore, participating midwives conveyed that socially disadvantaged women can be aggressive, hindering communication and the ability of the midwife to meet the woman's needs. These midwives did not appear to comprehend that (as stated by the participating women) socially disadvantaged women may need to be aggressive to have their needs met in a system where their needs and choices were dismissed. When midwives perceive the actions and reactions of socially disadvantaged women as being aggressive, they respond in accordance with the communication methods exhibited by the woman. However the midwife may have commenced the maternity care encounter with character assassination biases that coloured the interaction. Kirkham et al. (2002b) concluded that midwives often stereotype and categorise women to protect themselves from what they regard as unreasonable demands on their midwifery time and attention. Stereotyping the woman with complex needs as demanding, uncooperative, uninterested or non-complaint enables the midwife to keep control in a work environment that values task completion. Furthermore, when the woman is seen as causing a problem, either through poor communication or emotional distancing, the woman is also seen as responsible for rectifying the situation (Kirkham et al., 2002b). I would argue, however, that blaming the individual only applies to the woman and not to the individual midwife. When midwives in the current study were unable to value the socially disadvantaged woman within the immediate maternity care encounter, the fault was not seen as residing with the midwife but with constrictive work practices. Failure to meet the needs of the socially disadvantaged woman is positioned with either the individual woman or the maternity service, not the individual midwife.

Students in the current study supported participating midwives' understandings regarding the challenges of working with socially disadvantaged women. These students communicated that working with socially disadvantaged women was hard work. Again the complex psychosocial needs of socially disadvantaged women were seen as more difficult to address than the physical needs, which could be met through the completion of tasks. Students however, spoke of midwives avoiding women with complex needs and attempting to discharge or refer these women onto other services. These students positioned the blame for observed failure in meeting the needs of socially disadvantaged women equally with the midwife and local health district management. While students blamed management for not providing sufficient resources and time to support midwives in being available for socially disadvantaged women, they equally blamed midwives for not wanting to spend time with women with complex needs. Although participating students articulated that women, who require more support than can be provided within the immediate maternity care encounter, are not catered for, they also voiced that socially disadvantaged women require a disproportionate amount of midwifery time. The understanding that socially disadvantaged women require unreasonable amounts of midwifery energy or time would suggest that these students appeared to have adopted the prevailing understandings of participating registered midwives – that that completion of maternity care tasks and the meeting of immediate physical needs are more achievable, measurable and therefore valued within the maternity care environment.

Students participating in this study were all registered nurses undertaking a post graduate qualification in midwifery. These students, therefore, may have assimilated the dominant professional values of midwives, within the maternity care environments in which they undertook their clinical placements, faster than midwifery students who are not nurses. The need for a sense of belongingness in the maternity care workplace culture may be stronger for midwifery students who have previously worked as a nurse and therefore experienced a sense of belonging within a health care culture. Equally, student midwives who had previously not experienced a sense of belonging within a

health care culture may have a stronger need to become an insider and therefore assimilate the core values of the unit in which they undertake clinical placement. Although the previously mentioned study by Hollins Martin and Bull (2006) involved registered midwives and their need to avoid conflict and intimidation from senior staff by conforming to expected ways of being, a similar need was expressed by student midwives in the current study. For student midwives however, all registered midwives were viewed as senior staff. Furthermore, participating students desired a position as a registered midwife upon graduation, within the maternity unit in which they were undertaking clinical placements. Failing to belong was viewed by these students as jeopardising their future employment prospects.

Midwives participating in my study also spoke of the rewards of working with socially disadvantaged women. They described the personal satisfaction and pleasure they experienced when socially disadvantaged women had what was viewed by the midwife to be a 'good birth', or when the woman returned to the hospital to visit the midwife following the birth of her baby. While socially disadvantaged women were described by participating midwives as needing more support than non-disadvantaged women, when these midwives were able to meet the socially disadvantaged woman's needs it was described as emotionally rewarding. Being able to meet the needs of a socially disadvantaged woman can be seen as an act of altruism by midwives. Post (2005) found that doing good for others increases one's perception of self-efficacy, competence and improves psychological well-being. These findings support an earlier study by McCrea and Crute (1991), who examined midwives' understandings of midwife–woman relationships. Interviews were undertaken with 16 midwives working in a community midwifery team in Northern England to explore their understandings of what constituted a good or bad midwifery relationship. Midwives described how important it was to them to be valued by the woman. A good relationship constituted the woman acknowledging the midwife's help, with the relationship described as rewarding when the woman asked to have a specific midwife for her care (McCrea & Crute, 1991). The findings of these authors from two decades ago resonate with the views expressed by midwives participating in this study.

Midwives in the current study always portrayed working with socially disadvantaged women as rewarding. However, they also described the work as challenging, exhausting and emotionally draining. There was no discussion by midwives as to whether working with socially disadvantaged women was more rewarding than working with non-socially disadvantaged women. It may be that participating midwives were too uncomfortable to voice their individual views of working with socially disadvantaged women within a focus group setting. These midwives may have verbalised that working with socially disadvantaged women was rewarding because it was a culturally sanctioned response. Equally, as discussed in the last paragraph, they may have achieved personal psychological benefit from working with socially disadvantaged women; fulfilling their need to be valued. Findings from the current study may have been different if midwives were interviewed individually. Group pressure to voice a collective view can be strong in maintaining professional identity. Stapleton, Kirkham, Thomas and Curtis (2002) found that midwives employed and promoted self-censorship to reduce the risk of undermining their midwifery colleagues. Deery (2009) goes onto to say that midwives constantly calibrate their performances depending on who they are interacting with. She describes midwifery work as a drama played out within the cultural context of the maternity care environment, with midwives assuming a particular stage persona around colleagues that maintains their observed allegiance with the group's professional identity. Professional groups, including midwifery, have an image to uphold. For midwifery the underlying principles and philosophies of woman centred-care and partnership are valued and therefore held to be true for the group. When a group member disrupts the united front, impression management for the group is disturbed. Midwives who voice a different view to their professional group can be socially excluded and intimidated. Midwives need to conform; professional image must be maintained. Midwives in this study may have voiced the negative aspects of working with socially disadvantaged women as it was true for them. The inclusion of positive aspects always at the end of their recounted experiences may have been to ensure that their group membership was maintained as was their profession's collective image of valuing women.

Valuing the institution

Midwives participating in this study communicated that it was not possible to provide care that focuses on the needs of individual women in a maternity service that makes no allowance for, or recognition of, women's needs. Participating students observed that socially disadvantaged women requiring hospitalisation for non-medical reasons were considered, by midwives, to be a waste of public resources. The local health district was understood to value the health care dollar over the individual woman's needs. Midwives, through their actions and reactions to confined socially disadvantaged women, were perceived to be supporting the value structure of the local health district. Participants in the three groups spoke of the need for socially disadvantaged women to attend their maternity care encounters when and where the institution dictated. Length of stay was understood to be determined by the local health district, with maternity services developed, implemented and cancelled according to local health district needs. Registered and student midwife participants understood that local health district budgetary constraints, staffing requirements and public health agendas meant that the individual woman's needs were not considered. Participating women spoke more of local health district operational requirements that they saw directly affected their actions and interactions, such as admission times, discharge times, number and length of maternity care visits, the scheduling of visiting hours and number of visitors permitted to see the woman. These women also voiced that the operational requirements were planned and enforced by maternity staff, including midwives.

Participating women communicated that the maternity ward environment was designed to meet institutional needs. There was no consideration regarding the individual woman's requirements whilst in hospital. These women described hospital rules and regulations as illogical mechanisms, when considering the needs of childbearing women, which separated and isolated women from their support networks. Women in this study described being ignored by midwives when in hospital and yet communicated there was also a sense of surveillance. They described being watched while ignored, with the only protection from staff scrutiny being their bedside curtains. The

combination of hospital rules, surveillance, maternity ward routines and the isolating effect of the ward environment was compared to being in gaol. Similar understandings were described by women in a study undertaken in Ireland (Larkin, Begley & Devane, 2011). Larkin and colleagues explored the childbearing experiences of 25 women and, although the majority of women in the study were married and well educated, they also recalled feeling lonely and vulnerable within their maternity care encounters. The only times that women did not feel abandoned by maternity staff were during the stages of labour and birthing when a midwife was required to be physically present. These women described having a midwife present during the birth of their baby as a luxury. Women in both the current study and the Larkin and colleagues study described wanting someone, either a midwife or support person, to advocate for them - to guard against maternity care interventions they understood to be unnecessary. Women in the current study spoke of hospital regulations that require partners to leave the women alone. They expressed frustration and vulnerability when partners were made to leave and the midwives were not available for them. Women are emotionally and physically vulnerable within the maternity care environment; their sense of protection against hospital staff and routines is reduced when they feel abandoned.

Midwives participating in this study mirrored the views of the women when they spoke negatively of hospital policies and regulations. Participating midwives described many of the hospital rules as just a means to ensure women behaved in accordance with hospital operational requirements. However, participating women communicated that when they challenged hospital rules, midwives often exercised their position of institutional authority to encourage conformity. Midwives were seen as the enforcers of disempowering rules and regulations. These midwives may have supported and enforced hospital rules because they understood the rules were equally about ensuring they, midwives, acted in accordance with operational requirements. This understanding is supported by Stapleton and colleagues (2002), who imply that midwives are unable to support women in meeting their needs and may in fact restrict a woman's capacity for control and choice

within the maternity care encounter to ensure that they, the midwives, achieve a degree of power within the hierarchical structure of the maternity care environment. Furthermore, Hollins Martin and Bull (2006) found that midwives can feel obliged to follow hospital rules and policies, fearing the consequences of challenging the practices and beliefs of more senior staff. The fear of litigation and being ostracised by colleagues maintains conformity of written and unwritten rules. While Hollins Martin and Bull (2006), provide an explanation as to why midwives might encourage conformity of rules by women and their midwifery colleagues, Nolan (2003) questions whether midwives are able to empower women when they are part of a system that disempowers both women and midwives. Additionally, Porter and colleagues (2007) suggest that some midwives can be uncomfortable with shifting the balance of power towards the woman during decision-making processes. Placing the balance of power for decision-making with the woman can result in the woman not following hospital rules and policies. As discussed under the chapter heading – *Providing maternity care information: “we know best”*, the midwife is vulnerable in this position. Enforcing rules and regulations maintains a sense of control for the midwife.

Midwives were observed, by women and student midwives in the current study, to value and therefore prioritise workplace needs - the needs of individual women were a lower priority. Workplace needs were viewed as a high priority because of the pressure on midwives to complete tasks expected by local health district management. Stevens (2009) asserts that time, space and what processes are undertaken within particular timeframes and allocated spaces are controlled within health care institutions. Maternity services, in their need to meet the needs of many, develop and enforce institutional time that does not allow for individual differences or preferences of childbearing women, or meet the professional needs of midwives wanting to work to their full scope of practice. Hospital based midwifery practice is strongly regulated to conform to institutional time, enforcing task orientated work practices. Continuity of midwifery care is seen as a way forward in reorientating midwives towards a timeframe that accommodates childbearing women's physiological timeframe and the midwife's personal timeframe (Stevens, 2009).

Students in this study also described midwifery work within the hospital environment as being task-centred, with no observed difference between midwifery and nursing practices. Hospital midwives were portrayed by all three participant groups as being too busy to attend to the individual woman, with workloads and maternity ward routines seen as preventing midwives from being available to meet the woman's needs. Midwives, as individuals, are rarely blamed by women for not meeting their needs within a particular maternity care encounter. While the women in Larkin and colleagues' study (2011) described their maternity care experiences as being lonely and unsupported, they also accepted the non-availability of midwives as a consequence of system management. Again, the system was blamed in both the Larkin and colleagues' study and the current study for midwives' inability to be available, demonstrating that the woman is not valued within the individual maternity care encounter.

Student midwives also recognised that the maternity care environment required certain behaviours (or rules to be followed) regarding women with complex needs. These students saw midwives were culturally programmed to value tangible roles and responsibilities with measurable outcomes. Students voiced that midwives were "*stamped with the information that, this is how you do it in a complex situation*". These students acknowledged that midwives may have been acting in accordance with the culturally embedded value of task completion. It may have been easier for midwives to shift their values to meeting the immediate physical needs of the woman and routine task completion situations when the more complex psycho-social or emotional needs of the socially disadvantaged woman are more difficult to complete. Students understood that psychological and emotional support provided by midwives was not visible, and the long term health outcomes not measurable. Woman-midwife interactions absent of immediate visible or measurable outcomes are not seen to impact on local health district key performance indicators and are therefore not valued. Meeting a woman's psycho-social or emotional needs may not be valued by the midwife because they are not valued by the dominant workplace culture. Midwives are unable to tick a box and complete a task within the immediate maternity care encounter. For the

midwife, there is no external recognition that work has been accomplished. Midwives therefore place greater value on doing maternity care tasks, over 'being available' for the woman. Their midwifery worth within the maternity care environment is validated through task completion.

However, midwives in this study expressed their frustrations when attempting to support socially disadvantaged women with complex needs. These midwives described the difficulties they faced when their maternity service failed to provide the resources required to meet the more complex needs of women with emotional or psycho-social issues. Midwives spoke of services being discontinued, altered or moved to meet institutional requirements or public health agendas. They communicated a lack of input from women and midwives when planning or reducing maternity services. These midwives voiced that they were frustrated both for the women, who were without suitable services, and for themselves, who were no longer able to perform their role and refer appropriately. The frustration experienced by these midwives is understandable in light of McCrea and Crute's study (1991) that revealed midwives' sense of personal competence, confidence and job satisfaction was higher when they were able to do something for women. When midwives felt valued by the woman through their ability to meet the woman's needs their sense of midwifery worth was enhanced. Furthermore, any threat to the midwife's sense of worth impacted on the woman-midwife relationship (McCrea & Crute, 1991).

The collaborative involvement of women in the development and provision of local maternity services was one element of woman-centred care not directly mentioned by any participant in this study. The ability to value socially disadvantaged women's needs through involving them in the development and provision of maternity services is a pre-requisite for the achievement of the remaining elements of woman-centred care. That is, precedence of the woman's needs, choice and control within her maternity care encounters, and continuity of midwifery carer. A maternity service has little chance of meeting the needs of socially disadvantaged women when women and their voiced needs are absent from service and facilities planning and development and re-structuring. Absence of the socially disadvantaged woman's voice in local

health district planning and implementation processes not only ensures women's needs are silenced, the precedence of local health district needs and values are made transparent. A local health district, like any organisation, has values that are both shaped by and maintained through management styles and strategies (Carlopio, Andrewartha & Armstrong, 2005). Potential managers are recruited and remunerated while employees are rewarded for portraying organisationally sanctioned values. This in turn sets a preferred way of being within the organisation. This understanding 'rings true' with Stapleton, Kirkham, Thomas and Curtis (2002) who claim that the midwife-woman relationship is shaped by the midwife-doctor-management relationship operating within the maternity care environment. Local health district structures that value medically orientated work practices and managerial style operating processes will impact on the midwife's ability to practice woman-centred care. Through the absence of one element of woman-centred care, that is socially disadvantaged women's involvement in the development and provision of maternity services, the remaining elements are effectively negated.

9.2.2 Valuing midwifery: "*it's my way or the highway*"

Participating midwives voiced that their inability to work to their full scope of practice within their individual midwifery contexts resulted in them feeling not valued. Limiting the models of midwifery care available to socially disadvantaged women and the number of positions within models available demonstrates a precedence of organisational needs. These midwives communicated that managerial and medical control over midwifery models of care demonstrated not only a failure to value the needs of women but also demonstrated a failure to value midwifery as a profession. Midwives were of the belief that continuity of midwifery carer models of maternity care were prohibitive in cost and therefore unable to be expanded to meet the local birthing women's and midwives' need for non-hospital based models of care. This view was said to be conveyed by maternity service management. Midwives perception that midwifery-led care is more expensive than standard hospital care is contradictory to a recent economic analysis of birthing services for low risk women in the United Kingdom by Schroeder et al., (2012).

Schroeder and colleagues reported that birthing services provided in the woman's home cost the health service provider £1,026 compared to £1,510 for services provided in the hospital obstetric unit (Schroeder et al., 2011). While these figures are based on maternity services provided in the United Kingdom, Australia's maternity services are sufficiently similar to extrapolate that the savings to our health services would be comparable.

Participating midwives wanted to feel their professional knowledge and decision-making processes were valued by midwifery colleagues, management and other health care professionals. Midwives in this study communicated that their professional survival, however, was dependant on valuing and meeting the needs of the doctor, not the needs of the woman. These midwives conveyed that doctors were used to taking control within maternity care encounters - "*it's my way or the highway*". The midwifery body of knowledge was not seen to be valued within maternity care encounters by doctors and some midwifery colleagues. Professional survival for these midwives was attributed to emotional security and professional respect within the maternity care culture. Considering the need to preserve their sense of midwifery worth, it is understandable that a midwife might steer the midwife-woman interaction and decision-making process. Midwives who maintain a medicalised framework of interaction within the maternity care encounter are less likely to be marginalised by colleagues or have their practice scrutinised by those who value such interactions (Stapleton, Kirkham, Curtis et al., 2002). Within maternity care environments that value a medical model of care, the provision of woman-centred care requires the midwife to challenge the values sanctioned by their midwifery and medical colleagues, as well as management. According to Hollins Martin and Bull (2006), midwives that oppose the dominate workplace values expose themselves to workplace conflict with the risk of professional intimidation and social group exclusion. The risk is often deemed to be so high that conformity ensues. Pollard (2010), however, suggests that midwives may employ a medicalised framework of interaction to be recognised and accepted as a professional. It is the midwife's desire to be accepted and valued as a professional that motivates them to adopt the valued ways of acting and reacting within the maternity care

encounter. Some midwives, in their struggle to be acknowledged as a professional, may adopt the attributes of the professional group they understand has the power within their workplace. The result is professional dissonance for the midwife, who is unable to work with a woman to provide the conditions for mutual respect, trust, collaboration, partnership and shared power, while also taking on the position of expert.

Student midwives in this study discussed registered midwives' apparent ignorance regarding their task-focused midwifery practices in antenatal care clinics that were designated to be midwifery-led. These students questioned if the midwives they observed providing a medicalised model of care, recognised yet ignored their medicalised way of working, or were not overtly aware of their apparent inability to provide woman-centred care. Midwives who practise models of care in which incongruities between their professional philosophy and work practices are exposed may ignore the incongruities to protect their midwifery self-worth. Midwives were seen, by participating student midwives, to be 'doing nursing' tasks, rather than providing midwifery care in all areas of the maternity care environment. The exception to this observation was Midwifery Group Practice maternity care encounters. Midwives unable to practise what they understand to be woman-centred care may view efficient task completion and the offering of permissible choices to women, as a means to provide job satisfaction. This increases their midwifery self-worth and their sense of 'feeling safe'. Midwives working in a medically focused workplace with managerial dominance can receive greater managerial recognition of their midwifery worth when doing something for the woman that can be measured by the organisation. Although their midwifery worth can be classified as institutional worth, it is still valued within their dominant workplace culture. As discussed previously, midwives are habituated within a medically dominated workplace culture to place greater importance on task completion. When faced with competing needs, between those of a socially disadvantaged woman or those of the institution, midwives who have no established relationship with the woman may find it more difficult to align their practice to meet the woman's needs. The needs of a woman are more difficult to determine within the ever

present and pressing needs of the institution when there is no established woman-midwife relationship to frame the midwife's focus.

Both students and midwives who participated in the current study recognised that adequate time and resources were not allocated to midwifery ways of working. This was seen to be a consequence of maternity service management not valuing midwives or midwifery work. Midwives working in midwifery contexts with time and resource constraints may be unwilling to spend midwifery energy or time with women whose needs are unlikely to be met within the immediate maternity care encounter. It is more difficult to complete tasks within the immediate maternity care encounter when the midwifery undertaking is a psychosocial one that requires ongoing support. Over a decade ago Fahy (1998) asserted that the problem solving management styles of maternity care environments frame midwives' ways of working. Midwives working within a problem solving maternity care environment were more likely to 'do things to' the woman. 'Doing to' ensures institutional processes and results can be mapped and measured. Fahy also claimed that midwives who practise in ways that enable them to be 'with woman' are seen by management and colleagues to be 'doing nothing' (Fahy, 1998). Little appears to have changed in midwives' understandings and ways of working in hospital-based maternity care environments in the last decade. Socially disadvantaged women and student midwives participating in this study voiced that midwives were not available for the woman. Midwives were seen to prioritise 'doing things' or 'being available' for ward routines, colleagues and local health district requirements. The continuation of institutionally focused ways of working is understandable when one considers the consequences of going against workplace practices and policies. Stapleton , Kirkham, Thomas & Curtis (2002) drew attention to the transitory nature of the midwife-woman relationship in comparison to the midwife-maternity service relationship. Midwives are placed in an uncomfortable position when they align their ways of working with the needs of a woman rather than their workplace. The authors concluded that the majority of midwives "go with the flow" and follow the dominant workplace expectations of practice so their professional life is trouble-free (2002).

Midwives who measure their midwifery worth or value against efficiency of task completion employ a number of protective strategies to defend their inability to complete tasks when working with socially disadvantaged women. One strategy is to avoid working with women with complex psychosocial needs through staff allocation or woman allocation depending on the midwifery context. Another strategy is to blame the system, specifically workload pressures and non-continuity of carer models of practice, for their inability to be available for the woman. Finally, the midwife can blame the woman personally for her lifestyle choices and circumstances that make the meeting of needs too difficult. These midwives, in blaming the individual woman for her health status and personal life circumstances without taking into consideration the larger social, political and environmental issues, are employing what is termed 'victim blaming'. Tones and Tilford (2001) argued that viewing the individual patient in such a manner is essentially flawed and unethical from a public health perspective.

The student midwives also observed that midwives spoke disparagingly about socially disadvantaged women and their complex needs. As discussed earlier, under the chapter heading – *Valuing difference: "cattle class people"*, these students understood that midwives wanted women with complex needs to be discharged, or referred onto to other services, as quickly as possible. Midwives were viewed, by participating students, as wanting to shift the responsibility for meeting complex and ongoing needs of socially disadvantaged women. The midwife's need to shift responsibilities may be attributed to their need for self-worth, with self-worth achieved through the alignment of practices and values with those of the workplace.

Midwives working in Midwifery Group Practice (MGP) models of care were viewed by all other midwives and student midwives participating in my study as providing a superior model of midwifery care for women. Participating midwives not working in a continuity of midwifery carer model of practice understood their own midwifery practice to be inferior to those midwives working in MGP models of care. These midwives, therefore, understood their midwifery contribution within maternity care encounters was substandard - their midwifery worth was of less value to women and colleagues. These

midwives did not ‘feel valued’ professionally. Although midwives working in non-continuity of midwifery carer models of practice spoke highly of the care provided by MGP midwives, they were seen by the MGP midwives to be antagonistic regarding their workplace practices and customs.

While midwives working in MGP models of care understood that their midwifery colleagues viewed MGP models of care as woman-centred, they also understood their midwifery colleagues often opposed their presence and ways of working in the labour and birthing environments. They spoke of the hostility they experienced from midwives working in other models of care in the hospital environment. Midwifery Group Practice midwives recounted snide comments and gestures from midwifery colleagues when they entered or left the maternity care environment outside scheduled shift changes. Stapleton and colleagues (2002) proposed that the tensions between midwives who provide continuity of care models of practice and those midwives who do not, stem from the fact that not all midwives value continuity of midwifery carer models of practice to the same extent. Furthermore, midwives who prioritised women’s needs and provided what they considered to be woman-centred care, tended to under value their practice. Findings from this study contradict these findings as all participating student and registered midwives, including those working in continuity of carer models of practice, speak highly of midwives who visibly practised in ways that met the needs of individual women. One understanding is that the hostility or bullying that transpired between midwives working in different models of care stemmed from a sense of diminished midwifery worth. Midwives working in non-continuity of midwifery carer models of practice understood their midwifery worth was less valuable - they did not ‘feel valued’. When these midwives, intrinsically valuing woman-centred care, understood that woman-centred care was only possible within a continuity of carer model of practice, they possibly initiated bullying mannerisms to deflect their professional and personal discomfort. Bullying behaviours can also be initiated in order to coerce colleagues to conform to similar ways of working. Hastie (2006) reports that bully behaviours, or horizontal violence, is usually enacted to make others ‘fit in’ and is fiercest with

those perceived as most different and therefore the biggest threat to the culture existing within that maternity care environment.

When midwifery worth is aligned with a particular model of care rather than the midwife-woman interactions within individual maternity care encounters, midwives not working in the more esteemed model of care can be viewed as less valuable in midwifery terms. This way of viewing and valuing one model of midwifery care over another arose from a professional desire to provide best care for all childbearing women. In 1995 *The Midwifery Partnership – a model for practice* monograph was published in New Zealand by Karen Guilliland and Sally Pairman. The document was intended to be a descriptive model for midwifery practice based on a midwife-woman partnership, with woman-centred care as an essential aspect of the partnership. Although it was not their intention to divide midwives, Guilliland and Pairman stated “When midwives practise in an environment which excludes continuity of care, they cannot be described as practising midwifery...midwives who, for whatever reason, choose to provide fragmented care...are acting as midwives” (1995, pp. 35-36). This proposition has possibly imprinted on the Australian midwifery psyche and may, I believe, have contributed to the divisional valuing structures present within the midwifery profession. This stand is recounted in my study.

Interestingly, a second edition of Guilliland and Pairman’s monograph was recently published including an additional section that discusses the implementation of the Midwifery Partnership model in New Zealand over the past 15 years (Guilliland & Pairman, 2010). This edition considers the partnership model in relation to midwifery contexts such as hospital based midwifery care. The authors recognised that tensions existed between midwives working in continuity of carer models of practice and those who worked in non-continuity models of practice. While the authors did not elaborate on the nature of these tensions, they acknowledged that it took years for the tensions to resolve (Guilliland & Pairman, 2010). They also highlighted the change in relationships between midwives working in different models of care. They claimed that midwives working in continuity of carer models of practice and midwives working within hospital based models of care now work together, respecting each other’s knowledge to form partnerships

with the woman (2010). New Zealand maternity care services are well advanced in their implementation of woman and midwifery focused care options for childbearing women. This level of evolution in midwifery ways of working and valuing needs to be supported by the midwifery profession in all midwifery contexts in Australia.

9.2.3 Valuing midwifery students, education and future midwifery voices

Participating students communicated that woman-centred care and the elements that make up the concept woman-centred care are not valued within their clinical or academic environments. Their theoretical understandings of midwifery bore little resemblance to midwifery practice observed in the maternity care environment. Woman-centred care was viewed as a theory lacking in congruence with the existing midwifery reality of the hospital based maternity care environment. Student midwives in Ireland had recounted similar understandings 15 years earlier. In her 1995 study Begley interviewed 125 midwifery students in 7 midwifery schools across Ireland. She reported that students found the maternity care environment in which they undertook clinical placements too busy to provide woman-centred care. They understood maternity care provided within hospital environments was governed by workplace routines rather than the needs of individual women (Begley, 2004). Begley further claimed that maintaining an atmosphere of busyness reinforces the need to give ritualised care. Management-based systems of care are maintained and midwives work without examining their practice because they are too busy.

Student midwives in the current study communicated that they felt unsupported in their clinical learning of midwifery. They 'felt unsafe' to apply the midwifery understandings generated in their classroom to the maternity care environment. Students had questioned maternity service management, medical officers and midwives with whom they worked about observed maternity care practices and policies. They recounted being ignored, dismissed or intimidated into silence. Their voices were not valued. They did not see situations where midwifery theory, midwifery ways of working, or socially disadvantaged women were valued during their clinical placements. It

is probable, then, that these students will feel unsafe and unable to initiate woman-centred ways of working into their own midwifery practise following registration. This belief is supported by Bluff and Holloway (2008) who interviewed 20 student midwives and 17 midwives in various midwifery contexts in South England. They explore the influence of midwife role models on student learning in the clinical environment and found students were unable to distinguish between the written and unwritten rules of the maternity care environment. Observed practice within the maternity care encounter was a greater influence on student practice than verbal or written orders (Bluff & Holloway, 2008). Midwives who practise in ways that maintain medical dominance and system-based work styles enculturate student midwives to follow suit. Furthermore, a study by Levett-Jones and Lathlean (2008) explored the concept of belongingness in relation to student nurse learning, and although the authors examined student nurse clinical learning, their findings can be transferred to midwifery students. The authors concluded that the behaviour of registered colleagues with whom students spent their work day formed the most influential determinant of student learning and their sense of professional belongingness. A student's need to belong took precedence over their need to be clinically competent. When the student felt that they did not belong and sensed a lack of respect and acceptance by their registered colleague, cognitive impairment, reduced critical thinking skills and a failure to question practice resulted. Similarly, I believe, student midwives are equally vulnerable in their need to gain a sense of professional belongingness. They are equally vulnerable to becoming enculturated to the accepted ways of being in clinical placement environments that lack midwifery ways of being and woman-centred care models of practice.

Participating students spoke of the bullying culture that existed within their maternity care environments. These students described being verbally and, at times, physically abused by midwives. They conveyed a loss of self-esteem and confidence in their existing level of skill and knowledge as health care professionals. Students in the current study communicated that it was not only student midwives who were bullied by midwives. They recounted instances when midwives bullied new graduate midwives, junior medical officers and

other new staff members. All staff new to the maternity environment were seen to be at risk of bullying by midwives. New staff members may be particularly vulnerable to bullying by the midwife when the midwife has a diminished sense of midwifery worth or when their professional dissonance can be exposed. Student midwives, along with new staff members to a maternity care environment, are well positioned to expose the lack of congruence between a midwife's personal/professional philosophies and their midwifery practices. When the student, through their presence, exposes dissonance, the midwife can become consciously aware of the incongruities, resulting in professional and personal discomfort. Dissonance becomes more visibly obvious to the affected midwife when practice is compared with that of the student. Incongruous ways of working are reflected in what I call the midwifery mirror of dissonance: this results in personal and professional discomfort. The midwife responds by demeaning the student's way of understanding midwifery and midwifery education in order to preserve their self-identity and midwifery worth.

Similarly, the midwife may intimidate new staff members into conforming to practice in order to reduce personal and professional discomfort. The midwifery mirror of dissonance must be removed from view or covered to preserve midwifery self-worth. This is achieved by the new staff member leaving the maternity care environment and the reflection is veiled, or the new staff member conforms to the accepted ways of working and the reflection is comparable, comfort is restored. The workplace remains uncomfortable for both the midwife and new staff member when the mirror's reflective surface remains exposed. Many studies have discussed the bullying culture within midwifery and the pressure on midwives to conform to existing practices within the maternity care environment (Bluff & Holloway, 2008; Curtis et al., 2006; Hastie, 2006; Hollins Martin & Bull, 2006; Kirkham, 1999; Stapleton, Kirkham, Thomas et al., 2002). The bullying culture in maternity care environments that is currently perpetuated by disaffected midwives will continue unless the profession values the various roles and responsibilities of our midwifery colleagues. Professional dissonance can be reduced when we accept that there are multiple ways of providing what women perceive to be woman-

centred care and work together to provide that care. Midwives need to value their colleagues' midwifery contributions so that all midwives 'feel valued'.

Participating students also defended midwives' actions and reactions, suggesting midwives were possibly unaware that their behaviour was bullying in nature. Students reiterated the constant pressure midwives were under within the maternity environment, which they understood could lead to poor interpersonal communication. Although midwifery students and registered midwives participating in this study worked in different maternity care environments, students voiced similar beliefs and values to those of participating midwives. When student midwives defended midwives' behaviour, voicing similar understandings of socially disadvantaged women's lifestyle choices and the maternity care environment, they demonstrated a taking up of the self-protection mechanism used by midwives. Student midwives may do this in preparation for a time when they are unable to align their own midwifery ideologies and practise. They are covering their midwifery mirror of dissonance in readiness for what they perceive will eventuate following graduation.

Midwives were generally viewed by participating students as providing maternity care that met organisational needs rather than the individual woman's needs. Students in this study understood that most registered midwives they observed during clinical placements had knowledge of the midwifery concept woman-centred care but failed to apply the principles to their practice. Educating midwifery students about woman-centred care during their educational program, does not guarantee graduates will transfer their theoretical understandings into practice. These students communicated that registered midwives need to be reminded of the philosophical underpinnings of contemporary midwifery practice. Registered midwives need to continually engage in mandatory education to maintain congruence between their ways of working and midwifery's philosophical underpinnings of woman-centred care. In 2001, 94% of nursing and midwifery professionals practising in Australia had an undergraduate qualification or higher (Department of Education Science and Training, 2001). Although this statistic was not further analysed to reveal the percentage of practising midwives with a tertiary qualification, the

majority of Australian midwives must be aware of their professional responsibility to practise woman-centred care, either through formal midwifery education or the requirement to meet their national competency standards, which has woman-centred care as the overarching framework (ANMC, 2006). The midwifery concept and maternity care philosophy of woman-centred care has been a part of midwifery discourse for more than two decades and the largest group of Australian midwives practising are between the ages 35-44 (Department of Education Science and Training, 2001). It can be assumed, therefore, that the majority of practising midwives in Australia are aware, either through their initial midwifery qualification, post-graduate education or continuing professional development, of the concept of woman-centred care.

Midwifery students in this study also spoke of midwifery academia not truly valuing the philosophical underpinnings of midwifery. They understood that when the theory of woman-centred care was provided as a stand-alone module or only associated with normal birth and well women, it communicated to students that woman-centred care was not possible in other midwifery contexts. This understanding was reinforced in the clinical environment, where well women received continuity of midwifery carer models of practice and all other women, including socially disadvantaged women, received medicalised models of maternity care. Students expressed that there was no evidence of the elements of woman-centred care being provided outside the midwifery contexts of well women and Midwifery Group Practice maternity care encounters. Student midwives need to learn how to provide woman-centred care and to be available for the woman. Students are more likely to learn how to provide woman-centred care when they see such care in practice, regardless of the midwifery context (Begley, 2004; Bluff & Holloway, 2008; Levett-Jones & Lathlean, 2008). When the woman has more complex needs than the midwife is able to meet in the immediate maternity care encounter, students learn to ‘do for woman’ or to ‘do to woman’ and the medicalised and task focused maternity care environment is maintained.

Participating students voiced that the shortcomings of their midwifery education stemmed from the failure to integrate woman-centred care throughout their entire midwifery program. These students expressed that it

was not made clear through course content that woman-centred care is possible, regardless of the woman's circumstances, physical and emotional health, or midwifery context. Equally, participating midwives voiced concerns regarding student midwife education in the university environment. Midwives, however, articulated that midwifery students were being taught maternity care concepts and ways of working with women that do not exist in current maternity care environments. Furthermore, the participant midwives believe that maternity care reality and midwifery concepts taught in the university environment are not likely to match, even in the future! While student midwives wanted registered midwives to change their practices to align with current midwifery theories around woman-centred care, the midwives expressed that student midwives should refrain from learning midwifery theory and concepts that do not exist in the workforce. As the midwifery students participating in this study were recruited from a single university and were enrolled in a graduate diploma in midwifery program, the recounted educational experiences may be different to students enrolled in other universities offering postgraduate programs or bachelor of midwifery programs. These views, however, provide insight for midwifery educators and curriculum developers to be mindful of how woman-centred care is presented and assessed throughout each midwifery course and the midwifery program as a whole. When student midwives learn that it is hard to integrate woman-centred care into complex midwifery situations in the academic environment and this learning is reinforced on their clinical placements, then midwifery graduates are unlikely to feel safe to practise woman-centred care in all midwifery contexts.

All participants in this study articulated that socially disadvantaged women's needs are not acknowledged. Institutional and individual health care professionals' needs take precedence; the socially disadvantaged woman and her needs are not valued. The socially disadvantaged woman can only feel valued within her maternity care encounters when her needs take precedence over those of the local health district and her voice is respected as central to decision-making processes. Conditions that can enhance both the woman and midwife feeling valued within maternity care encounters are discussed further

in the next chapter – Reflecting on new *understandings: implications for midwifery practice, education and research*.

9.3 Being available

In order for a woman to feel valued, the midwife needs to be available to listen and act upon the woman's concerns, requests and needs. The woman needs to understand that the midwife is '*being available*' for her.

As discussed in chapter 3, midwifery as a profession is described as women assisting women to birth. Midwives are mandated by their title 'midwife' to be with-woman throughout the childbirth continuum. While the concept of being with-woman is not disputed, different terms have been used within midwifery discourse to describe how midwives interact with women during maternity care encounters. Terms have included 'spirituality of presence' (Pembroke & Pembroke, 2008), 'with woman' (Carolan & Hodnett, 2007) and 'being fully present' (Fahy, 1998). These terms, however, have been used almost exclusively within the context of continuity of midwifery carer models of practice and/or the labour and birthing environments. They have been used less frequently in relation to non-continuity of midwifery carer models of maternity care or maternity care encounters that occur outside the birthing environment. These terms can appear, therefore, to be restricted to particular midwifery contexts, alienating a large number of midwives currently practising in Australia.

The term 'being available' is about being there for the woman; ready, physically and emotionally each and every maternity care encounter, regardless of the model of care, duration of the maternity care encounter or midwifery context. I acknowledge that the term 'being available' is similar to the term 'being with woman' which is defined as "the provision of emotional, physical, spiritual, and psychological presence/support by the caregiver as desired by the labouring woman" (L. Hunter, 2002, p. 650). However, 'being available' is more closely aligned with Pembroke and Pembroke's term 'spirituality of presence' that draws on the concepts of availability and responsibility (Pembroke & Pembroke, 2008). As discussed in chapter 3, the concept of 'availability' was first introduced by the French philosopher Gabriel

Marcel. Availability assumes the carer, or midwife, within a midwifery context, is receptive and accepting of the woman and her family's experiences and needs (Lantz, 1994). The midwife actively participates with and for the woman so that the woman's needs may be met. The midwife is non-judgemental and demonstrates empathy in standing with the woman, ready to support her in the way that the woman requires. In doing so, the woman becomes aware that, in that moment, the midwife is focused on the woman and her needs.

While 'being available' is comparable to the term 'with woman' and 'spirituality of presence', 'being available' is more woman and midwifery inclusive than previously used terms when describing midwife-woman interactions. Women in this study spoke of midwives focusing on their individual needs within the maternity care encounter; "*...she actually stayed and...had a bit of a chat...it makes you feel important, that you know they actually care about you.*" Participating women also spoke of midwives that were unavailable; "*it's like the midwife's got her back to me, she's out the door again,...I was a little bit upset because I thought, you know, she's not really there for me*". 'Being available' is a midwifery term applicable to all midwife-woman interactions. Every registered and student midwife can recognise and use the term 'being available' within their own midwifery context. Being available is also a term that women can understand. Midwives can use the phrase within maternity care encounters, "I am available for you", to demonstrate their willingness to be there for the woman. Using a term that enables all midwives to understand that their midwifery contribution is valued can enhance their midwifery self worth.

I define the midwifery term 'being available' as - *being open to and ready for use or service by the woman. Having sufficient power or efficacy to facilitate the woman's intended outcomes for the immediate and, when appropriate, future maternity care encounter/s.* When the midwife is 'being available' for the woman, the woman understands she is valued. The woman, therefore, feels safe to have a voice and make a choice within her maternity care encounter.

9.3.1 Being available: making midwifery connections in “a positive way”

Midwives in this study acknowledged their professional role in supporting socially disadvantaged women. They spoke of continuity of midwifery carer models of practice as better suited to supporting a *“woman to start her mothering journey in a positive way.”* These midwives understood that continuity of midwifery carer models of practice can facilitate positive transformations for socially disadvantaged women. While they articulated that such a model presents some challenges for midwives in supporting women with complex needs, it was viewed as the best model of midwifery care to enable midwives to be available for women. Furthermore, non-continuity of midwifery care models of practice were associated with not being available for women. These midwives communicated that non-continuity of midwifery carer models of practice had no recognised positive influences on socially disadvantaged women’s health outcomes, life circumstances or psychological wellbeing.

Although participating women did not receive a continuity of midwifery carer model of maternity care, they recognised a positive influence on their experience when midwives were ‘nice’ to them. These women understood that being a ‘nice’ midwife involved spending time with the woman and being helpful in meeting her needs. Women can commence their mothering journey in a way that is determined, by them, to be positive when the midwife takes the time to be available for the woman and assist her in meeting her individual and self-determined needs. These women experienced a ‘nice’ midwife and therefore a positive experience in a non-continuity of midwifery care model of practice. The elements of what women describe to be a ‘nice’ midwife may be more achievable in continuity of midwifery care models of maternity care. The development of an ongoing woman-midwife relationship facilitates the midwife’s understanding of the woman’s needs.

In 2003 Chris Warren explored the value of midwifery continuity of carer models of practice. Warren reviewed nine studies between the years 1987 and 1999 that reported on the experiences of both women and midwives. Six studies compared the benefits of continuity of midwifery carer with non-

continuity of midwifery carer. Seven clinical aspects, such as intervention occasions during labour and birth, number of choices offered to women and breastfeeding rates were measured. Women's and midwives' satisfaction levels were measured in 5 of the 6 studies. Positive scores were higher for all measured outcomes in the continuity of midwifery carer models of practice groups (Warren, 2003). Three of the studies also examined aspects of care that women ranked higher than continuity of care by a known midwife. In all three studies women ranked the provision of clinically safe or competent care higher than continuity of carer. Being cared for by a person who was considered to be kind was also ranked higher. In 2 of the 3 studies women ranked the provision of sufficient information and the ability to have choice higher than the provision of continuity of midwifery care (Warren, 2003). Therefore, the provision of care that is perceived by the woman to be kind, along with sufficient information to facilitate choice and control, may be more important than the model of care in isolation.

Hatem, Sandall, Devane, Hora and Gates published a systematic review (2009, July 9) comparing midwife-led and other models of maternity care for childbearing women. Eleven studies and more than 12,000 women were included in the review. The findings of Hatem and colleagues supported those of Warren (2003) in concluding that women receiving midwifery-led care were more likely to have a known midwife attend their birth, to experience a greater sense of control, birth vaginally and to initiate breastfeeding. As well, women were less likely to require analgesia, have an episiotomy or experience an instrumental birth. Although there was no significant difference in caesarean or neonatal death rates the positive affects of midwifery-led care resulted in Hatem and colleagues concluding that midwifery-led care be offered to all childbearing women with consideration around the additional needs of women with medical complications.

A further systematic review published in 2011, involving more than 15,000 women and 21 studies also reported that women receiving continuous support during labour and birth were more likely to have positive measureable birth outcomes and be satisfied with their care (Hodnett et al., 2011, February 16). While use of analgesia, length of labour, number of surgical births and number

of babies with low Apgar scores at five minutes were significantly less, there was no impact on maternal and neonatal complications, breastfeeding rates and other intrapartum interventions. The authors reported that continuous support was most beneficial when the carer was not a hospital staff member or part of the woman's pre-pregnancy social network and epidural anaesthesia was not readily available. No conclusions were made regarding the onset or timing of continuous support (Hodnett et al., 2011, February 16). It is possible that the finding related to the carer not being a member of the hospital staff is associated with hospital-based staff being more closely affiliated with institutional requirements rather than the woman's needs. Pollard (2010) found that midwives working in medically dominated and institutionally focused environments are obligated to meet institutional needs. Continuous care from a midwife working in a model of midwifery care based outside the domains of the hospital may provide different care than those working within the confines of the institution.

Socially disadvantaged women in this study voiced their preference for maternity care information to be provided by a person with whom they had an established relationship - a person who was able and available to meet their individual needs. Continuity of carer was viewed by participating women as facilitating the formation of a relationship, allowing them to seek clarification on issues, ask further questions and have pertinent information needs met over a period of time. They described the establishment of an ongoing relationship as enabling trust to develop and they were able therefore to express their concerns and needs with someone they trusted. These women also articulated that they had a greater sense of control in maternity care encounters in which they knew their carer. While Larkin and colleagues (2011) reported that when women knew their carer they had a greater sense of internal control during labour and birth, and therefore understood their birthing experience to be a positive one, it was also reported that midwives can create the conditions in which the woman has a negative birthing experience. When midwives worked in ways that were not in accordance with the woman's needs or were overtly medicalised the woman's sense of control was diminished.

Socially disadvantaged women in the current study expressed a desire to form a relationship with their maternity carer. Although these women spoke positively about knowing their maternity carer, these views were based on care provided by their local doctor. All participating socially disadvantaged women, with the exception of one, received a non-continuity of midwifery carer model of maternity care. The local health district in which these women received their maternity care did not provide a specific continuity of midwifery carer model of maternity care, such as a designated Midwifery Group Practice, for socially disadvantaged women. In addition, the risk assessment processes of the local health district excluded women with needs considered to be physically and/or psycho-socially complex from the existing continuity of midwifery carer models of practice. While these women may have benefitted from a continuity of midwifery carer model of maternity care, the opportunity to receive such a model of care was not made available to them. Contrary to previous studies reporting that childbearing women are likely to be satisfied with the model of maternity care they received (M. Porter & Macintyre, 1984; van Teijlingen, Hundley, Rennie, Graham & Fitzmaurice, 2003), women in the current study spoke positively of, and wanted, a model of maternity care they had not been exposed to. This finding may have resulted from earlier group discussions by the women. It is possible that these women were influenced, prior to the focus group meetings, by the recounted experiences of the woman in the group who had received a continuity of midwifery carer model of maternity care. However, there is clear evidence that women benefit from, and want, a relationship with their maternity carer. There is also evidence of higher personal satisfaction scores from both women and midwives involved in continuity of midwifery carer models of maternity care (Hatem et al., 2009, July 9; Hodnett et al., 2011, February 16; Warren, 2003). The establishment of a midwife-woman relationship made possible through continuity of carer is more likely to support the aspects of maternity care women rank highest. That is, a midwife with a kind disposition towards the woman, a midwife who provides sufficient and relevant information to enable the woman to engage in decision-making, a midwife who shares control and responsibility; and a midwife who is available for the woman.

Although registered and student midwives in my study spoke only of the positive elements for women of continuity of midwifery carer models of maternity care, continuity of carer does not in itself guarantee that a positive midwife-woman relationship will be formed. When continuity of midwifery carer is positioned as the essential element of woman-centred care, rather than a means to facilitate it, choice and control can be overlooked within single maternity care encounters. Continuity of midwifery carer models of maternity care that do not enable the woman choice, control and the opportunity to engage in a mutually respectful partnership fail to distinguish the midwifery relationship from other health situated relationships. General practitioners and private obstetricians provide continuity of carer for childbearing women. They may also provide other elements of woman-centred care. Therefore, woman-centred care cannot be premised on continuity of carer alone. This understanding of continuity of carer and the characteristics of the individual carer is supported by the participating women's voiced concerns regarding continuity of midwifery carers and the possible negative consequences. One woman communicated that having a different midwife each shift was a "*blessing as you get rid of the horrible ones,*" and other women in the group nodded in agreement. When midwives do not interact in ways that facilitate positive experiences for the woman, the woman views the change of shift as a means to end the negative experience. This understanding is similar to women in a study by Larkin and colleagues (2011), who described being fearful of continuous care from a midwife whose approach to labour and birthing was different to that of the woman. While the women participating in this study communicated that they wanted a continuity of carer model of maternity care, it was the ability to establish a trusting relationship with the carer that was most important, not the qualifications held by the person or the environment in which the interactions occurred.

Participating midwives support this understanding when they articulated that the establishment of a relationship between the woman and midwife is dependent upon the midwife demonstrating respect for the individual woman. Maintenance of the midwife-woman relationship was understood to rely on the midwife's ability to cultivate trust and mutual respect, as well as the abilities of

the recipient – the woman. A relationship need not be framed by time. Trust and respect can be established within a short time frame when the midwife demonstrates she values the woman by ‘being available’. The absence of trust and mutual respect within a single maternity care encounter diminishes the woman’s ability to feel safe. The woman’s sense of not ‘being safe’ may continue onto future maternity care encounters, impacting on her health care interactions and potentially influencing the maternity care she receives and birthing outcomes. Continuity of carer models of midwifery practice have the potential to establish and, more importantly, maintain trusting and mutually respectful relationships between women and their midwife.

Midwives in this study supported participating women’s views when they communicated that it was the existence of an ongoing relationship that made it possible to provide care that focused on the woman. However, time limitations and not the absence of a relationship were blamed for care that focuses on task completion during non-continuity of midwifery carer maternity encounters. Both registered and student midwives in the current study communicated that it is not possible to make a connection with a woman during a half hour maternity care encounter. A connection can be described as a relationship or association, a communication link between two entities, or the space in which transferring occurs from one to another (Connection, n.d.). Within a midwifery context a connection can be made during every maternity care encounter; it is about the midwife ‘being available’ for the woman so that the woman feels a connection has been made. Making a connection, while not exclusive to ongoing relationships, is supported by the interactions that occur within ongoing woman-midwife relationships.

Time limitations and workload pressures, while mentioned as hindering midwife-woman interactions, were seen as less significant in limiting the midwife’s ability to meet a woman’s emotional, educational and physical needs within continuity of midwifery carer models of practice. The existence of an ongoing relationship was seen as buffering the effects of workload pressures, with midwives able to meet the woman’s needs over an extended period of time or number of encounters. Again, continuity of carer in itself does not guarantee a positive emotional connection for the woman, or that maternity

care information will be tailored to the woman's individual needs. Some midwives in this study, who worked in a Midwifery Group Practice model of care, expressed that continuity of midwifery care is a better model of maternity care because women are "*captive*" and "*vulnerable to listening*" with "*primarily the baby the number one thing.*" These midwives indicated that continuity of midwifery care allows midwives to continuously and incrementally address the health care information that they understand the woman requires. However, the woman and her individual needs seem to be not valued in these comments. The baby's needs took precedence, along with the midwife's need to impart their knowledge. The focus of maternity care encounters involving socially disadvantaged women is to inform women of what is required of them to ensure the best outcome for their baby. These comments by midwives also demonstrated a contradiction in understandings regarding socially disadvantaged women's ability to accept responsibility for their baby's well-being. The midwives have previously articulated that socially disadvantaged women release responsibility for choice and control and do not have the ability to care about health outcomes for self or baby. However, in these comments, the midwives convey that socially disadvantaged women do accept responsibility for their baby's physical health and well-being and are more likely to follow directions by the midwife in a continuity of carer model of maternity care.

Continuity of midwifery carer models of practice place greater responsibility on the midwife not to use their position of professional power in non woman-centred ways. While continuity of midwifery carer models of practice can be more effective in providing individualised information, contextualised care and establishing mutually respectful relationships with socially disadvantaged women, the opportunity for disempowering practises is equally present. When continuity of midwifery carer is provided without any of the other elements of woman-centred care, the conditions present in the maternity care encounter create an effective public health agenda indoctrination environment. The midwife can continuously and incrementally present institutionally sanctioned or personally biased health care agendas.

Participating midwives conveyed that they were more able to be available for the woman during maternity care encounters in which the relationship was already established. Conversations and information did not have to be repeated. The midwives understood they were in a better position to provide relevant information to the woman when a relationship was formed. Furthermore, women in the current study communicated that they were more likely to accept maternity care information from a trusted and respected person with whom they had an established relationship. However, women in this study also spoke of their concerns regarding the potential for a reduction in the quality of maternity care if and when they declined advice or requests from their maternity carer. These women articulated that their fear of openly rejecting their maternity carer's advice or requests would result in care being denied. Their sense of responsibility for self and baby was such that the majority of participating women overtly agreed to all requests by their maternity carers, even when in reality they did not want to conform. The woman is likely to follow directives to ensure her care and carer remain stable at a time in her childbirth continuum where she is experiencing a heightened sense of vulnerability. Satisfaction of care experiences may rank lower on the woman's hierarchy of needs scale when physical and emotional stability is required during the immediate maternity care encounter of labour and birth.

A study by Hundley, Milne, Glazer and Mollison (1997) concluded that assessing women's satisfaction with choice, control and continuity of carer during labour and birthing is a complex issue. The study carried out in Scotland involved 2,463 women who were allocated to either a continuity of midwifery carer model of maternity care or a standard model of maternity care. All women were determined as low risk. The authors reported that women in the continuity of midwifery carer group were more likely to have choice regarding mobility, birth position and pain relief. However, the wording of the response to the question regarding pain relief selected most by women in the continuity of carer group was "I made my own decision with the staff's approval". The words "with the staff's approval" are ambiguous as to whether women did make their own decisions. The majority of women in both groups selected this response option. Although the authors state that women in the

continuity of carer group had more choice regarding positioning during birth, figures reveal that that same percentage of women in each group responded with “no, not really” when asked would you have liked to try another position - 79% in the continuity group and 79.4% in the standard care group. Response rates may reveal that the midwifery carers in both groups assisted the women to birth in the position most suited to the woman. Equally, options presented by the staff may have been interpreted by women as the best available. The women, therefore, were satisfied with their perceived choices. Interestingly, while most women voiced no preference for third stage management, of the women who had voiced a preference, women in the standard care group were significantly more likely to receive what they wanted. Only 68% of women in the continuity of carer group received the care they wanted, compared to 81% in the standard care group. This finding needs to be explored further as it is not made clear when the decisions about how third stage was to be managed took place. It is not made clear if the woman decided on third stage management preferences in isolation or with guidance from staff. Women in the continuity of care group may have wanted a particular option but were more comfortable to be guided by their midwife as third stage occurred. Equally, women in the non-continuity of care group may have been guided prior to labour by the option preferred by the midwife. Therefore the women were more likely to respond that their wishes were met.

Current midwifery literature portrays continuity of midwifery carer models of maternity care as the primary way midwifery relationships can be formed between a midwife and woman. This understanding is acknowledged and reinforced within the clinical environment by midwives and taken up by students. As discussed under the previous chapter heading – *Valuing midwifery*, this way of understanding midwifery relationships and woman-centred care fails to recognise the midwifery worth of midwives not practising such models. While a continuity of midwifery carer model of practice facilitates the midwife’s ability to be available, the absence of it appears to allow registered and student midwives to blame ‘the system’ for not providing care that focuses on the individual woman’s needs and for not being available

during the immediate maternity care encounter. The midwife's personal responsibility for 'being available' within a maternity care encounter is shifted.

The cost of being available: "having a breakdown"

Within the midwifery profession, great importance is placed on the element of continuity of care by a known midwife. Many of the midwives in this study elected to practice in a Midwifery Group Practice in an attempt to align their midwifery ideologies and work practises. However, working in a Midwifery Group Practice that provided care specifically for socially disadvantaged women appeared to be stressful for these midwives. They communicated that their midwifery workload had increased when they commenced working in a Midwifery Group Practice. While some midwives spoke of distancing themselves from the women to maintain their emotional well-being, other midwives spoke of drowning under the workloads associated with meeting the complex needs of socially disadvantaged women. These midwives said that it was too difficult to provide the kind of care that aligns with, and lives up to, their professional ideologies on a continuous basis for socially disadvantaged women. They suggested there may be a time limit in which midwives can be expected to work so closely with women requiring high levels of emotional support and that the cost of being available for socially disadvantaged women was hazardous to the well-being of the midwife. These midwives viewed non-continuity of carer models midwifery practice as providing midwives with a degree of protection from burnout. Two midwives broke down during the focus group, communicating they were so stressed by the emotional burden of continuously working with socially disadvantaged women that they felt they were on the verge of having "*a breakdown*". These midwives had been working in a Midwifery Group Practice for less than a year and communicated that they were likely to cease working in that model of care in the near future.

Burnout was described by Sandall in 1997 as emotional exhaustion with a lowered sense of personal accomplishment at work. Sandall examined the impact of the Changing Childbirth report on midwives' work and personal lives. She compared the work practices of three different models of midwifery care typically provided in England; caseload midwifery, community midwifery and

hospital based midwifery. She found that the greater the degree of perceived control over workload, rather than the actual workload, the lower the midwife's sense of emotional exhaustion. It has been reported over the last two decades that continuity of midwifery carer models of practice, such as caseload midwifery, afford the midwife increased degrees of autonomy and control over their work practices. However, midwives in these models of practice continue to report their dissatisfaction with disruption to family life, unsociable hours and on-call practices (Gu et al., 2011; Sandall, 1997; Todd, Farquhar & Camilleri-Ferrante, 1998). While midwives report increased satisfaction, only 18% of midwives in the study by Todd and colleagues stated that they intended to remain in their current position for a long time (1998). Conversely, McCourt and Stevens (2009) argue that midwives providing continuity of care build strong collegial support networks with other continuity of care midwives, lessening the stress often associated with emotion work. The authors add that midwives in such a model of care express a feeling of being valued by women, their medical colleagues and the maternity service management. They no longer see themselves as a cog in the organisational machine but a valued and respected member of a health care team working with and for women (McCourt & Stevens, 2009).

Recent studies exploring midwives' satisfaction with work practices in continuity of midwifery carer models of practice have revealed there is an adjustment period required when midwives commence working in these models of practice. To sustain the degree of commitment to continuity of carer and lessen the degree of burnout experienced, supportive organisational and personal systems need to be in place, as well as having a supportive family (Collins, Fereday, Pincombe, Oster & Turnbull, 2010; Fereday & Oster, 2010; Gu et al., 2011; Homer, Brodie & Leap, 2008). Midwives in the current study who expressed distress or burnout associated with the demands of their work practises did not appear to be adjusting. However, this may have been because they had not had time to adjust. They had been working in a Midwifery Group Practice model of care for less than a year.

Participating midwives discussed their attempts to control or minimise the challenging aspects of working with socially disadvantaged women and

expressed their need for formalised support mechanisms. They spoke of informal support mechanisms they implemented such as phones calls to midwifery colleagues, tea room conversations during meal breaks and group discussions during midwifery team meetings. Midwives, however, conveyed the lack of recognition by management of the emotionally challenging work that midwives perform. They expressed a need for acknowledgement through mandated support processes. Participating midwives also understood that their professional body, The Australian College of Midwives, did little to provide emotional support to midwives in the clinical environment. They spoke of clinical supervision and reflective practices being part of the midwifery discourse that exists in literature only. Participating students supported the views of these midwives when they also communicated that midwives were observed to work under stressful conditions with no recognition by maternity service management of their need for support. Students spoke of the lack of support in the maternity care environment for midwives. This understanding can impact on student midwives' perceptions and expectations of their future working environment and conditions, and has the potential to influence their way of working with women.

The understandings of midwives in this study echo those of midwives in an action research project by Deery (2005). Deery explored the support needs of 8 community based midwives in a maternity service in Northern England. Although midwives in both the current study and Derry's study expressed a lack of formal support from management in the form of clinical supervision, midwives in Deery's study shed some light on why clinical supervision has not been successfully implemented in all maternity care environments. Clinical supervision is described as a formal, interrelational approach to professional learning and development, with midwives learning through reflective practice and self-directed discussions with a more experienced person (Deery, 2005). Data from the focus group phase of Deery's project suggested that while midwives found clinical supervision both beneficial and essential for their practice, they also expressed a lack of time to participate in clinical supervision. The additional burden of attending clinical supervision was seen as another requirement of management. Once again, the need to meet

institutional needs was seen to take precedence over the midwives' personal need for emotional support, and their professional desire to meet the needs of women (Deery, 2005). Unless midwives understand clinical supervision is not aligned with workforce needs and are able to participate without perceived additional burdens on their workload, implementing clinical supervision is unlikely to be well received by midwives. Midwives may subconsciously sabotage what they suggest is required to support them.

The emotional vulnerability communicated to be associated with caring for socially disadvantaged women was not limited to midwives working in continuity of care models of practice. All midwives participating in this study conveyed that being available for women with complex needs lead to a state of vulnerability for the midwife. These midwives spoke of the need to be emotionally protected. Midwives can become unavailable to women with complex psycho-social needs in order to afford themselves some protection against the emotional and professional costs of working with such women. This disconnection between the woman and midwife sets in motion a cyclic process of distancing which impacts on the care provided and received, as well as the midwife's sense of job satisfaction. The midwife, in being unable to connect with the woman, is unable to provide what is perceived as woman-centred care. The conflicting ideologies between care that midwives would ideally like to provide and the care midwives are able to provide is a major source of what Hunter terms 'emotion work' in midwifery (2004).

Not being available: "not seeing midwives"

Women participating in this study spoke of being isolated and ignored by midwives when hospitalised. They described being uninformed regarding their care, with maternity care staff too busy to spend time with them - that is, to be available. When the midwife is not available for the woman, the woman understands that she is not valued. Participating women understood that midwives only acted as if they were engaging with women. Midwives were seen to be always in a hurry, just passing by on their way to someone or something else when they asked questions such as "*Are you alright?*" Midwives were described by participating women as asking perfunctory

questions only – ‘the midwives’ mumble’. These women understood that they were not to respond in a way that would create work for the already busy midwife. This way of asking a question silenced the woman, ensuring the midwife was not required to interrupt their scheduled tasks and listen to the woman. This understanding is similar to those of women participating in a Department of Health funded evaluation of information leaflets for women in multiple health service sites in England and Wales (Kirkham & Stapleton, 2001). Women in Kirkham and Stapleton’s report described midwives’ general air of busyness as signalling they were too rushed to listen to women. The apparent busyness prevented women from engaging in conversation and was reported to create a distancing between midwives and women (2001). Midwives, with their air of busyness, signal to women they are not available.

Failure on the part of the midwives to connect with, or be available for, women participating in the current study resulted in the women being largely unaware of the roles and responsibilities of their maternity carers. These women spoke of the “*ladies*” and the “*nurses*” they met during their maternity care encounters, with one woman stating, *“I don’t think I really saw the midwives, it was just whoever was in the room that day...”* While the term midwife was used during women’s recounted experiences of labour and birthing, one woman recounted asking her partner to retrieve “*the people*” who helped her birth, in order to have a photo for her baby’s album. This woman did not recall the midwives introducing themselves or providing their names and designations at any time during her labour or birth. While it is possible that the midwives did introduce themselves at some point during this woman’s birthing encounter, the physical and emotional vulnerabilities experienced may have resulted in her forgetting the carers’ names. Her lived experience was that no one introduced themselves during an important event in her life. This situation could have been prevented through the provision of a continuity of midwifery carer model of maternity care. The woman, her partner and support people would have met the midwife or midwives present for her birthing experience. However, it must be said that it is the absence of an appropriate introduction by the midwife at the commencement of each maternity care encounter, and not the lack of an ongoing relationship, that leads to uncertainty regarding who

is providing care for a woman during her maternity care encounters. In the study by Hundley and colleagues a small number of women in both the continuity of midwifery carer and non-continuity of midwifery carer models of maternity care were unaware of who supported them during labour and birth (1997). Within each maternity care encounter it is the midwife's responsibility to establish, initially through a suitably implemented introductory phase of the therapeutic relationship, the midwife-woman relationship. It is unlikely that a midwifery connection can occur when the woman is unsure of who is providing her care. It is equally unlikely that trust can develop when a connection has not been established.

Student midwives in this study provided further understanding of how these women might have experienced difficulty in distinguishing midwives and midwifery work from nursing. Students talked of midwifery work in the hospital environment as being no different in practise to their previous clinical experiences as nurses. These students communicated that midwives were observed to take on the work practices and communication styles aligned with a biomedical model of health. It is when midwives act in a similar manner to nurses, in the hospital environment, that childbearing women, student midwives and other health care professions tend to see midwives as obstetric nurses. Women in this study observed task orientated midwives in the hospital environment. It is understandable therefore, that these women viewed their maternity care to be provided by nurses.

Not being available: distancing

Although some midwives spoke of socially disadvantaged women as seeking non-continuity of carer models of maternity care so they could remain hidden within the system, this understanding was contradicted by other comments made by midwives, students and women. Participants previously spoke of socially disadvantaged women not having choice regarding the model of maternity care they were allocated. All three participant groups conveyed that socially disadvantaged women had no choice regarding access to models of maternity care, or control over their ability to establish a close and ongoing relationship with a midwife. Therefore, socially disadvantaged women did not

have the capacity to avoid closeness. Participating midwives who understood that socially disadvantaged women avoided continuity of carer models of maternity care in order to avoid closeness, were able to shift the responsibility for establishing a midwifery connection to the woman. Midwives who claimed that women made themselves unavailable were able to justify their inability to 'be available' for the woman. Furthermore, participating students positioned the responsibility for the midwifery care received with the women. These students understood socially disadvantaged women received poorer quality maternity care as a consequence of the distancing behaviours and erection of emotionally protective barriers by the women.

Women in this study also perceived an existence of an emotional barrier between socially disadvantaged women and midwives. However, participating women understood that the barrier was created by the midwives. Neither participating midwives nor students acknowledged that midwives may have also erected barriers, distancing themselves as a protective mechanism against the emotional vulnerability they associated with working with socially disadvantaged women. Kirkham, and colleagues (2002b) talk of stereotyping as a means of protection for the midwife. When midwives understand a woman belongs to a particular socially constructed group, the midwife is able to distance themselves from the woman and address only the needs assessed by the midwife to be appropriate to that group. An emotional barrier is constructed between the woman and midwife based on the midwife's judgements. Stereotyping reduces the need to engage the woman in discussions, thus making midwifery work more efficient. When both parties erect emotional barriers, the midwifery connection is made that much more difficult to establish. The midwife is viewed as not available for the woman. Consequently, the woman does not feel safe or valued and is unlikely therefore to make herself available for the midwife.

While registered and student midwives participating in this study viewed socially disadvantaged women as emotionally unavailable, requiring a greater investment of midwifery energy to connect, they also communicated that socially disadvantaged women often need to distance themselves, through the erection of an emotionally protective barrier, to avoid the judgemental attitudes

of midwives. The judgemental attitudes of midwives were also discussed by women participating in the current study. They spoke of needing to conform to directives and requests from their maternity carer. Again, these women communicated they were afraid to say no, for fear their maternity care would be withdrawn. The women also conveyed that they felt pressure to prove they were responsible mothers prior to discharge. The midwives were seen to own the babies while they were in the hospital environment. These women described a sense that they were expected to pass a 'good mother' test. While midwives allowed them to have and hold their baby in hospital, the baby was not truly theirs until discharged from the maternity ward and away from midwifery surveillance. The concept of midwifery surveillance or the midwifery gaze has been discussed by Fahy (2008), who draws on Michel Foucault's notions of 'disciplinary power', the 'clinical gaze' and the 'panopticon'. These concepts are evident within the midwifery context. Both the midwife's personal body of knowledge and the workplace practices affect how the midwife sees the socially disadvantaged woman. There is no such thing as an objective observation of the woman with the midwifery gaze serving as a system of power in controlling the woman's behaviour (Fendler, 2010). These women were threatened by a perceived punishment, that is, failure to gain access to their baby. These women experienced being looked at or observed by the midwives, yet not seen for who they were or what they needed. They were disciplined to conform to the expected norms of behaviour, thus ensuring they were not punished. Foucault refers to the acceptance of discipline as a civilised means of controlling people as normalising (Fendler, 2010).

Midwives are also subject to the midwifery gaze as well as workplace culture gaze that serve as a system of power in controlling their behaviours. Fahy contends that when we are aware our movements and behaviours are being monitored, we moderate our actions to align with the dominant group, the group with power (2008). Furthermore, Fahy suggests the consequences of failing to conform to the expected and accepted actions of the dominate group include being shunned and ostracised. Although Fahy was describing midwifery practises in this instance and the consequences for the midwife who fails to conform with the dominate medical culture, women in my group spoke

of their fears of being shunned, with care diminishing when they disobeyed the midwife's directive. Women in the current study felt they were under the 'midwifery gaze' and understood the consequence of failing to conform was removal or refusal of care. Women also perceived there was a potential for denied access to their baby if they did not modify their actions to align with the expectations of the dominate midwifery group.

Both the socially disadvantaged women and student midwives participating in this study spoke of the judgemental attitudes of midwives towards socially disadvantaged women. When a woman understands she is being judged, her actions and reactions are likely to correspond to her understandings of how she is being treated, regardless of the conscious intentions of the midwife. When midwives do not demonstrate the woman is being valued, the formation of a collaborative midwife-woman connection is obstructed through the erection of a protective barrier by the woman. Maternity care encounters that facilitate conditions which communicate trust and respect, regardless of the time frame, create a safe environment in which the woman is more able to connect emotionally with her carer. While the physical environment impacts on the woman's experiences of her maternity care encounters, it is the individual health care professional who is responsible for facilitating the conditions that enable the woman to 'feel safe' within her maternity care encounter.

Distancing by the socially disadvantaged woman was understood to be more prevalent during maternity care encounters that occurred within local health district environments. Participating midwives voiced that maternity care encounters occurring at the woman's home appeared to increase the woman's sense of control. These midwives spoke of the midwife having less authoritative power when visiting the woman in her home, and described women as being less defensive in their responses. Women may have felt more empowered in their homes; however it is also possible that the way in which midwives interacted with women altered when the environment changed. Midwives' communication styles have been shown to be different depending on the environment in which the maternity care encounter occurs. McCourt (2006) concluded that midwife-woman interactions occurring in the hospital environment tended to focus on establishing a corporate relationship.

Institutional speak was used to convey screening processes and health agendas. However, midwives working in continuity of midwifery carer models of practice, who visited women in their homes, used conversational speak. The focus of the maternity care encounter outside the hospital environment was on the establishment of the woman-midwife relationship.

In addition, the women may have felt empowered on their own territory to have a voice and choice. Participating midwives' perception that women had an increased sense of control in their own environment is in alignment with Fahy's concept of 'birth terrain' (2008). Fahy describes how the birthing terrain impacts on a woman's sense of self, either increasing her confidence in self or decreasing it. There are two sub-concepts of terrain, the surveillance room and sanctum. While the surveillance room is characterised by geographical layout and conditions that meet the functional needs of the health care professional, the woman's home is a sanctum. The woman's home is an environment that meets her need for privacy, safety, comfort and familiarity (Fahy, 2008). The woman is in control of her environment and her confidence in self is heightened. Communication of self needs is therefore simpler. When the midwife makes time to 'be available' in the woman's environment, the woman is more likely to feel she is being valued and that her needs take precedence.

9.3.2 Being available: "a nice one"

Women in the current study saw their maternity care encounters as a game of chance; they may or may not have been allocated a midwife they considered "a nice one". These women described a "nice" midwife as one that demonstrated a valuing of the woman as an individual. Nice midwives, as described by participating women, said hello and goodbye during the woman's maternity care encounter, took the time to listen to the woman, asked the woman what she wanted to know and provided relevant and timely information. Women in a study by Kirkham, Stapleton, Thomas and Curtis also spoke positively of midwives who provided support in a way that met the needs of the individual woman. The women referred to these midwives as "gold mines" (2002). On the contrary, women in a study by Larkin and

colleagues conveyed that “you could be unlucky with your midwife” (2011, p. 6). Women understood they were unlucky when the midwife supporting them during labour and birth diminished their sense of control. A woman’s lowered sense of control was brought about by failure on the part of the midwife to provide relevant information, spend time with the woman and advocate for the woman’s preferred option of care.

Participating women talked of midwives that were perceived to go above and beyond their call of duty by keeping the woman informed of what was occurring in relation to her maternity care. They recounted instances where midwives were kind and caring, speaking respectfully and empathetically. They also recalled the not so kind and caring midwives - midwives who made them feel bad or stupid, midwives who yelled at them during labour and birth, midwives who intimidated them into conforming to accepted and expected actions. One midwife voiced similar understandings when she described the midwife’s need to be *“kind and caring”* when working with socially disadvantaged women. Being kind is defined as being helpful, well-meaning, selfless, desiring to do good for others, and going out of one’s way to assist another (Kind, n.d.). Participating students also supported the views of socially disadvantaged women concerning midwives being nice and the potential for a positive experience for the woman. These students described how women were optimistic regarding their maternity care encounters when the midwife was seen to be a nice one through making themselves available for the woman. *“You could just see there was a little flicker of hope in [the woman’s] eyes.”* Being nice to the woman is not a new concept. Gail Thomas wrote in (2000) that “there are only two bottom lines in midwifery practice – be nice and don’t drop the baby” (p.174). While the phrase don’t drop the baby is a metaphor for the provision of evidenced based, safe midwifery care and is the science of midwifery, being nice is the underpinning principle that ensures the woman-midwife relationship is established and maintained within the professionally helpful zone of the therapeutic relationship, and is the art of midwifery.

A socially disadvantaged woman’s maternity care experience can be enhanced when the midwife finds the time to talk to the woman and listens to what the woman has to say. When the midwife is ‘being available’ for the

woman, the woman understands she is valued by the midwife. When the midwife commences the maternity care encounter with an introduction and completes the encounter by saying goodbye, the midwife is ‘being available’ and the woman feels valued and respected. When the midwife asks the woman what she wants to know and follows up on requests made by the woman, the midwife is seen by the woman to be going “*above and beyond*” their call of duty. Midwives considered to be “*nice ones*” were providing care that focused on the woman in the immediate maternity care encounter. All the elements of care that constitute a “*nice midwife*” were experienced by these women during non-continuity of midwifery carer maternity care encounters. A non-continuity of midwifery carer model of practice does not, therefore, prevent instances of care that focuses on the woman. However, a continuity of midwifery carer model of practice can provide the conditions in which a woman can feel valued and therefore safe through the availability of the midwife. This understanding is supported by those of Schmied and colleagues (2011) who performed a metasynthesis of 31 studies exploring the experiences of women requiring breastfeeding support. The authors concluded that “providing an authentic presence helps to ensure that support given is appropriate to the woman’s needs and enhances its perceived effectiveness” (Schmied, Beake, Sheehan, McCourt, & Dykes, 2011, p.51). Authentic presence is described as care that reflects a mutually trusting relationship and while continuity of care is more likely to facilitate the development of trust and authentic presence, the authors conclude that the concept of “being there” or being available can occur “even when the midwives and postnatal wards are busy” (Schmied et al., 2011, p. 51).

Midwives working in any midwifery context can provide what these women described to be woman-centred care. A single maternity care encounter in which the midwife is seen to take the time to ‘be available’ and meet the woman’s immediate needs can be a positive woman-centred maternity care experience for the woman. Midwives can be kind and caring in maternity care encounters regardless of the model of maternity care being provided. When the midwife is available for the socially disadvantaged woman, the woman can feel valued and therefore safe enough to have choice and a voice within her

maternity care encounter. Although midwives can ‘be available’ during a single maternity care encounter, encounters that are part of an established and ongoing relationship foster the midwife’s ability to be available. The maternity care conditions and midwifery strategies that can support the midwife in feeling *valued* and *safe* so that they can be *available* for the socially disadvantaged woman are discussed in the next chapter – *Reflecting on New understandings: implications for midwifery practice, education and research.*

10 Reflecting on new understandings: implications for midwifery practice, education and research

This study has provided a new understanding of how woman-centred care and maternity care encounters are experienced, within Australian maternity services, by some socially disadvantaged women, some midwives providing care for socially disadvantaged women and some midwifery students observing woman-midwife interactions. Although this study is limited in what conclusions can be drawn from the data and the findings cannot be generalised to all socially disadvantaged women, registered and student midwives, or midwifery contexts, the findings do provide some insight into the ways those involved in working with socially disadvantaged childbearing women experience the midwifery concept and maternity care philosophy of woman-centred care. Understandings generated from this study, along with the participants' responses to the question "*How might maternity care encounters be more woman-centred for socially disadvantaged women?*", form the basis for the remainder of this chapter, where the implications for midwifery and maternity practice, midwifery education and further midwifery research are discussed.

10.1 Midwifery and maternity care

One socially disadvantaged woman summed up the implications for midwifery practice and maternity care by saying, "*Until something about the whole system's done I don't think you're going to get that extra attention and care...or someone that's got the time to go the extra mile, it's just the public system is the way it is with the hospital.*" However there are things that maternity service management and individual midwives can do to ensure socially disadvantaged women have a positive maternity care encounter that they understand as woman-centred. More than two decades ago women spoke of a "production-line atmosphere" in the maternity care environment (M. Porter & Macintyre, 1984). Women in the current study demonstrated that nothing has changed when they spoke of the midwives working as process workers and the "*factory processes*" that take place in the hospital

environment. While these women spoke of midwives being too busy to be with them and listen to their needs, they also spoke of health professionals that went “*above and beyond the call of duty*”. Going above the call of duty meant following through on providing information the woman had requested and the midwife offered to supply. Although many midwives voiced that it was hard to follow-up on the results of tests and procedures, it is not an impossible midwifery task. Midwives need to inform the woman that they will either provide her with the information that she requires prior to the completion of the immediate maternity care encounter or that they will pass on the task to a colleague who will provide the information later. The woman will understand that her needs are valued and that the midwife has implemented a process to ensure the woman’s need for information is met. Improving collaboration and communication between midwifery colleagues, other health care professionals and women has the potential to enhance the woman’s health knowledge and engagement in her maternity care.

In relation to what the individual midwife can bring to each maternity care encounter, these women wanted a “*nice one*”. They didn’t want to have to fight to have their needs met and they didn’t want midwives that made them “*feel bad*” when they asked questions or decided to choose an option of care that was not in alignment with the midwife’s choice. They wanted health information in a format that suited their level of understanding. That is, they wanted midwives to spend time discussing health information that met their specific needs. The following characteristics, provided by participating women, are the requisites for a positive and woman-centred maternity care encounter:

- The midwife acknowledges the woman’s presence at the commencement of each maternity care encounter by saying hello.
- The midwife introduces themselves so that the woman knows the name of the person who is providing her care.
- The midwife asks the woman what she wants to know and then provides it in a manner that suits the woman’s level of understanding.
- The midwife allows sufficient time for the woman to voice her needs and concerns and responds appropriately.

- The midwife listens to the woman.
- The midwife follows through on what they say they will do.
- The midwife concludes the maternity care encounter by saying good bye.

This list of characteristics demonstrates a valuing of the woman and her needs. The midwife is ‘being available’ for the woman and the woman is more likely to feel safe to seek further information so that she can become an active participant in her maternity care. These characteristics are achievable within each and every maternity care encounter, regardless of the model of maternity care or the midwifery context. A maternity care encounter in which these characteristics are employed creates the conditions in which a midwifery connection can be made and a midwife-woman partnership can develop.

Some of the women in this study voiced that they wanted to know the “*people*” who were caring for them. Although this statement refers to knowing the names of the midwives who supported the woman in labour and birth, the majority of participating women expressed that they wanted their maternity care to be provided continuously by someone that they knew. These women understood that knowing their carer would facilitate the development of a mutually trusting relationship, giving them a greater level of say, or control, in their care. Similar understandings were reported by McCourt and Pearce (2000) who explored the maternity care experiences of socially disadvantaged women receiving either standard maternity care or caseload care by midwives in England. Women receiving standard care were more likely to be dissatisfied with their care, reporting that care was not focused on meeting their needs. Women receiving caseload midwifery care reported a greater sense of control within their maternity care encounters and valued the opportunity to form a relationship with ‘their midwife’. Although the women in the study expressed similar values and expectations around maternity care to those of the general population of birthing women, disparities in their expectations and the reality of maternity care experiences were greater. The authors concluded that continuity of carer may be of more importance for socially disadvantaged women when their life circumstances and health disparities are taken into consideration (McCourt & Pearce, 2000).

While continuity of midwifery carer does not necessarily ensure either woman-centred care or increased personal control for women (Jomeen, 2010), it has the potential to support woman-midwife interactions that foster the elements of woman-centred care. A small number of women in the current study voiced that non-continuity of midwifery carer models of practice afforded them some protection from the not so “*nice ones*”. However these women had not experienced midwifery care within a continuity of midwifery care context.

Midwives need to negotiate respectfully with the woman at the commencement of every maternity care encounter, concerning the degree of participation in decision-making that the woman wants. This process of collaborative and shared decision-making empowers the woman and supports the formation of the midwifery partnership. While women in the current study wanted to be involved in discussions concerning their care, they also wanted the midwives to take responsibility for most of their health related decisions. Midwives, therefore, need to be aware that women are not being neglectful of their responsibilities as a mother when they appear to be silent in the decision-making process. Women often make informed and considered decisions to refer to the expert – the midwife. Seeking the woman’s input into her desired level of engagement in decision-making processes demonstrates a valuing of the woman’s need to feel safe in her choices. Freeman and Griew wrote of a shared woman-midwife decision-making process in 2007, stating that it had the potential to give women an active voice in their maternity care and to influence woman-midwife relationships and institutional norms (Freeman & Griew, 2007). This style of collaborative decision-making may be more beneficial for women who are often absent from policy or service development working parties. Women participating in this study did not voice any understanding that they were able to influence their maternity care environment.

Findings from the current study also reveal that socially disadvantaged women can be treated or viewed differently to non-disadvantaged women during their maternity care encounters. Participating students and midwives frequently voiced stereotypical comments and understandings concerning

socially disadvantaged women. Stereotyping of service users supports the establishment and maintenance of the perceived needs of particular groups of service users and therefore maintains existing processes (J. Green et al., 1990). Midwives as agents for social change need to be role models for students and their health professional colleagues. They can do this by demonstrating a valuing of the individual woman, by not making stereotypical comments and by not being critical towards the woman based on her socio-economic position or on her perceived different way of being in the world.

Wilkinson and Marmot (2003) claim that a person's health is sensitive to their social environment. When socially disadvantaged women do not feel valued by the health care professional, they are less likely to engage in health care decisions or healthy behaviours. Midwives are in an ideal position to socially construct opportunities for socially disadvantaged women to improve their sense of control and power within maternity care encounters. As discussed in chapter 2, the issue of responsibility in addressing differences in socially disadvantaged women's experiences of maternity care encounters and maternal health outcomes lies primarily with midwives (Krieger, 2002). Midwives, their medical colleagues and maternity service providers need to have knowledge of, and take into account when working with socially disadvantaged women, the various models and approaches that address health disparities. Furthermore, maternity care encounters and health care interventions that fail to address the individual woman's needs, or take into consideration her socially constructed life circumstances, are unlikely to be effective.

Findings from this study also provide understandings that can influence local health districts and maternity services to consider differently the maternity care encounters and experiences of socially disadvantaged women. No maternity service can realistically expect to meet the needs of socially disadvantaged women when their voiced needs are absent from service development, implementation and evaluation processes. No woman participating in the current study voiced that they were involved in such processes. Therefore local health district and maternity services need to develop strategies to entice this group of women to have an active voice in

the provision of services. A document titled - The National Maternity Services Plan 2010, released in July 2011, is a five year plan to ensure that maternity care provided in Australia, regardless of the location of service, will be woman-centred, culturally-competent and sustainable. It will also be safe, of high-quality, evidenced-based, and contribute to closing the gap between the birthing outcomes of Aboriginal and Torres Strait Islander women and non-Indigenous women (Australia. Dept of Health and Ageing, 2011, p. iii). The document informs the reader that significant consultation with medical professionals and midwifery stakeholder groups occurred during the planning process and while priority 2 – service delivery, action 2.3 is to develop and expand appropriate maternity care for women who may be vulnerable due to medical, socio-economic and other factors, there is minimal reference to how women might be involved in the development or implementation of this action plan. Furthermore, there is no discussion as to how local maternity services will involve women from groups of women identified as vulnerable (Australia. Dept of Health and Ageing, 2011). Priority 4 – infrastructure, action 4.2 is to ensure that maternity service planning, design and implementation is woman centred. Again there is minimal discussion as to how women might be involved in the development and implementation of this action plan. Although action 4.2 states that “women’s expectations for their maternity care must be considered” (Australia. Dept of Health and Ageing, 2011, p. 52), there is no reference to how this might occur. Also the measurable outcomes of the plan, called signs of success in the document, do not include statements concerning women’s recruitment or involvement measures.

Brodie and colleagues (2009) claim that consumer involvement in local service provision improves social cohesion and empowers communities, with participation benefitting the individual and improving service provision for all users through influencing institutional change. However a Cochrane review by Nilsen and colleagues concluded that there is little evidence of the effects of consumer involvement in health care provision (Nilsen, Myrhaug, Johansen, Oliver & Oxman, 2010). Therefore, it is important that local maternity services put greater effort into involving socially disadvantaged women in the provision of maternity services in order that their needs can be

met. Equally, local health district management need to develop reliable ways of measuring the benefits of involvement for the individual woman, the local birthing outcomes as well as the local health district key performance indicators. Establishing reliable methods of measuring consumer involvement and the effects of consumer involvement on both the service and individual consumer is important.

Participating women communicated that the maternity ward environment was designed to meet institutional needs. Maternity care environments need to be designed, therefore, in such a way that the physical, emotional and social network needs of the woman and her family can be met. The geographical layout of the ward must meet the woman's need for privacy as well as her need for interaction with others. Maternity service rules need to be re-examined to ensure all policies and rules (both written and unwritten) are based on best practice, not outdated cultural norms of the unit or antiquated organisational practices (such as visiting hours). Equally, midwives in this study found it difficult to position themselves professionally as woman-centred in a maternity care environment in which institutional needs took precedence over those of the woman. When faced with competing needs, those of a socially disadvantaged woman or the institution, midwives with no established relationship with the woman may find it more difficult to align their practise to meet the woman's needs. It is the midwife's desire to be accepted and valued as a professional that motivates them to adopt the valued ways of acting and reacting within the maternity care encounter.

Local health district and maternity service management need to encourage a shift in the workplace culture to one that positions the woman at the centre of care, both within the individual maternity care encounter and the organisation of maternity services. The midwifery body of knowledge needs to be recognised and valued within the maternity care environment by medical staff and management. Midwives need to be considered the lead maternity care provider within maternity services and refer to their medical colleagues when necessary as do general practitioners. Mutual respect between the professions needs to be implemented within the maternity care environment and supported by management. Midwives need to be safe to be woman-

centred in their practice. A valuing of the woman and midwifery ways of being need to become the dominate workplace culture. When the midwife, regardless of the midwifery context, feels valued and safe in the care they provide, they can guide and guard the woman to have a positive maternity care experience.

Mutually respectful relationships between the midwifery and medical professions and maternity care management can facilitate decision-making processes that encourage midwives to support the woman in her choice. Shared responsibility for decision-making processes, based on a woman-centred philosophy, can diminish the current shame and blame framework that midwives in my study understood to exist (see page 9-241). All decision-making processes in the maternity care environment need to be based on Page's five steps for putting science and sensitivity into practice (L. Page, 2002) and incorporate the Australian Nursing and Midwifery Council's - Midwifery Practice Decision Flowchart (appendix I) (ANMC, 2010a).

Page's five steps for evidenced based maternity care that includes the woman as a partner in decision-making processes are:

- Finding out what is important to the woman and her family;
- Using information from the clinical examination;
- Seeking and assessing evidence to inform decisions;
- Talking it through, and
- Reflecting on outcomes, feelings and consequences (L. Page, 2002, p. 47).

When the maternity care environment and management value decision-making processes based on evidence as well as the needs of the individual woman, with the woman an active partner in the decision-making process, the midwife can feel guided and guarded in her role to guide and guard the woman.

Findings from this study reveal that continuity of midwifery carer is perceived to be the essential element of woman-centred care that enables woman-centred care to be provided. Continuity of midwifery carer models of practice

were also viewed by participating registered and student midwives to be valued more highly by midwifery colleagues and childbearing women. Midwives therefore, who worked in such models were regarded to have a greater midwifery worth. Conversely, midwives not working in the prized model of care understood they were valued less in midwifery terms. There is a potential for workplace conflict, bullying and emotional burnout to be reduced when midwives understand that their midwifery worth and body of knowledge is equally valued regardless of the model of care or midwifery context. The midwifery profession, educational institutions and maternity care management need to promote a valuing of midwifery in all its forms. Based on the recounted experiences of registered and student midwives in my study, it is possible that a hierarchy in midwifery worth is emerging in Australia. The development of a midwifery hierarchy has the potential to divide the midwifery profession and midwives in the clinical environment. The Australian College of Midwives needs to demonstrate the values of inclusiveness, respect, and diversity in midwifery ways of being. A midwifery professional body that demonstrates these values and encourages all its members to support each other in these values will be better equipped to provide both midwives and women with positive maternity care experiences.

Midwives in the current study described the emotional and professional difficulties they faced when their maternity service failed to provide the appropriate resources or support required to continuously support women with complex needs, student midwife learning, the mentoring of other staff and their own professional development. While student and registered midwives spoke of the lack of support from maternity service management in creating a safe environment in which to cultivate the learning of self and others, registered midwives also voiced that their professional body fails to support midwives in the clinical environment with their continued professional development. Continuous professional development is required by the Australian Health Practitioner Regulation Agency as a requirement of annual registration for midwives. The midwife must “act to enhance the professional development of self and others” (Competency 13 ANMC, 2006, p. 13). However, these midwives did not feel they had the time to teach others or

continue to learn. The current push for e-learning by local health districts devalues midwives. The push for e-portfolios and clinical supervision in the midwife's own time is seen as an additional burden. Maternity service management and the Australian College of Midwives need to support midwives in the clinical environment to continue their professional development in a manner that facilitates and values continued learning. Equally, midwives need to be supported to guide and guard student midwives in their learning, demonstrating a valuing of midwifery time to supporting each other in professional development. Teachers working for the New South Wales Department of Education have mandated pupil free days for staff development. Midwives need to be valued sufficiently by the New South Wales Ministry of Health and our professional body to secure scheduled woman-free days or blocks of time to enable professional development, clinical supervision and other support mechanisms.

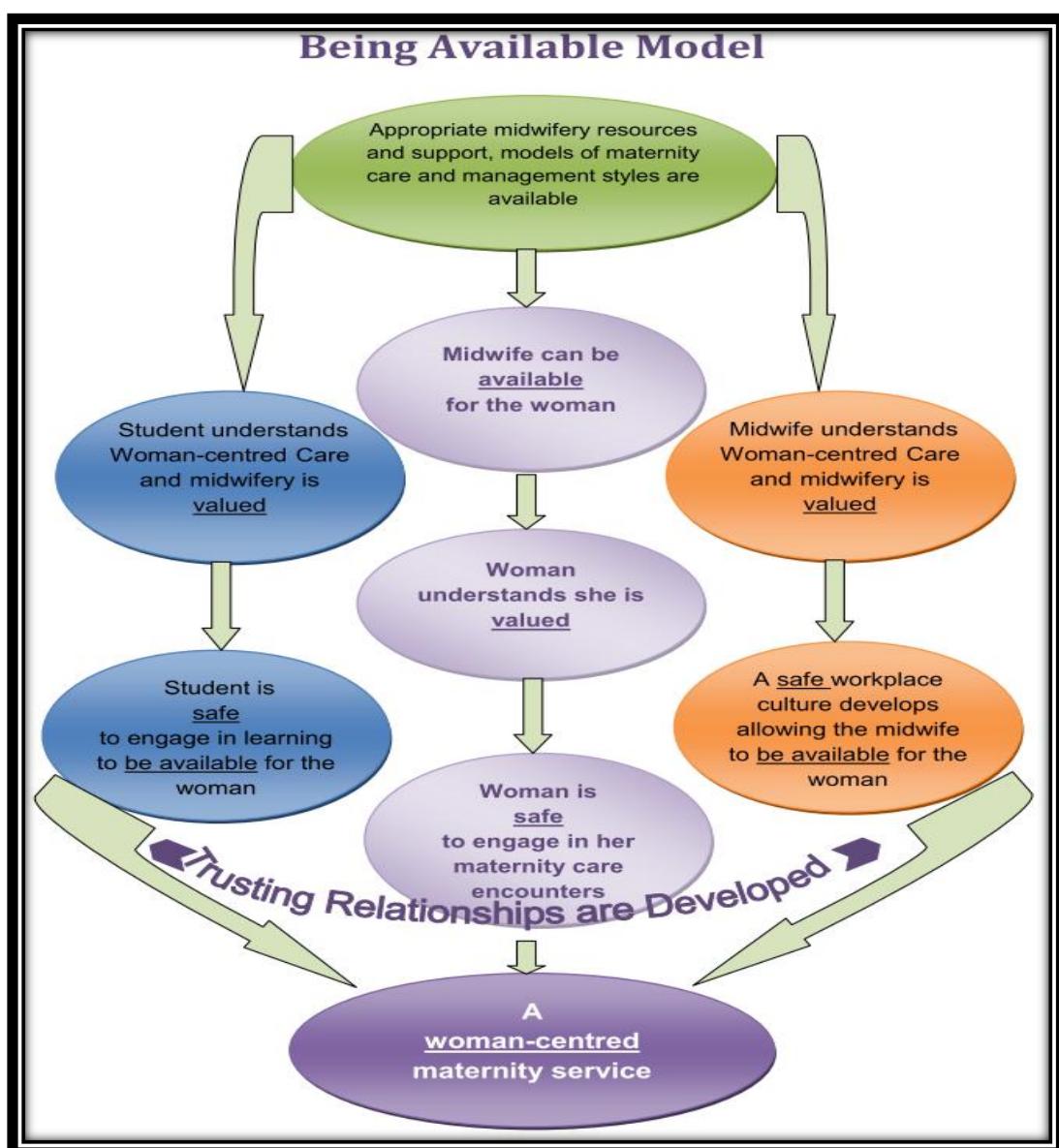
In Australia the midwifery movement towards more woman-centred ways of working and a greater number of continuity of midwifery carer models of maternity care continues. While the midwifery profession, midwives and childbearing women in Australia need to continue their push for woman-centred and midwifery focused models of maternity care, we need to be mindful of all the midwifery ways of being with woman. Continuity of midwifery carer is the vehicle that allows the profession to journey towards woman-centred maternity care options for women but it is not the destination. All forms of transport (or midwifery care) that are road worthy (safe and evidenced-based) and can reach the destination (woman-centred care), are equal in value to the driver and passenger (midwife and woman). Perhaps the intra-professional and inter-professional conflicts, shifts in midwifery self-worth and the bullying culture that currently exist in some Australian maternity care environments is an evolutionary step through which we, as a profession, must pass. In New Zealand maternity care services the implementation of woman and midwifery focused maternity care options are more advanced. Although Guilliland and Pairman (2010) acknowledge that there were disruptions to midwifery ways of being when continuity of midwifery carer models of practice came into being in 1995, they claim that

now midwives working in either a continuity or non-continuity of midwifery carer model of practice work respectfully together. New Zealand midwives, regardless of the model of midwifery practice, are said to value each other's midwifery knowledge. (Guilliland & Pairman, 2010).

Australian midwives, with the support of their professional body and maternity service management, need to arrive at this stage in the evolution of midwifery ways of working and valuing each other. In order for midwives to have a sense that their midwifery knowledge is valued, a multi-layered approach is required. Not only do the midwifery professional body and maternity service management need to be involved but midwifery educational facilities need to educate future midwives about the value of midwifery and woman-centred care in all its forms. This is discussed further under the chapter heading – *Midwifery education*. Currently, the majority of midwives in Australia work in on-continuity of midwifery carer models of practice. The absence of a continuity of midwifery carer model of practice appears to have allowed the midwives in this study to position the blame for their inability to provide the other elements of woman-centred care with maternity service management. However it is the individual midwife who is responsible for enabling a woman to feel safe and valued within her maternity care encounter. A midwife needs to be able and capable of facilitating the conditions that communicate trust and respect, regardless of the time frame or midwifery context. A safe environment is then created in which the woman is more able to connect emotionally with her carer and engage in her maternity care. The conditions are created that can facilitate a positive maternity care experience for the woman. In order for the midwife to be available for the woman, to create the conditions in which a woman is able to feel valued and safe to have a voice and make a choice, the midwife must equally have the resources and conditions in which they can feel valued in their midwifery choices and safe in their midwifery voices. Midwifery management that makes available the resources and conditions that support midwives to be available for both the childbearing woman and student midwife learning, demonstrate a valuing of midwifery and women. These conditions facilitate maternity care encounters that can be, what the socially disadvantaged women in this study described

as, woman-centred. Figure 10.1 - *Being available: model for maternity care*, demonstrates a maternity service management model that has the potential to facilitate woman-centred maternity care encounters and midwifery ways of being available for the woman.

Figure 10-1 Being available: model for maternity care



10.2 Midwifery education

Findings from this study indicate that participating student midwives did not feel valued in the clinical environment. They also understood that midwifery ways of being were not valued in the clinical environment and expressed that they did not feel safe to practise midwifery ways of working with women during their clinical placements. These students understood that they were not highly regarded as future midwifery colleagues, or considered with respect. It was made obvious to them through the actions and reactions of the maternity care culture that they were not valued. Given that student midwives are likely to take on the behaviours and values of registered midwives with whom they work (Bluff & Holloway, 2008), it is important that all midwives become supportive of, and value, student midwife learning. They also need to role model midwifery ways of working with women that demonstrate a valuing of the woman by being available. There is also potential for improved student learning and application of midwifery theoretical knowledge in the clinical environment with better guidance from midwives. Maternity services therefore need to better support midwives to be available for student midwife learning. While these students recounted being ignored, dismissed or intimidated into silence, research supports that improving a student's sense of being accepted and valued within the clinical environment will improve their clinical competence, critical thinking skills and therefore improve patient safety (Levett-Jones & Lathlean, 2008).

Findings from the current study also revealed that not all midwives value current midwifery teachings. Some midwives in this study expressed that universities do not teach students midwifery theories or models of care that can be used in the maternity care environment. Equally, students in this study suggested that registered midwives do not understand or value what students are taught in the university and how that knowledge might be applied in practice. It is important, therefore, that registered midwives understand what is involved in student midwife education so that they can better guide and guard students in their learning in order to align midwifery theory and practice.

Students also suggested that registered midwives need to continually engage in mandatory woman-centred care and normal birth education sessions to maintain congruence between their ways of working and midwifery's philosophical underpinnings of woman-centred care. While midwives are reported to be the guardians of normal birth, there is no requirement for midwives to maintain any formal education in the area of midwifery ways of being. Mandatory education is currently concerned with occupational health and safety, fire safety, infection control, adult resuscitation, fetal welfare, obstetric emergencies and neonatal resuscitation. The introduction of annual mandatory attendance at one continuing professional development activity that focuses on midwifery ways of working with women during the childbirth continuum, would demonstrate a valuing of midwifery ways of being, as well as supporting midwives to maintain their midwifery philosophical underpinnings.

Midwifery students in this study also spoke of midwifery academia as not truly valuing the philosophical underpinnings of midwifery. Participating students voiced that the shortcomings of their midwifery education stemmed from a failure to integrate the elements of woman-centred care throughout their entire midwifery program. When the concept of woman-centred care is provided as a stand-alone module or only associated with normal birth, well women or continuity of midwifery carer models of practice, it communicates to students that woman-centred care is not possible in all midwifery contexts. The views of students in the current study provide an understanding that woman-centred care needs to be incorporated into all content and assessed throughout each midwifery course and the midwifery program as a whole. Equally, midwifery students can benefit from learning the concepts of 'being available', 'feeling valued' and 'feeling safe' within the maternity care encounter. These concepts have the potential to facilitate meaningful woman-midwife interactions regardless of the midwifery context, to develop a sense of midwifery worth of self and colleagues and to make possible a model of care that the woman describes as woman-centred.

10.3 Evaluating the study: limitations and possibilities for further midwifery research

Smith and colleagues (2009) suggest that researchers refer to Lucy Yardley's work - *Dilemmas in Qualitative Health Research* (2000), when evaluating their own research processes. As discussed in the thesis section titled – *Processes for new understandings*, the four characteristics that define good qualitative research are:

- Sensitivity in context;
- Commitment and rigour;
- Transparency and coherence; and
- Impact and importance (Yardley, 2000, p.219).

These four characteristics were covered in depth in chapter 4 – *Researching understandings*. In addition to Yardley's four characteristics, Smith and colleagues suggest the researcher reflects on what was learnt during the research process, what was done well and not so well (limitations), and what might be done differently in the future (potential research opportunities). I will refer to Yardley's characteristics and Smith and colleagues' points for consideration in discussing the limitations of this study and possibilities for further research.

10.3.1 Evaluating the study

What was done well: I believe I followed the Interpretative Phenomenological Analysis textbook as closely as possible and although some processes were modified to suit my midwifery philosophical underpinnings and the needs of participants, I maintained methodological congruence - that is, the fit between the research philosophical stance and the research design and methods. The initial collection of data, achieved by going to participants and holding focus groups in four different states in Australia, was also done well. Although not all engaged reasoning processes were documented in my research journal, incorporation of the engaged reasoning journal reflections into my decision-making and other research processes was done well. See appendix J for an extract of my research journal.

All of Yardley's characteristics of good quality research were done well. Commitment; concerned with the degree of attentiveness to the participant, and rigour; referring to the completeness of data collection, closely align with sensitivity in context, and were done well in the following ways. Attentiveness to the needs of all participants was demonstrated through the use of sensitive data collection, analysis and verification processes. The data collection approach selected, focus groups, was appropriate for women. Attentiveness was also demonstrated through the facilitation of segregated focus groups for data collection. I wanted each group of participants, that is, socially disadvantaged women, registered midwives and student midwives, to feel safe in voicing their understandings of maternity care encounters. I approached participants and facilitated the focus groups in venues in which participants would feel as comfortable as possible, given the inherent power imbalances between researcher and participant. The completeness of data collection and analysis, along with the characteristics of transparency and coherence, were demonstrated through the inclusion of a data analysis sequence table (page 4-97), justification for modifying the chosen research approach (provided in chapter 4) and the presentation of separate findings chapters for each participant group. Each findings chapter provided the understandings of a separate group of participants. Large extracts from participant's transcripts, using their words verbatim, were fashioned into three narratives that were followed by preliminary analysis as well as extracts from the individual group's table of emerging themes.

Yardley (2000) claims that coherence also refers to the degree of consistency and logic between the research approach selected and philosophical perspective adopted by the researcher. As stated in chapter 4, Interpretative Phenomenological Analysis is considered to be a person-centred research approach. The analytical process involved a collaborative woman-centred approach, with participants engaged in preliminary interpretative processes. In addition, Smith and colleagues (2009) suggest that coherence can be judged by the reader - does the thesis present a coherent argument with themes presented as plausible conclusions arising from the data? I believe that I have

walked the reader through each step of the research process with clear examples of how the process was undertaken.

The final characteristic that defines good qualitative health research is the ability to inform intended audiences of something that is interesting, important and can have an impact on practice (Yardley, 2000). The results from this study have highlighted the difference in understandings, as described by socially disadvantaged women, registered midwives and student midwives, around what constitutes woman-centred care. A clearer understanding of what woman-centred care means for all participants involved in maternity care encounters, and how it might be accomplished for socially disadvantaged women, is important for midwifery practice. The implications for midwifery practice, education and research have already been discussed in this chapter.

What was done not so well: limitations of this study, or aspects that were not done as well as they could have been were - recruitment strategies, data collection mechanisms for the follow-up focus groups, selection of, and inclusion criterion for individual participants and clear identification of individual participant voices. While recruitment processes and the challenges associated with recruiting socially disadvantaged women were discussed in detail in chapter 4 – *Researching understandings*, it should be mentioned here that personal knowledge of the women through the formation of a relationship prior to recruitment attempts would have assisted the research process. I should have met with the women to gain their trust prior to any attempt to recruit them into a research project. According to Yancey and colleagues (2006), distrust is a barrier to recruitment and that distrust can be eliminated through effective communication between researchers and potential participants as to common goals for both. This strategy may have assisted with recruitment of midwives as well. Although I worked closely with midwives from two local health district maternity services, I only managed to achieve one focus group from within my own state. Midwives may have been distrusting of my research agenda. I could have made it clearer to midwives at both local health district maternity services as to the potential goals for midwives, women and myself.

Stage two of the data collection process was planned to involve travelling to the primary sites of data collection again. However, time restrictions and travel expenses were considered prohibitive for repeating the same number of follow-up focus groups. Therefore teleconferencing and shared venues were arranged for follow-up focus groups. I also believed that holding collective follow-up focus groups for stage two would best ascertain if any participant/s disagreed with the preliminary findings from each participant group (as a whole). I now understand that I could have taken the preliminary findings to each follow-up group, provided collective feedback and sought instances of agreement or difference in understanding. Going to participants for the second focus group would have demonstrated my valuing of their time and potentially increased participation rates.

Finally, inclusion criterion and individual participant details could have been tailored to provide more in-depth and integrated findings. While all participants in this study had the ability to describe a maternity care encounter in which a socially disadvantaged woman had been the recipient of care, participants from each group did not interact. Therefore, no recounted experience was a description of the same maternity care encounter from a different, or idiographic perspective. It would have been interesting and perhaps more valuable to explore how a socially disadvantaged woman, the registered midwife working with that woman and a student midwife observing the woman-midwife interaction all experienced the same maternity care encounter.

Furthermore, with the exception of one woman, no woman participating in this study experienced a continuity of midwifery carer model of maternity care. Given that all participating midwives and students in this study understood continuity of midwifery carer to be the essential element of woman-centred care, it would have been interesting to have the views of socially disadvantaged women who had experienced such a model of care. Participating student midwives were all from one university and were all registered nurses undertaking a post graduate midwifery qualification. Their views may have been different from undergraduate midwifery students. The aspects that were not done so well, selection and inclusion criteria and clear identification of individual participant voices are discussed next under the

chapter heading - *What might be done differently: possibilities for future midwifery research.*

10.4 What might be done differently: possibilities for future midwifery research

Findings from this study indicate that further midwifery discussions and research need to occur regarding what a midwife-woman relationship entails within various models of maternity care and midwifery contexts. Can a midwifery partnership or midwife-woman relationship develop in non-continuity of midwifery carer encounters? Findings from this study also indicate that women do form relationships with the “*nice ones*” and research in this area has the potential to support midwives in understanding and valuing their midwifery worth in different midwifery contexts.

As stated earlier in this chapter, no socially disadvantaged woman in this study, with the exception of one, received a continuity of midwifery carer model of maternity care. What are socially disadvantaged women’s experiences of continuity of midwifery carer models of maternity care? With the current push for continuity of midwifery carer models of practice to be expanded in Australian maternity services, further research into socially disadvantaged women’s experiences of continuity of midwifery carer models of care can support midwives in providing care that meets this group of women’s needs.

Greater understanding of how women define and evaluate the maternity care they receive is also required. No one but the woman can determine if she has been a recipient of woman-centred care. However evaluation of the midwifery care provided is rarely sought from the woman in a formal manner by the midwives involved in the woman’s care, or at a time that might result in more valuable and measurable indicators of the service and care provided. It has been reported that women’s experiences of birth alter over time (Lundgren, 2005). Seeking women’s views of their care through patient surveys is not considered the best form of care or service evaluation. Lundgren recommends that “the basis for maternity care should be influenced by women’s long-term experiences of childbirth” (2005, p. 346). Research into how to appropriately

evaluate socially disadvantaged women's midwifery care experiences has the potential to ensure that the care provided is more closely aligned with what women determine to be woman-centred.

This research, while exploring the different, or idiographic, perspectives of individual groups of participants, exposes an opportunity for further research that explores the inter-related understandings of participants involved in the same maternity care encounter. Research examining the understandings of a socially disadvantaged childbearing woman, the midwife working with the woman in a midwifery continuity of carer model of practice, and a student midwife observing the woman-midwife interactions can increase midwifery understandings of the maternity care experiences of socially disadvantaged women and the experiences of those working with women with complex psychosocial needs. Although, the findings were presented as narratives created from a collection of participants' own words, aligning with the midwifery philosophy of woman-centred care, research that is able to clearly identify individual participant voices may provide a richer understanding of individual's experiences and support the recommendations resulting from this study.

Further research into undergraduate student midwife experiential learning of woman-centred care would be valuable in increasing midwifery educators' understanding of the best methods to teach midwifery philosophies to enable application in practice. Student midwives in the current study voiced negative comments in relation to their learning of woman-centred care, both in the academic environment and clinical settings. While these students were all registered nurses undertaking a post graduate midwifery qualification and their views may be different to those of undergraduate midwifery students, further research exploring undergraduate midwifery students experiences would add further knowledge in this area of midwifery education. Midwifery educational programs and curriculum development and implementation, are other areas of midwifery education that need further research. Students in this study voiced that the values and elements of woman-centred care were rarely discussed following their initial teachings that related to normal birthing processes and the well woman. How can midwifery expect student midwives to learn that

woman-centred care is possible in all midwifery contexts when there is minimal midwifery dialogue around woman-centred care outside the labour and birth context involving well women and normal birth processes? Further research into curriculum implementation, including content and assessment strategies, that facilitates woman-centred care processes in all midwifery contexts has the potential to support midwives in the provision of woman-centred care in practice. Finally, other issues important to the field of midwifery that were apparent in the data (e.g. bullying culture), while falling outside the scope of this thesis require further research.

10.5 Conclusion

Findings from this study indicate that it is time for midwives and other health professionals working in the maternity care environment to re-consider how care described by the woman to be woman-centred can be implemented within every maternity care encounter, and how midwives can provide that care with both parties feeling safe and valued. I argue that midwives need to understand that no one element can define woman-centred care, and no one but the woman can determine if she has been a recipient of woman-centred care. It is the individual midwife or health care professional who creates the conditions within each maternity care encounter that facilitates or impedes a woman's ability to have a voice and choice. While continuity of midwifery carer models of practice are better suited to facilitating positive relationships between women and midwives and to assisting midwives to focus their attention on the needs of the individual woman rather than the institution, 'being available' is about being there, physically and emotionally, for the woman within each and every maternity care encounter, regardless of the model of care. The needs of the individual woman can be taken into consideration during every maternity care encounter, regardless of the midwifery context or model of care.

In order for the midwife to be available for the woman, however, the midwife needs to be guarded and guided by the maternity unit management and local health district management to work autonomously within their full scope of professional practice. Continuity of midwifery carer models of practice need to

be promoted as the primary option of maternity care for all childbearing women, with the midwife feeling safe to provide midwifery-led models of care. The midwife needs to feel that midwifery ways of working with women are valued by midwifery colleagues and other health care professionals within the maternity service. The midwife, regardless of the model of care, needs to feel safe to be available for student midwives and women within the maternity care encounter. When the student midwife is guarded and guided by the midwife, the student will feel valued and safe to engage in learning to be a woman-centred midwife, and when the midwife is available for the woman, the woman will feel valued and safe enough to have a voice and engage in choice. The woman is more likely, therefore, to receive what she understands to be woman-centred care.

Section 6: Appendices

Appendix A: Women's information statement



Appendix 1

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Women's Information Statement for the Research Project:
Woman-centred care: the experiences of registered midwives, student midwives and women
Document Version 1; dated 23/03/09

You are invited to participate in the research project identified above which is being conducted by Associate Professor Alison Ferguson, from the School of Humanities and Social Science, Faculty of Education and Arts; Dr Helen Bellchambers, School of Nursing and Midwifery, Faculty of Health; Lyn Ebert PhD candidate, School of Nursing and Midwifery, Faculty of Health at the University of Newcastle.

The research is part of Lyn Ebert's studies at the University of Newcastle, supervised by Associate Professor Alison Ferguson.

Why is the research being done?

Woman-centred care is defined as care that focuses on the individual woman's needs; providing her with choice, continuity and control over maternity services. Research of women's experiences of maternity care has been conducted largely with women whose age and social, economic, and educational background may result in different experiences and perceptions than women experiencing social, economic and/or educational difficulties. The purpose of this study is to:

- Explore women's experiences of woman-centred care, as provided by midwives;
- Provide women experiencing social, economic and/or educational difficulties with a voice regarding their experiences within the health care system.
- Explore woman-centred care from the perspective of midwives working with women experiencing social, economic and/or educational difficulties; and
- Explore student midwives experiences of woman-centred care as observed during the midwife-woman interaction.

Who can participate in the research?

We are seeking women who have received midwifery care and may be experiencing social, economic and/or educational hardship. As a group member of the Wyong School as Community Centre (SaCC) you are invited to participate in the study. To join the study you should:

- Have given birth in the previous 24 months; **or**
- Have received maternity care from a registered midwife within the previous 24 months; **or**
- Currently attend one of the Wyong SaCC groups.

This study may not be suitable for you if you:

- Have not given birth within the previous 24 months; **or**
- Have not received maternity care from a registered midwife within the previous 24 months; **or**
- Do not attend one of the Wyong SaCC groups.

What choice do you have?

Participation in this research is entirely your choice. Only those women who give their written, informed consent will be included in the project. Whether or not you decide to participate, your decision will not disadvantage you. If you do decide to participate, you may withdraw from the project at any time without giving a reason. You have the option of withdrawing any information which you feel identifies you.

What would you be asked to do?

If you agree to participate, you will be asked to take part in one (1) small focus group and one larger (collective group). The initial focus group will consist of 3-5 women. The focus groups will be held at Wyong SaCC. You will be asked to share your experiences of maternity care you received while pregnant, during labour and birth and following the birth of your baby. You would be asked to include the following information:

- What type or model of care you received? That is, midwifery-only care with primarily one midwife throughout, shared care with midwives and G.P., or hospital based care with different midwives at each visit?
- How you came to have that type or model of care?

I (Lyn Ebert) will conduct the focus group. The focus group will be audio-recorded. Audio-recordings allow me to attend to the focus group discussion and listen rather than write throughout the group meeting. After the recorded information has been typed up you will be invited to meet with other women from SaCC as a larger group. This focus group will consist of 9-15 women. Participating in the first focus group does not oblige you to participate in the second (larger group). During the larger group meeting you will have the opportunity to hear the group's collective experiences. You will then be invited to share your ideas of how future midwifery care experiences could be improved for you. This larger group will also be audio-recorded.

How much time will it take?

Each focus group will last no longer than 90 minutes. The focus groups will be held within Wyong SaCC operating times. You are not expected to spend any longer than 3 hours in total over 2 sessions.

Participation involves:

- One (1) focus group that lasts up to 90 minutes,
- One (1) collective focus group (with all the women in the study) that lasts up to 90 minutes.

What are the risks and benefits of participating?

There are no anticipated risks or direct benefits to you in participating in this research.

How will your privacy be protected?

Any information collected by the researcher which might identify you will be stored securely and only accessed by the researchers unless you consent otherwise, except as required by law. There are limits on assurances of confidentiality as research data/records may be subpoenaed by law. The focus group is the unit of analysis and as such is non-identifiable. Audio recordings will be destroyed following the recordings being typed up. Written information from the recordings will not identify participants or third parties. Any information collected by the researcher will be retained for at least 5 years at the University of Newcastle.

During the focus group discussions you will be asked to avoid using the names of third parties, for example the midwife, doctor or other health professionals. All names will be removed from the written version of the recording. You are also requested to maintain the confidentiality of the group discussion and not divulge the specific content to outside parties.

Please be aware that if you disclose information that indicates that you or your child are at risk of harm the researcher is obliged under the Child Protection Act (1998) to report this to the relevant authorities. If you disclose incidences of illegal behaviour during the focus group with specific details about an incident (eg date, place, perpetrators), I may need to advise the relevant authorities.

How will the information collected be used?

Information collected will be presented in a thesis to be submitted for Ms Lyn Ebert's Doctor of Philosophy. As well as the thesis, results will be published in health professional journals. Individual participants will not be identified in the thesis or papers arising from the study. If you want, you will be provided a summary of the results from this study.

During the second focus group (larger group meeting) you will have the opportunity to hear the group's collective experiences. A written summary combining information from the initial focus groups will be available for you to read. You are able to change, add or delete any information that you can identify as yours, and that you feel has been misinterpreted by me. A summary of the second focus group findings and recommendations will be provided upon request. Again you can change, add or delete any information that you can identify as yours, and that you feel has been misinterpreted by me.

Should you wish to receive a copy of the final report summary, please phone or email the researcher, (contact details at the end of this form) following the second (collective) focus group to make arrangements for a copy to be sent to you.

What do you need to do to participate?

Please read this Information Statement and be sure you understand its contents before you consent to participate. If there is anything you do not understand, or you have questions, contact the researcher (Lyn).

If you would like to participate, please complete the attached consent form and return it in the reply paid envelope provided, or leave the form with the Wyong SaCC group facilitator, who will contact me (Lyn) to retrieve it. I will then contact you to confirm the focus group dates and times.

In addition, women attending a SaCC group on the dates the focus groups are running may join in the study. Additional information sheets and consent forms will be available for women to read, ask questions and make a decision regarding participation on the day.

Further information

If you would like further information please contact Lyn Ebert (student researcher), phone number (02) 43923246, or Alison Ferguson (Chief Investigator) phone number (02) 4921 5716.

Thank you for considering this invitation

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Associate Professor Alison Ferguson
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Complaints about this research

This project has been approved by the University's Human Research Ethics Committee, Approval No: H-2009-0194.

Should you have concerns about your rights as a participant in this research, or you have a complaint about the manner in which the research is conducted, it may be given to the researcher, or, if an independent person is preferred, to the Human Research Ethics Officer, Research Office, The Chancellery, The University of Newcastle, University Drive, Callaghan NSW 2308, Australia, telephone (02) 49216333, email Human-Ethics@newcastle.edu.au.

Appendix B: Conference midwives’ information statement

Appendix 4

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Australian College of Midwives 16th National Conference "Midwives and Women: A Brilliant Blend"
Conference Midwives' Information Statement for the Research Project:
Woman-centred care: the experiences of registered midwives, student midwives and women
Document Version 3; dated 29/06/09

You are invited to participate in the research project identified above which is being conducted by Associate Professor Alison Ferguson, from the School of Humanities and Social Science, Faculty of Education and Arts; Dr Helen Bellchambers, School of Nursing and Midwifery, Faculty of Health; Lyn Ebert PhD candidate, School of Nursing and Midwifery, Faculty of Health at the University of Newcastle.

The research is part of Lyn Ebert's studies at the University of Newcastle, supervised by Associate Professor Alison Ferguson.

Why is the research being done?

Woman-centred care is defined as care that focuses on the individual woman's needs; providing her with choice, continuity and control over maternity services. Research of women's experiences of maternity care has been conducted largely with women whose age and social, economic, and educational background may result in different experiences and perceptions than women experiencing social, economic and educational difficulties. The purpose of this study is to:

- Explore woman-centred care from the perspective of midwives working with socially disadvantaged women;
- Explore socially disadvantaged women's experiences of woman-centred care, as provided by midwives;
- Explore student midwives experiences of woman-centred care as observed during the midwife-woman interaction; and
- Provide women experiencing social, economic and/or educational difficulties with a voice regarding their experiences within the health care system.

Who can participate in the research?

We are seeking registered midwives who are currently practicing in a clinical capacity and working with women identified as experiencing social, economic and/or educational hardship. As a registered midwife you are invited to participate in the study. To join the study you should:

- Be registered to work as a midwife in Australia, **and**
- Have worked in a clinical capacity within the previous 12 months, **and**
- Have worked with women identified as disadvantaged within the previous 12 months.

You cannot participate in this study if you:

- Are not currently registered as a midwife in Australia, **or**
- Have not worked in a clinical capacity within the previous 12 months, **or**
- Have not worked with women identified as disadvantaged within the previous 12 months.

What choice do you have?

Participation in this research is entirely your choice. Only those midwives who give their written, informed consent will be included in the project. Whether or not you decide to participate, your decision will not disadvantage you. If you do decide to participate, you may withdraw from the project at any time without giving a reason. You have the option of withdrawing any information which you feel identifies you.

What would you be asked to do?

If you agree to participate, you will be asked to take part in one teleconference focus group (with 3-5 participating midwives) and one follow-up focus group either by teleconference **or** a face-to-face collective focus group (with a larger number of participating midwives) to be held at the University of Newcastle, NSW. You will be asked to share your experiences of providing midwifery care for disadvantaged women. You would be asked to include the following information:

- What model of care you currently provide/practice? That is, midwifery-lead care, independent midwifery practitioner, share care or hospital based care.
- How you came to be providing that model of care?

I (Lyn Ebert) will conduct the focus group. The focus group will be audio-recorded. Audio-recordings allow me to attend to the focus group discussion and listen rather than write throughout the group meeting. After the recorded information has been transcribed you will be invited to meet with other participating midwives as a larger group, either face-to-face **or** via teleconference. Participating in the first focus group does not obligate you to participate in the second group. During the second meeting you will have the opportunity to hear the midwifery group's collective experiences. You will then be invited to share your ideas of how future midwifery care experiences could be improved for disadvantaged women and how midwives might be better supported to work with disadvantaged women and their families. This second group will also be audio-recorded.

How much time will it take?

Each focus group will last no longer than 90mins. You are not expected to spend any longer than 3 hours in total over 2 sessions. Participation involves:

1. One (1) teleconference focus group (with 3-5 midwives) that lasts up to 90 mins, and
2. One (1) collective teleconference focus group (with a larger number of midwives), lasting approximately 90 mins.

Or

2. One (1) collective (face-to-face) focus group with a larger number of midwives), lasting approximately 90 mins at the University of Newcastle, NSW.

What are the risks and benefits of participating?

There are no anticipated risks or direct benefits to you in participating in this research.

How will your privacy be protected?

Any information collected by the researcher which might identify you will be stored securely and only accessed by the researchers unless you consent otherwise, except as required by law. There are limits on assurances of confidentiality as research data/records may be subpoenaed by law. The focus group is the unit of analysis and as such is classed non-identifiable data. Audio recordings will be destroyed following transcription. Transcripts of recordings will not identify participants or third parties. Data will be retained for at least 5 years at the University of Newcastle.

During the focus group discussions you will be asked to avoid using the names of third parties, for example the women, her partner, doctor or other health professionals. All names will be removed from the written version of the recording. You are also requested to maintain the confidentiality of the group discussion and not divulge the specific content to outside parties.

Please be aware that if you disclose incidences of illegal behaviour during the focus group with specific details about an incident (eg date, place, perpetrators), I may need to advise the relevant authorities.

How will the information collected be used?

Information collected will be presented in a thesis to be submitted for Ms Lyn Ebert's Doctor of Philosophy. As well as the thesis, results will be published in health professional journals. Individual participants will not be identified in the thesis or papers arising from the study. If you want, you will be provided a summary of the results from this study.

During the second focus group (either a teleconference group **or** larger group meeting) you will have the opportunity to hear the group's collective experiences. A written summary combining information from the initial focus groups will be available for you to read. You are able to change, add or delete any information that you can identify as yours, and that you feel has been misinterpreted by me. A summary of the second focus group findings and recommendations will be provided upon request. Again you can change, add or delete any information that you can identify as yours, and that you feel has been misinterpreted by me.

Should you wish to receive a copy of the final report summary, please phone or email the researcher, (contact details at the end of this form) following the second (collective) focus group to make arrangements for a copy to be sent to you.

What do you need to do to participate?

Please read this Information Statement and be sure you understand its contents before you consider participating. If there is anything you do not understand, or you have questions, contact the researcher (Lyn) through the notice board in the conference lobby or phone 0438923246.

If you would like to participate, please complete the consent form and return it to the researcher (via notice board in the conference lobby) during the conference. Alternatively, you can return it via post to address listed on the bottom of the consent form. I will then contact you to confirm the focus group date and times.

Further information

If you would like further information please contact Lyn Ebert (student researcher), phone number 43923246, or Alison Ferguson (Chief Investigator) phone number (02) 4921 5716.

Thank you for considering this invitation

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Complaints about this research

This project has been approved by the University's Human Research Ethics Committee, Approval No: H-2009-0194.

Should you have concerns about your rights as a participant in this research, or you have a complaint about the manner in which the research is conducted, it may be given to the researcher, or, if an independent person is preferred, to the Human Research Ethics Officer, Research Office, The Chancellery, The University of Newcastle, University Drive, Callaghan NSW 2308, Australia, telephone (02) 49216333, email Human-Ethics@newcastle.edu.au.

Appendix C: Student midwives' information statement



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**Student Midwives' Information Statement for the Research Project:
Woman-centred care: the experiences of registered midwives, student midwives and women**

You are invited to participate in the research project identified above which is being conducted by Associate Professor Alison Ferguson, from the School of Humanities and Social Science, Faculty of Education and Arts; Dr Helen Bellchambers, School of Nursing and Midwifery, Faculty of Health; Lyn Ebert PhD candidate, School of Nursing and Midwifery, Faculty of Health at the University of Newcastle.

The research is part of Lyn Ebert's studies at the University of Newcastle, supervised by Associate Professor Alison Ferguson.

Why is the research being done?

Woman-centred care is defined as care that focuses on the individual woman's needs; providing her with choice, continuity and control over maternity services. Research of women's experiences of maternity care has been conducted largely with women whose age and social, economic, and educational background may result in different experiences and perceptions than women experiencing social, economic and educational difficulties. The purpose of this study is to:

- Explore student midwives experiences of woman-centred care as observed during the midwife-woman interaction.
- Explore socially disadvantaged women's experiences of woman-centred care, as provided by midwives;
- Explore woman-centred care from the perspective of midwives working with socially disadvantaged women; and
- Provide women experiencing social, economic and/or educational difficulties with a voice regarding their experiences within the health care system.

Who can participate in the research?

We are seeking student midwives who have observed the midwife-woman interactions between midwives and women experiencing social, economic and/or educational hardship. As a student midwife you are invited to participate in the study. To join the study you should:

- Be currently enrolled in the Graduate Diploma in Midwifery at the University of Newcastle, **and**
- Have completed a minimum of five (5) continuity of care experiences, **and**
- Have observed midwife-woman interactions with women identified as disadvantaged.

This study may not be suitable for you if you:

- Are not enrolled in the Graduate Diploma in Midwifery at the University of Newcastle, **or**
- Have not completed five (5) continuity of care experiences, **or**
- Have not observed midwife-woman interactions with women identified as disadvantaged.

What choice do you have?

Participation in this research is entirely your choice. Only those student midwives who give their written, informed consent will be included in the project. Whether or not you decide to participate, your decision will not disadvantage you. If you do decide to participate, you may withdraw from the project at any time without giving a reason. You have the option of withdrawing any information which you feel identifies you.

What would you be asked to do?

If you agree to participate, you will be asked to take part in one (1) initial focus group and a follow-up focus group. The initial focus group will be held at the University of Newcastle, Callaghan campus during the first Childbearing Woman and Her family (NURS6590) study day in October. You will be asked to share your experiences of observing the midwife-woman interaction. To help me gain a better understanding of your experience you may be asked to some or all of the following questions:

1. Can you describe the various models of midwifery care in which you have observed midwives working with socially disadvantaged women? *Have you observed midwifery-lead care, an independent midwifery practitioner, shared care, or hospital based care?*
2. Do you feel, socially disadvantaged women are given a choice regarding the model of care they receive, including place of birth and birth attendant?
3. To what extent do you think socially disadvantaged women are able to take control regarding screening tests, procedures and other health care options?
4. Can you describe how information is presented to women so they can make informed decisions?
5. Can you describe the type of relationships that you observed between midwives and socially disadvantaged women?
6. To what extent do you feel midwives are able to address socially disadvantaged woman's emotional, psychological and social needs as well as physical needs?
7. How do you feel about the midwife's role of reducing social and health inequalities?
8. To what extent did the midwives you observed provide care focused on the woman's individual needs?

I (Lyn Ebert) will conduct the focus group. The focus group will be audio-recorded. Audio-recordings allow me to attend to the focus group discussion and listen rather than write throughout the group meeting. After the recorded information has been transcribed you will be invited to meet again. Participating in the first focus group does not oblige you to participate in the second group. During the second focus group you will have the opportunity to share your ideas of how future midwifery care experiences for disadvantaged women and student learning in the clinical setting could be improved. The second focus group will also be audio-recorded.

How much time will it take?

Each focus group will last no longer than 90 minutes. You are not expected to spend any longer than 3 hours in total over 2 sessions. Participation involves:

- One (1) initial focus group that lasts up to 90 minutes during a study day in NURS6590.
- One (1) follow-up focus group that lasts up to 90 minutes (date and time to be announced during initial focus group).

What are the risks and benefits of participating?

There are no anticipated risks or direct benefits to you in participating in this research.

How will your privacy be protected?

Any information collected by the researcher which might identify you will be stored securely and only accessed by the researchers unless you consent otherwise, except as required by law. There are limits on assurances of confidentiality as research data/records may be subpoenaed by law. The focus group is the unit of analysis and as such is non-identifiable. Audio recordings will be destroyed following transcription. Transcripts of recordings will not identify participants or third parties. Data will be retained for at least 5 years at the University of Newcastle.

During the focus group discussions you will be asked to avoid using the names of third parties, for example the midwife, woman, doctor or other health professionals. All names mentioned will be removed from the written version of the recording. You are also requested to maintain the confidentiality of the group discussion and not divulge the specific content to outside parties.

Please be aware that if you disclose incidences of illegal behaviour during the focus group with specific details about an incident (eg date, place, perpetrators), I may need to advise the relevant authorities.

How will the information collected be used?

Information collected will be presented in a thesis to be submitted for Ms Lyn Ebert's Doctor of Philosophy. As well as the thesis, results will be published in health professional journals. Individual participants will not be identified in the thesis or papers arising from the study. If you want, you will be provided a summary of the results from this study.

During the second focus group you will have the opportunity to hear the group's collective experiences. A written summary combining information from the initial focus group will be available for you to read. You are able to change, add or delete any information that you can identify as yours, and that you feel has been misinterpreted by me. A summary of the second focus group findings and recommendations will be provided upon request. Again you can change, add or delete any information that you can identify as yours, and that you feel has been misinterpreted by me.

Should you wish to receive a copy of the final report summary, please phone or email the researcher, (contact details at the end of this form) following the second (collective) focus group to make arrangements for a copy to be sent to you.

What do you need to do to participate?

Please read this Information Statement and be sure you understand its contents before you consent to participate. If there is anything you do not understand, or you have questions, contact the researcher (Lyn).

If you would like to participate, please complete the consent form and return it to the address shown on the consent form, bring the consent form to the first NURS6590 study day or leave the completed form with the midwifery program convenor, Bronwyn Agnew, who will contact me (Lyn) to retrieve it.

Further information

If you would like further information please contact Lyn Ebert (student researcher), phone number (043923246), or Alison Ferguson (Chief Investigator) phone number (02) 4921 5716.

Thank you for considering this invitation

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Complaints about this research

This project has been approved by the University's Human Research Ethics Committee, Approval No: H-2009-0194.

Should you have concerns about your rights as a participant in this research, or you have a complaint about the manner in which the research is conducted, it may be given to the researcher, or, if an independent person is preferred, to the Human Research Ethics Officer, Research Office, The Chancellery, The University of Newcastle, University Drive, Callaghan NSW 2308, Australia, telephone (02) 49216333, email Human-Ethics@newcastle.edu.au.

Appendix D: Interview schedule for women

Appendix 9

Interview Schedule for Women's Initial Focus Group/s

Woman-centred care: the experiences of registered midwives, student midwives and women

Associate Professor Alison Ferguson, Dr Helen Bellchambers, PhD Student Lyn Ebert

Document Version 2; dated 19/06/09

I. Opening

A. (Establish Rapport): Welcome and thank you for allowing me to share some time with you. My name is Lyn Ebert and as a research student interested in women's experiences of midwifery care, specifically woman-centred care, [insert name of facilitator] thought it would be a good idea to speak with you.

B. (Purpose): I am asking that you share your personal experiences of midwifery care from your first booking in visit with the midwife, when you found out you were pregnant up until the last visit from or with a midwife, after the birth of your baby/ies.

C. (Motivation): I hope to use your shared knowledge and stories to gain a better understanding of how women living through economic, social and/or educational hardships experience midwifery care.

D. (Time Line): Each focus group should take 2 hours at the most.

Transition: Let me begin by asking you to take control of this group. Would each of you please take a turn in sharing your experience of pregnancy and the midwifery care you received? Each person here will have a turn to recall her story and experiences. The other members of this group can ask questions of the person sharing if they don't understand something. Please try not to use the names of third parties, for example the midwife, doctor or other health professionals. If you forget, do not worry, all names will be removed from the written version of the recording.

II Body

(Focus group 1, 1st participant's name): Please share with the group your experiences of midwifery care, from when you first learnt that you were pregnant up until the last visit from/with a midwife, after the birth of your baby/ies. I may ask you some, or all of the following questions to help me gain a better understanding of your experience:

1. What type of care did you receive throughout? *That is, was it midwifery-only care with primarily one midwife throughout, shared care with midwives and G.P., or hospital based care with different midwives at each visit?*
2. What made you choose that type of care?
3. Did you feel that you had a choice about which midwife you saw each visit?
4. Can you describe the relationship you had with the midwife or midwives caring for you?
5. To what extent did you feel you were able to have control regarding what happened to you and your baby/ies?
6. Regarding tests and procedures can you describe how the options were discussed with you so that you could make a decision?
7. Do you feel the midwives understood what your day-to-day life was like for you at that time?
8. For you what was the worst thing about the care you received during your pregnancy, labour and birth and/or after the birth of your baby?
9. For you what was the best thing about the care you received during your pregnancy, labour and birth and/or after the birth of your baby?

Transition: (if other participants have not joined in the conversation): Thank you [name of participant1] for sharing your experiences. [Participant 2: name], would you like to share your experiences now?

(Focus group 1, 2nd and subsequent participants): Please share with the group your experiences of midwifery care, from when you first learnt that you were pregnant up until the last visit from/with a midwife, after the birth of your baby/ies. I may ask you some, or all the following questions to help me gain a better understanding of your experience:

1. What type of care did you receive throughout? *That is, was it midwifery-only care with primarily one midwife throughout, shared care with midwives and G.P., or hospital based care with different midwives at each visit?*
2. What made you choose that type of care?
3. Did you feel that you had a choice about which midwife that you saw each visit?
4. Can you describe the relationship you had with the midwife or midwives caring for you?
5. To what extent did you feel that you were in control of what happened to you and your baby/ies?
6. Regarding tests and procedures can you describe how the options were discussed with you so that you could make a decision?
7. Do you feel the midwives understood what your day-to-day life was like for you at that time?
8. For you what was the worst thing about the care you received during your pregnancy, labour and birth and/or after the birth of your baby?
9. For you what was the best thing about the care you received during your pregnancy, labour and birth and/or after the birth of your baby?

(Above steps repeated until all participants have shared their experiences)

Transition: Thank you for sharing today. It has been a pleasure finding out more about your experiences. Let me briefly summarize the information that I have recorded during this focus group.

III Closing

A. **(Summarize)** I am hearing that your experiences involve _____.

B. **(Maintain Rapport):** I appreciate the time you took for this focus group. Is there anything else you think would be helpful for me to know so that I can successfully make known your experiences of midwifery care?

C. **(Action to be taken):** I should have all the information I need. I would like to ask you to attend a collective focus group here on the _____[date] at _____[time]? During that meeting I will have the information from today in written form as well as information from other (women's) focus groups. I will bring enough copies of information collected to date for everyone attending the collective focus group to keep a copy. If you are unable to attend the collective focus group and would like a written summary of information collected from the women's focus groups please contact me. My contact details are on the information statement that you have. We can go over the collective information and see if you are happy with how I have interpreted your stories. You will have the chance to change, add or delete any information that you can identify as yours and that you feel has been misunderstood by me.

Thanks again. I look forward to seeing you on _____[date].

Appendix: E: Interview schedule for registered midwives

Appendix 11

Interview Schedule for Registered Midwife Initial Focus Group/s

Woman-centred care: the experiences of registered midwives, student midwives and women

Associate Professor Alison Ferguson, Dr Helen Bellchambers, PhD Student Lyn Ebert

Document Version 2; dated 19/06/09

I. Opening

A. (**Establish Rapport**): Welcome and thank you for allowing me to share some time with you. My name is Lyn Ebert and as a research student interested in midwives' experiences of providing woman-centred care to disadvantaged women, I thought it would be a good idea to speak with you.

B. (**Purpose**): I am asking that you share your personal experiences of working with disadvantaged women. This may include your interactions during booking-in visits through to the final postnatal visit or any interaction in between.

C. (**Motivation**): I hope to use your shared knowledge and stories to gain a better understanding of how midwives work with women living through economic, social or educational hardships. The information obtained from you will be coupled with information obtained from women experiencing economic, social or educational hardships and student midwives who observe midwife-woman interactions, specifically when the women are identified as experiencing economic, social or educational hardships.

D. (**Time Line**): The focus group should take 2 hours at the most.

Transition: Let me begin by asking you to take control of this group. Would each of you please take a turn in sharing your experience of providing midwifery care to disadvantaged women? Each person here will have a turn to recall their stories and experiences. Other members of this group can ask questions of the person sharing if they don't understand something. Please try not to use the names of third parties, for example the woman, her partner, doctor or other health professionals. If you forget, do not worry, all names will be removed from the written version of the recording.

II Body

(**Focus group 1, 1st participant's name**): Please share with the group your experiences of working with disadvantaged women. I may ask you some, or all of the following questions to help me gain a better understanding of your experience:

1. Can you describe the model of midwifery care you currently practice? *Is it midwifery-lead care, independent midwifery practitioner, shared care, or hospital based care?*
2. Why do you think you chose that model?
3. Do you feel, socially disadvantaged women are given a choice regarding the model of care they receive, including place of birth and birth attendant?
4. To what extent do you think socially disadvantaged women are able to take control regarding their care options?
5. Can you describe how information is presented to women so they can make health care decisions?
6. Given your current model of practice, can you describe the type of relationships that you are able to establish with socially disadvantaged women?
7. To what extent do you feel able to address the socially disadvantaged woman's emotional, psychological and social needs as well as her physical needs?
8. How do you feel about your role as a midwife to reduce social and health inequalities?
9. What is it like for you working with socially disadvantaged women?

Transition (if other participants have not joined in the conversation): Thank you [participant1] for sharing your experiences. [Participant 2] would you like to share your experiences now?

(Focus group 1, 2nd and subsequent participants) Please share with the group your experiences of working with disadvantaged women. I may ask you some, or all of the following questions to help me gain a better understanding of your experience:

1. Can you describe the model of midwifery care you currently practice? *Is it midwifery-lead care, independent midwifery practitioner, shared care, or hospital based care?*
2. Why do you think you chose that model?
3. Do you feel, socially disadvantaged women are given a choice regarding the model of care they receive, including place of birth and birth attendant?
4. To what extent do you think socially disadvantaged women are able to take control regarding their care options?
5. Can you describe how information is presented to women so they can make health care decisions?
6. Given your current model of practice, can you describe the type of relationships that you are able to establish with socially disadvantaged women?
7. To what extent do you feel able to address the socially disadvantaged woman's emotional, psychological and social needs as well as her physical needs?
8. How do you feel about your role as a midwife to reduce social and health inequalities?
9. What is it like for you working with socially disadvantaged women?

(Above steps repeated until all participants have shared their experiences)

Transition: Thank you for sharing today. It has been a pleasure finding out more about your experiences. Let me briefly summarize the information that I have recorded during this focus group.

III Closing

A. **(Summarize):** I am hearing that your experiences involve _____.

B. **(Maintain Rapport)** I appreciate the time you took for this focus group. Is there anything else you think would be helpful for me to know so that I can successfully make known your experiences of working with disadvantaged women?

C. **(Action to be taken)** I should have all the information I need. I would like to ask you to attend a collective focus group here on the _____ [date] at _____ [time]? Some midwives from the Australian College of Midwives 16th National Conference in Adelaide this year may attend the collective focus group. During that meeting I will have the information from today in written form as well as information from other (midwives') focus groups, including information obtained from conference participants. I will bring enough copies of information collected to date for everyone attending the collective focus group to keep a copy. If you are unable to attend the collective focus group and would like a written summary of information collected from the midwives' focus groups please contact me. My contact details are on the information statement that you have. We can go over the collective information and see if you are happy with how I have interpreted your experiences. You will have the chance to change, add or delete any information that you can identify as yours and that you feel has been misinterpreted by me.

Thanks again. I look forward to seeing you on _____ [date].

Appendix F: Position paper 4a: woman-centred care



Position Paper No. 4a
WOMAN-CENTRED CARE

Introduction

‘Woman-centred care’ is the term used for a philosophy of maternity care that gives priority to the wishes and needs of the user, and emphasises the importance of informed choice, continuity of care, user involvement, clinical effectiveness, responsiveness and accessibility. All four countries of the UK introduced policies for maternity services reform in the early 1990s that aimed to make the planning and delivery of maternity care more responsive to women’s own needs and wishes, and to improve women’s ability to make informed choices about many aspects of their care (Department of Health, 1993; Department of Health and Social Services Northern Ireland, 1994; Scottish Office, 1993; Welsh Office, 1991).

These policies are still in place and have the support of the current Government, but they have been overtaken by new health policies and priorities. This paper sets out the RCM’s position on woman-centred care. It was first published in February 1995, and has been updated here to take account of recent developments in the NHS.

The fundamental principles of woman-centred care are:

- Ensuring women are equal partners in the planning and delivery of maternity care
- Recognising the service is there to meet their needs and wishes, rather than those of staff or managers
- Giving women informed choice in terms of the options available during pregnancy, labour and the postnatal period - such as who provides care, where it is given and what it contains
- Giving women continuity so they are able to form trusting relationships with those who care for them
- Giving women control over the key decisions affecting the content and progress of their care.

The RCM believes that truly woman-centred care must encompass:

1. A philosophy that affirms women’s own strength, power and skills, and commitment to promoting physiological labour and birth.
2. Midwifery-led care of normal pregnancy, birth and the postnatal period.
3. Services that are planned and provided close to women and the communities in which they live or work.
4. Integrated care across acute and primary sector boundaries.
5. A public health perspective, which takes account of wider social and environmental factors, commits resources to preventative health care, and aims to reduce health and social inequalities.

6. Maximised continuity of care and carer, with one-to-one midwifery care throughout labour.
7. A focus on pregnancy and childbirth as the start of family life, not just as isolated clinical episodes, taking full account of the meanings and values each woman brings to her experience of motherhood.
8. Funding structures and commitments that recognise the lifelong outcomes of maternal and infant health.
9. User involvement that goes beyond the tokenistic, to develop a real partnership between women and midwives.
10. Family-centred care that facilitates the development of confident, effective parenting.
11. Strengthened midwifery leadership, in order to promote professional excellence and maximise the contribution of the maternity services to the wider public health agenda.
12. Fair pay and family-friendly working conditions for all midwives.

Woman-centred care in the changing NHS

Properly implemented woman-centred care delivers many of the key priorities of the current NHS policy agenda:

- It puts greater power and control in the hands of those who use the health services, treating them as active partners in their own care
- It promotes seamless, integrated care across sectoral boundaries and professions
- It takes a holistic perspective, encompassing emotional, psychological and social as well as physical needs
- It supports the development of confident and effective parenting
- It promotes wider public health by working with women and their communities to develop strategies to promote breastfeeding and lifestyles which enhance wellbeing, and by offering a wide range of screening, testing and immunisations
- It reduces health inequalities by increasing disadvantaged women's access to services that are responsive to their specific needs
- It raises quality standards while remaining cost-effective.

Midwives and woman-centred care

The RCM is committed to the development of woman-centred care. Midwives are the experts in normal pregnancy, childbirth and postnatal care, and provide integrated care across the primary and secondary sectors. Nationally and locally, the midwifery profession works with user representatives to develop accessible, cost-effective, high quality services that meet women's physical, emotional and social needs.

Effective implementation of woman-centred care requires the development and sustenance of innovative models of service delivery. Midwifery-led care, where midwives act as the lead professional, with good liaison and referral links to medical colleagues, are popular with women, cost-effective, and deliver good outcomes. However, continuing improvements in care are difficult to achieve where midwifery is under-resourced, understaffed or demoralised (Ladipo et al, 1999). Successful implementation of woman-centred care depends on commissioners and managers recognising the role and value of midwifery care, and investing in this care with appropriate resourcing, fair pay, family-friendly working conditions, and support for midwifery leadership.

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February 2001
Royal College of Midwives

Appendix G: Interview schedule for student midwives

Appendix 10

Interview Schedule for Student Midwife Initial Focus Group/s

Woman-centred care: the experiences of registered midwives, student midwives and women

Associate Professor Alison Ferguson, Dr Helen Bellchambers, PhD Student Lyn Ebert

Document Version 2; dated 19/06/09

I. Opening

A. (**Establish Rapport**): Welcome and thank you for allowing me to share some time with you. My name is Lyn Ebert and as a research student interested in midwives experiences of providing woman-centred care to disadvantaged women, I thought it would be a good idea to speak with you.

B. (**Purpose**): I am asking that you share your personal experiences of working with midwives and disadvantaged women. This may include your observations of midwife-woman interactions during booking-in visits through to the final postnatal visit or any interaction in between.

C. (**Motivation**): I hope to use your shared knowledge and stories to gain a better understanding of how students learn in the clinical setting to work with women living through economic, social or educational hardships. The information obtained from you will be coupled with information obtained from women experiencing economic, social or educational hardships and midwives working with women experiencing economic, social or educational hardships.

D. (**Time Line**): Each focus group should take 2 hours at the most.

Transition: Let me begin by asking you to take control of this group. Would each of you please take a turn in sharing your experience of learning how to be a midwife providing care to disadvantaged women? Each group member will have a turn to recall their stories and experiences. Other members of the group can ask questions of the person sharing if they don't understand something. Please try not to use the names of third parties, for example the woman, her partner, midwife, doctor or other health professionals. All names will be removed from the transcript.

II Body

(**Focus group 1, 1st participant's name**): Please share with the group your experiences of observing midwives working with disadvantaged women. I may ask you some, or all of the following questions to help me gain a better understanding of your experience:

1. Can you describe the various models of midwifery care in which you have observed midwives working with socially disadvantaged women? *Have you observed midwifery-lead care, an independent midwifery practitioner, shared care, or hospital based care?*
2. Do you feel, socially disadvantaged women are given a choice regarding the model of care they receive, including place of birth and birth attendant?
3. To what extent do you think socially disadvantaged women are able to take control regarding screening tests, procedures and other health care options?
4. Can you describe how information is presented to women so they can make informed decisions?
5. Can you describe the type of relationships that you observed between midwives and socially disadvantaged women?
6. To what extent do you feel midwives are able to address socially disadvantaged woman's emotional, psychological and social needs as well as physical needs?
7. How do you feel about the midwife's role of reducing social and health inequalities?
8. To what extent did the midwives you observed provide care focused on the woman's individual needs?

Transition: (if other participants have not joined in the conversation): Thank you [participant1] for sharing your experiences. [Participant 2], would you like to share your experiences now?

(Focus group 1, 2nd and subsequent participants): Please share with the group your experiences of observing midwives working with disadvantaged women. I may ask you some, or all of the following questions to help me gain a better understanding of your experience:

1. Can you describe the various models of midwifery care in which you have observed midwives working with socially disadvantaged women? *Have you observed midwifery-lead care, an independent midwifery practitioner, shared care, or hospital based care?*
2. Do you feel, socially disadvantaged women are given a choice regarding the model of care they receive, including place of birth and birth attendant?
3. To what extent do you think socially disadvantaged women are able to take control regarding screening tests, procedures and other health care options?
4. Can you describe how information is presented to women so they can make informed decisions?
5. Can you describe the type of relationships that you observed between midwives and socially disadvantaged women?
6. To what extent do you feel midwives are able to address socially disadvantaged woman's emotional, psychological and social needs as well as physical needs?
7. How do you feel about the midwife's role of reducing social and health inequalities?
8. To what extent did the midwives you observed provide care focused on the woman's individual needs?

(Above steps repeated until all participants have shared their experiences)

Transition: Thank you for sharing today. It has been a pleasure finding out more about your experiences. Let me briefly summarize the information that I have recorded during this focus group.

III Closing

A. **(Summarize):** I am hearing that your experiences involve _____.

B. **(Maintain Rapport):** I appreciate the time you took for this focus group. Is there anything else you think would be helpful for me to know so that I can successfully make known your experiences of learning from and working with midwives who provide care for disadvantaged women?

C. **(Action to be taken):** I should have all the information I need. I would like to ask you to attend a collective focus group here on the _____ [date] at _____ [time]? During that meeting I will have the information from today in written form as well as information from other (student midwives') focus groups. I will bring enough copies of information collected to date for everyone attending the collective focus group to keep a copy. If you are unable to attend the collective focus group and would like a written summary of information collected from the student midwives' focus groups please contact me. My contact details are on the information statement that you have. We can go over the collective information and see if you are happy with how I have interpreted your experiences. You will have the chance to change, add or delete any information that you can identify as yours and that you feel has been misinterpreted by me.

Thanks again. I look forward to seeing you on _____ [date].

Appendix H: Emerging themes table for socially disadvantaged women

Interpretative Phenomenological Analysis – Analysis Table

Women

Theme	Woman's Quote	Exploratory comments
<p>Being Valued Being available</p>	<p>Suzie P.1/14: <i>"After about, I don't know, I think it was a month of going to see my doctor, he said you have to go to [name of] hospital'. [The doctor] "give[s] you a referral letter [and] just send[s] you off to the hospital. You don't really get a choice; you got to go to wherever the boundaries of the [local] hospital are".</i></p> <p>Sharon P.2/14: <i>"It [choice of care models] was never even mentioned, I did ask my doctor when I found out [I was pregnant]. I said, "how do I go about seeing a midwife"? and he said, "you don't". "I never had any option really with having a personal midwife"</i></p>	<p>(comes under choice and of model of care) The woman is not asked where she would like to go. There are no discussions invited regarding models of care. Her needs are not considered. The doctor makes the decision as to what the woman needs/wants. Does the doctor value the medical model, is the doctor aware of other models. When the woman attempts to engage in a discussion with the doctor, her needs are ignored – the doctor is not available for the woman. This contrasts with the midwives saying that women do not want MGP and continuity of carer</p>
<p>***** Being Valued Being available Being safe</p>	<p>Sharon P.2/14: <i>"it's just conditioned in us [women], especially like if it's you're first pregnancy [you] put all your faith in the carer that you've been given [and] you'd be scared not to [do what they tell you], cause it's all about you don't want to do the wrong thing by your child". "I think you do what they say because like, you're going to be a mother and you want to do everything the special people who are the professionals tell you to do because you don't want anything to happen to your baby and if that's what they</i></p>	<p>(comes under choice - responsibility) Here Sharon is expressing that society expects women who are pregnant to act in a particular way that demonstrates they are doing the best for their baby/children. Particular ways of being are valued by society. Women acting in a responsible manner will conform to whatever the health professionals (the experts) deem necessary to ensure the safety of their baby. The women make them selves available to the</p>

Theme	Woman's Quote	Exploratory comments
	<p><i>need you to do, you jump through the hoops".</i></p> <p>Tina P.2/14: <i>"...you have to have it done, because, well you [think] they know best and... you do whatever they tell you..."</i></p>	<p>requests of the health professionals to demonstrate their acceptance of responsibility for the safety of their baby, a behaviour valued by society – a good mother.</p>
<p>Being Valued Being available</p>	<p>Sharon P.2/14: <i>I was seeing midwives at the hospital, they were like, "This is what's going on. It was like you were walking in to a motel room, and you've got all those pamphlets and that's it, that's all you got".</i></p>	<p>(comes under health information) The midwives were not available for the woman. There was no relationship. Sharon was told what would happen, there were no discussions around issues that might be relevant or important to Sharon as an individual. Sharon was not valued as an individual.</p>
	<p>Sharon P.3/14: <i>"because she knows about my family history and stuff [relevant information] and I mean I did like to go over it with her as well...".</i></p> <p>Suzie P.3/14: <i>"She would say, "I really recommend that because of your age you have this" because I was thirty six when I had [name of baby]. This sort of thing isn't really necessary, but it's an option, but it has these risks associated with it".</i></p>	<p>(comes under health information – relationships) When the health care professional is available for the woman she has the opportunity to discuss issues relevant to her. Here the women discuss how they were able to have their needs met by health professionals with whom they had an ongoing or established relationship. The woman is safe to discuss issues.</p>
<p>***** Being available → Being Valued → Being safe → *****</p>	<p>Tina P.3/14: <i>"if they've known you and got to know who you are and how you fit in your family and how the family goes it's just much more comfortable because you feel like you can trust and if you need to ask for something you don't you know [understand], you know the person?"</i></p> <p>Suzie P.3/14: <i>"She was very good and she went over and beyond her job and she made sure she rang the hospital, she just</i></p>	<p>Here the women discuss how trust is established with a relationship. Trust and ongoing relationships = safety for the woman. Being available not only demonstrates that the woman is valued; it shows the woman she is safe to trust the midwife to be an advocate, support her and be available for her. This aligns with students and midwives</p>

Theme	Woman's Quote	Exploratory comments
	<p><i>didn't say she'd do it she actually did it and then she rang me back to confirm that she did it and let me know what was going on... Whereas the other ones yeah they might have said they were going to do something and then didn't do it, they got busy so I don't know I think that it's a lot of your job I guess, she obviously loves her job and knows what she does and she goes that [bit] further".</i></p>	<p>The woman feels she is valued when the health professional keeps the woman informed and included (partnership) in her own health actions. The woman sees that when the midwife practices this way that she values her job.</p>
<p>Being available Being Valued</p>	<p>Sharon P.3/14: <i>"I'm not saying the older ones aren't [helpful] but it was for me, it was always the younger ones that went further and I even observed one of the ones that even helped me with him [the baby] came in a little bit more than what the others did and a lot of them didn't come in at all, only to give me the medication".</i></p>	<p>(care by midwives) Midwives described as being available for the woman – attending to her needs and supporting her in hospital demonstrated that they valued the woman. Not being available, only performing tasks (medications) demonstrated that they didn't value the woman as a person.</p>
<p>Being available</p>	<p>Suzie P.3/14: <i>The younger ones [midwives] that are coming through that are working by the book not having those life experiences [of] having had children don't have the ability to communicate and to actually follow through. They're following it in black and white".</i></p>	<p>(differences in care by midwives) Women disagree on what influences the care received from midwives – age, experience. (Working by the book), not treating each woman as an individual reduces the likelihood of the woman understanding the midwife is available and the woman is valued.</p>
<p>***** Being available Being valued Being safe *****</p>	<p>Sharon P.4/14: <i>"[I] literally saw someone different every time. If you don't have constant care with the same carer, that relationship isn't there. Cause it takes time to build up the trust. You know what I mean? There's no attempt at continuity with who you see, I mean if you're having to see whoever you get when you go in, then there's no real chance for [getting to know anyone]".</i></p>	<p>(under continuity of care(r), trust and relationships) Women understand that seeing someone different each visit (fragmented care models) reduces the ability to establish trust, which creates a safe space in which a relationship forms. Trust is required to maintain a relationship – this aligns with RMS and SM</p>

Theme	Woman's Quote	Exploratory comments
	<p>Tina P.4/14: <i>If you're constantly seeing the same person, they'll ask how your day is, you know, how have you been, and whatever. Whereas the next person would be, just seeing someone different, they have to spend the time there with you, [during] the consultation, catching up, like getting up to speed with where you are in your pregnancy".</i></p> <p>Tina P.4/14: <i>"even when you're in the actual hospital, like after you've given birth, there's like a different lady [midwife] everyday, but that's more the nurses, that's not the midwives".</i></p>	<p>understanding There is little chance for the midwife to get to know the woman.</p> <p>When there is no relationship, the midwife has little chance of being available as the midwife spends time familiarising themselves with all the medical details that need to be covered within the maternity care encounter. There is no time left for the woman to discuss issues relevant or sensitive that may take time. Tina has such fragmented care that she is unaware that midwives are providing care. The hospital environment coupled with midwives not being available for her creates a situation in which she understands that nurses care for you in hospital.</p>
<p>Being available Being valued</p>	<p>Sharon P.4/14: <i>"[It's] not that they don't have the time [to form a relationship with you], it's just that that's sort of a secondary thing, "Oh how are you feeling? Is there anything that's going on that you want to discuss"?</i></p> <p>Tina P.4/14: <i>"I didn't get introduced to them [the midwives] at all. I see them afterwards [after the birth] before they left, I actually called one back in and got my partner to take a photo of them, just so I could show my daughter later on these were the people in the hospital".</i></p> <p>Suzie P.4/14: you're "<i>treated like a number</i> [and] until something</p>	<p>(Care by midwives and relationships) Sharon understands that she is not valued. Being with her or being available is secondary to the institutions or other people's needs. The midwife communicates that she does not really want an answer from Sharon that would warrant the midwife to be available for her. Tina does not recall the midwives even introducing themselves to her. She has no knowledge of who was present when she gave birth. The midwives were present but not available. Tina sees that her experience was of less value than other experiences for the</p>

Theme	Woman's Quote	Exploratory comments
	<p><i>about the whole system's done I don't think you're going to get that extra attention and care that you'll get from your GP or someone that's got the time to go the extra mile, it's just the public system is the way it is with the hospital".</i></p>	<p>midwives. Suzie understands that she is not valued as an individual, midwives are not available for her, the health service does not value her needs. She accepts that women's needs are not valued within public health.</p>
<p>Being available Being Valued Being safe</p>	<p>Sharon P/4/14: <i>"Half the time you go up there and you've got a ten o'clock appointment and then they see you at.....11 o'clock or 12 o'clock cause they're running so late...you get in at 1 o'clock". "Especially if you've got other kids, you sit up there for three hours at the hospital [and] you're not just sitting there with pregnant ladies; you're waiting for the [sick] people to go to have their check, physiotherapy and whatever".</i></p>	<p>(precedence of woman's needs) <i>Sharon is forced to come to the hospital for her care. The women make themselves available for the health service rather than the other way around. The needs of the service are valued above those of women. There is a safety concern with having appointments in shared premises. The women are concerned that they share their antenatal appointment environment with sick people. That their children may be exposed to illnesses and or cause distress to other people who are unwell.</i></p>
<p>***** → Being available → Being Valued → Being safe → ***** →</p>	<p>Suzie P.5/14: <i>"It's just harder to get anything you want really, isn't it? It's a struggle and you have to explain yourself. It's not expected".</i></p> <p>Sharon P.5/14: <i>"if we [birthing women] were treated differently, like we were the centre of what's happening to us and our body, perhaps then we would feel a bit more in control to say, this is me and part of me and this is what I'd like. But, you feel that it's part of them, like you're having the baby but they'll get it for you".</i></p>	<p>(precedence of woman's needs and control) <i>Women understand that they are not valued; their needs are not viewed as important. They struggle to have a voice in the system. They do not feel safe to say this is what I want. The system and midwives are not available for the woman; the woman is an intruder in their domain.</i></p> <p>Midwives perform tasks and do what is</p>

Theme	Woman's Quote	Exploratory comments
<p>***** → Being available → Being Valued → Being safe → ***** →</p>	<p>Sharon P.5/14: Midwives “either didn't have the time or the inclination to find out anything other than what they need, what you were there for. It was very much, a little bit like a factory thing. Churn you in one end, churn you out the other. Give you an appointment card for the next appointment and off you go”.</p>	<p>necessary as per hospital functioning. The woman's individual needs are not considered here. The woman sees she is processed; her care is a production line that runs efficiently, meeting institutional needs without valuing her as a human being also with needs.</p>
<p>Being available Being safe</p>	<p>Suzie P.5/14: “...you don't want to be having a baby and having to argue about whether or not your waters are going to [be] artificially broken”. “I just think it sucks that you have to be a bolshy cow and you have to go and find out all the stuff for yourself in order to get the choices that you want. It's not just finding out everything yourself, but it's the combination of finding out everything yourself and being strong enough and having someone with you who is strong enough and able to enforce what you want”.</p>	<p>(Choice, control and woman's needs) Suzie wants to feel safe enough to make a choice and not have to defend her decision. She voices that she had to look up the information to make a choice. Does this mean that the midwives were not available for Suzie to discuss her options? Is this about being safe in the hospital environment? The woman feels unsafe in decision making so needs support – which midwives are not providing???</p>
<p>Being Valued Being safe</p>	<p>Sharon P.5/14: “...when I was labouring, “one of them [a midwife] was really nasty actually. She was telling me not to make a sound. She was yelling at me saying, you're not even trying, you're putting too much energy in to noise. And she's saying, you're not supposed to make any noise. I was, wow that's crazy, you can't. I'll just sit here and sing a song in my head”.</p>	<p>(Authoritative power and control) Sharon is being told how to act in labour. Her needs are not considered. The midwife is not displaying that he/she values the woman's way of being during labour and birth. Sharon does not feel that she is in a safe environment in which she can be herself – she is silenced by the midwife. Why does the midwife want Sharon to be quiet?</p>
<p>Being available Being Valued</p>	<p>Sharon P.6/14: The doctor was performing my perineal repair “and I could still feel it, and I'm looking at the midwife, I was</p>	<p>(Autonomy, power and control) This aligns with what the midwives and students say about the medical staff. Midwives</p>

Theme	Woman's Quote	Exploratory comments
Being safe	<p>crying and she's going "I know" and I'm thinking why you can't say anything. She [the midwife] didn't say anything she was just, I don't know. Cause he'd jumped in and say "I will do it" and she was supposed to do it".</p>	<p>are not valued, then how can they practice to their full potential and advocate for the woman? The midwife does not feel safe to be available for the woman. The woman felt unimportant and unsafe here. No one was advocating her rights.</p>
Being available Being Valued Being safe	<p>Sharon P.6/14: <i>"I was left alone and not told a lot and you know when I was told something was happening, well this is what's going to happen because you've got no choice and [that's] just the way it is". With "the sheer mayhem at the hospital no-one paid any attention to what was going on because they were all so run off their feet. You know they were running just to keep up with everything that was happening rather than being able to take time and care to see what was really going on with women".</i></p>	<p>Choice, control and the hospital environment Sharon understands that she was alone and ignored in the hospital – no one was available for her. She was not valued as a person with individual needs and concerns. She was told what would be happening rather than presented with options and engaging in a collaborative discussion. The hospital environment-routine was blamed as the reason that no one knew what was going on with the woman – is this a safe environment ??.</p>
Being available Being Valued	<p>Tina P.6/14: <i>"[I] see them at the desk they are sitting there just talking and they said earlier that they were busy, like you think, well that's what they were doing there before, just sitting there talking and I mean just after the caesarean I couldn't walk straight away so that's what they could have been doing I don't know".</i></p>	<p>Midwifery in the hospital environment Tina viewed midwives as unavailable for her. She contradicts Sharon's view that midwives are too busy to be available. Tina sees that midwives do not want to assist her – her needs are not important (not valued).</p>
Being available Being Valued Being safe	<p>Cath P.7/14: <i>"When you're in a room with four other people and they all close their curtains and they don't talk to you for the whole day and you're just in your bed with no one talking to you and you're waiting going I hope I get a visitor today you're like oh it's visiting time. Yeah people close their curtains and they won't talk to you and all</i></p>	<p>The hospital environment The women explain that the hospital environment is isolating, they feel ignored and have no support. This aligns with what midwives say. However..... Why aren't the midwives available for them?</p>

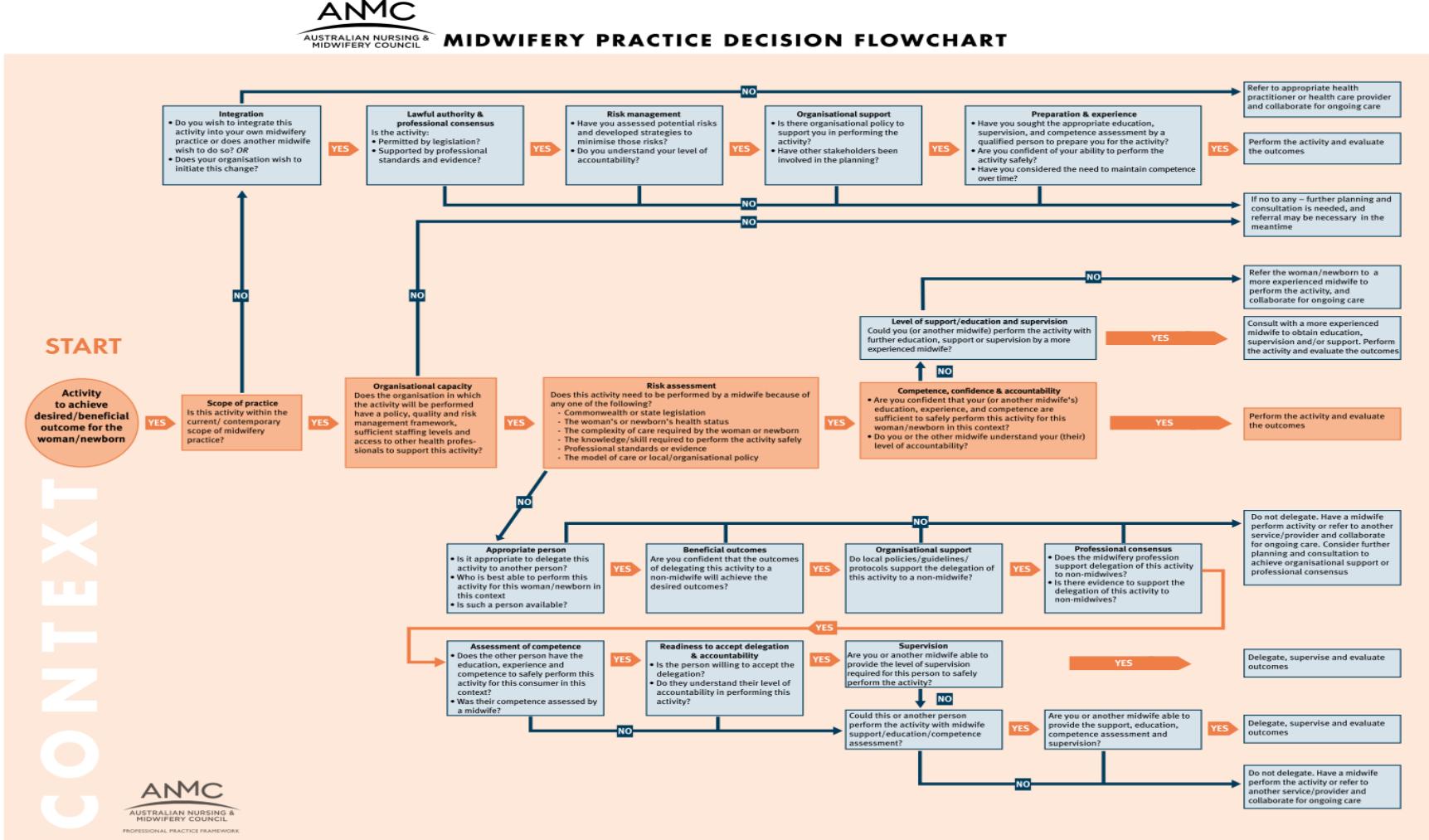
Theme	Woman's Quote	Exploratory comments
	<p><i>you've got is a magazine to read, yep finished this one now what do I do". "All the curtains were closed up, the midwives come and they opened the curtains and then the mothers come and closed them [again]".</i></p> <p>Suzie P.7/14: <i>"I wanted my privacy [by closing the curtains] and that was because you lose all dignity having a baby ...and to hide from that nurse [midwife]"</i></p> <p>I didn't "want to stay in hospital. I did for her [baby's] safety and my safety, because <i>I felt like I was in a goal because there was no one to talk to</i>".</p> <p>Tina P.7/14: <i>"The nurses [midwives] and that kept to themselves and every now and then if I wanted to go have a cup of tea or something I'd have to go out and wait and ask them to just keep an eye on [my baby] we weren't allowed tea in the wards at all, any hot drinks, you had to go outside for that"</i>.</p>	<p>Workload? No relationship? No obligation to provide emotional availability for the woman.</p> <p>Women create a barrier with the curtains for personal space/safety from surveillance by staff.</p> <p>Largely, women do not want to stay in hospital, they do for the safety of their baby. Responsibility and caring.</p> <p>Midwives are not available for the women and yet women must approach midwives to ask permission to have a cup of tea – rules and regulations that espouse safety on behalf of the baby. The mother is not seen as responsible for the safety of her own baby. Can't have a cup of tea on the ward.</p>
Being available Being Valued Being safe	<p>Suzie P.7/14: <i>I didn't "want to stay in hospital; I did for her [baby's] safety and my safety, because <i>I felt like I was in a jail because there was no one to talk to</i>".</i></p> <p>Sharon P.8/14: <i>"If you've got other kids at home you stay in hospital, it's the only way of getting a rest".</i></p>	<p>The hospital environment – responsibilities and responsible choices</p> <p>As discussed previously the hospital environment is isolating and does not meet the needs of women. Why would they choose to stay? They stay because it is the safest option for self and baby. They also might stay if mothering roles and caring responsibilities at home are so great that hospital is the only time they will be cared for. This quote aligns with the students quote "she's a waste of a bed" and</p>

Theme	Woman's Quote	Exploratory comments
<p>Being available Being Valued Being safe</p>	<p>Sharon P.8/14: <i>"...the third time they didn't seem to want to help me as much and so I struggled a bit with that [breastfeeding] by myself...they just figured that I knew what I was doing and they just left me. I want[ed] more [support] and [the midwives would] come around basically to give me my tablets basically and that was it".</i></p> <p>Sharon P.8/14: <i>"one [midwife] sat there for 40 minutes to help me feed him, and then she'd come back and check on me. But then I never saw her, I saw her once more and then I didn't see her again because she was on a different shift and she wasn't working. She just took that extra time whereas the others would come in and they'd just attach him and then they'd leave. But she actually stayed [with me] and made sure that he was attached to me and sucking properly yeah and had a bit of a chat to me when I was feeding".</i></p> <p>Tina P.8/14: <i>"I had some really nice nurses [midwives]. As they'd end their shift, they'd come and say goodbye or as they'd start they'd come in and say, "If you need anything, I'll be looking after you for the night. Just press the button".</i></p> <p>Suzie P.8/14: <i>"one of the midwives we had was very nice like that. She'd actually come and say my shifts ending... they were just heaps nice, and talked to you". And "I remember a midwife giving me a foot massage when I</i></p>	<p>midwives' – she "wants to be spoilt".</p> <p>Taking the time to be 'with-woman' When midwives do not make themselves available for the woman, she can struggle with her transition to motherhood. Worried that she is not doing it right and concerned about the health of her baby. She feels unsafe and wants support that is not offered. Again the midwives were seen to be focused on tasks rather than being with the women.</p> <p>When the midwife is available and takes the time to be 'with-woman' (even when it is not a continuity of care(r) maternity care encounter the woman feels valued. She is supported in her actions – breastfeeding.</p> <p>Saying hello (introducing yourself) at the commencement of the maternity care encounter, and goodbye upon completion and informing the woman of your availability demonstrates that you are valuing her and her needs.</p> <p>Just being "with –woman" taking time the time to make yourself available and talk shows that you</p>

Theme	Woman's Quote	Exploratory comments
	<p>was in labour. That was lovely. [It's] Just the little things, you know, [when] they were just heaps nice, and talked to you".</p>	value her
<p>Being available Being Valued</p>	<p>Sharon P.9/14: "[I would like] someone who is very helpful and tells you all the things that you actually want to know like [the things] you ask about, [not] someone just rushing you through and not taking the time to explain to you properly. Someone who asks you how you're feeling". I would like "to be treated as an individual; midwives should listen to [my] needs and care about [my] lifestyle regarding appointments."</p> <p>Cath P.9/14: Care in my home, "that would be awesome ...especially if you've got other kids. Students should learn more about home care [providing care in the woman's home]."</p> <p>Suzie P.9/14: "the hospital coordinate some form of continuity. That would be a nice approach. I know that's hard but you know if you could get the same midwife or the same few midwives when you went in, that would be great rather than, I mean I went to [name of hospital] and I literally saw someone different every time".</p> <p>Tina P.9/14: "The other thing is I wanted to look into a water birth as well and one of my friends just told me that you can't just have it at any hospital, it's only like private hospitals".</p>	<p>What women want – what women value The women express that they want a midwife to meet their needs as an individual. That tells you what you want to know – being helpful is about being available for the woman. And being available demonstrates that you (the midwife) value the woman as an individual and what her needs are. Not the needs of the institution.</p> <p>Women want their needs to be the focus not the institutions. The institution's needs are seen to be more important (valued over) than the woman's. Care is provided within the hospital or health service grounds not where the woman might want it. Is the woman consulted about where she might want her care????</p> <p>Women want a relationship with a known midwife. This contradicts what the midwives say. They want a known caregiver to be available for them.</p> <p>When a woman's needs are not met she understands her needs are not valued. Why did this woman seek information from a friend rather than the midwife? This aligns with midwives –</p>

Theme	Woman's Quote	Exploratory comments
<p>*****→ Being available→ Being Valued→ Being safe→ *****→</p>	<p>Sharon P.9/14: "[I would like to] not be the guinea pig where they go, "do you mind?" Once I feel how far dilated you are, if someone else has a go up there"? They need to respect if you don't [want students to do additional vaginal examinations], and you feel like you can't [say no], and you go all right, [because] if I say no then they're going to leave me alone all the time. So you sort of go, yeah, okay, even if you don't want them to [so] you're [not] going to be treated differently".</p>	<p>seek information from friends comment</p> <p>Women want to be safe enough to say no to midwives. They want to be respected/valued. Women worry if they say no, or go against advice from health professionals they will be treated differently. They are concerned about the health and safety of their baby and self and feel no choice in doing what midwife proposes. This also aligns with and contradicts what midwives say about choice and caring and students say about choice.</p>

Appendix I: Midwifery practice decision flowchart



Appendix J: Extract of research journal

Today was meant to be “D” day the first data collection day. I was going to have my first focus group with disadvantaged women. I had prepared, worried turned up and waited – no one showed. So now I will write a narrative and reflect on the situation as part of the research process and to commence truly keeping a journal. Haven’t really done this before so here we go.....

Narrative: I arrived at the SaCC venue 20 minutes before my first focus group was to take place. I was met by the SaCC facilitator and shown to the room where the focus group would be held. I set up my equipment ready for recording and the facilitator set up the lounge chairs and coffee table (it was a great room for recording and feeling comfortable). I sat waiting and after 20 minutes of waiting no one arrived. The facilitator kept looking outside to see if any women who had mentioned they would like to participate were coming. I asked the facilitator if it was likely that anyone was coming. She said no, and was very apologetic for the no show of women. I assured her it was not her fault and that these things happen. I said I would see her Friday for the next booked focus group. She told me she had more hopes for the Friday group, I thanked her for her time and left.

Reflection: I don't know how to get disadvantaged women to participate – how does any research around disadvantaged groups occur? For my Masters research I examined the relationship between midwives and women who smoked during pregnancy. I wanted to examine the interactions and see if midwives (working theoretically in partnership with women) were supporting women through partnership models of care/interactions in their smoking behaviours during pregnancy. I thought the lack of women participants in my Masters research was due to the fact that I attempted to have midwives working with the women recruit their own woman (creating a woman-midwife dyad). I thought the lack of women participants was due to the authoritative power women perceived midwives to have and the dependence upon the same midwives for their care during pregnancy,

labour and birth. In other words the woman may have been concerned about talking against the midwife who would be responsible for her care during her pregnancy, labour, birth and for a period following birth. The women may have thought information they provided would get back to the midwives. This is in line with a distrust of authoritative figures by disadvantaged health care users (Yancey, Ortega, & Kumanyika, 2006).

For my current PhD study I am attempting to recruit disadvantaged women through a known person (facilitator) to the women. I ensured the recruiting process and participating environment were completely separate from any health care setting. I thought the women would feel safe that their views are not available to their health care providers. I assumed the women would want to have a say about their care (outside the health facility). The environment is familiar for the women and the women themselves are familiar to each other. I have attempted to give as much power and choice to the women in the recruitment process and data collection process (focus groups with peers on self-designated days) as possible (from my perspective).

Learning Objectives:

Could I have changed anything in the recruitment process to improve participation?

What reasons might prevent women from participating?

Literature review:

Socially disadvantaged people generally participate less in health research and health promotion campaigns (Boyce, 2001; Janson, Alioto, & Boushey, 2001; Kelly & Cordell, 1996; Senturia et al., 1998; Yancey et al., 2006). Various explanations have been put forward as to why socially isolated, racially marginalized, impoverished, women, educationally deprived and physically disabled people are difficult to recruit or retain in research projects. I specifically searched Google scholar, then the University of Newcastle library Catalogue, NEWCAT for the journals identified in Google scholar. I then searched the references from the articles obtained and searched within the university databases for additional

articles. The terms used for searching were disadvantaged, groups, participation, research, recruitment, retention and minority.

From the articles obtained I found that when discussing racial minorities the articles are predominately from developed countries such as America and Canada. I did not find any articles discussing the recruitment of disadvantaged people in the Australian context. Recruitment challenges focus predominantly on participation in clinical trials. There is limited research within the past decade on participation by non-indigenous or non-ethnic minority populations in qualitative research. To address the issues I am facing with recruiting socially disadvantaged non-indigenous women into a qualitative project I have drawn on research from articles examining various aspects of recruitment and retention of disadvantaged groups in health promotion and quantitative research projects.

What reasons might prevent women from participating

Kelly and Cordell (1996) claim to have developed a woman-centred approach to recruiting socio-economically disadvantaged women into clinical trials for Human Immunodeficiency Virus (HIV) research. They discuss the barriers to women participating in research and how these barriers might be overcome using a woman-centred approach. Although this article is related to quantitative research the use of the term woman-centred caught my interest as it parallels a midwifery philosophy of care.

Women, according to Kelly & Cordell prefer to be recruited and researched by women; recruitment and retention rates in which the researcher is female are double that in which the researcher is male (1996). Impoverished women are also less likely to access environments in which research is occurring, that is health care services; therefore they miss research participation opportunities (Kelly & Cordell, 1996). Disadvantaged women often cannot participate due to transport, child minding responsibilities and failure by researchers to schedule participation in a woman-centred manner. Women will not participate if they believe the research topic is irrelevant to their circumstances (Kelly & Cordell, 1996). The Sacc facilitator

revealed to me that when she discussed the study with the women they expressed that the research topic – *woman-centred care: women's, midwives and student midwives experiences*, was not relevant to them. This may be a reason that women did not attend the focus group. They could not see how reflecting on or recounting their birthing experience to a researcher could be of any benefit to them. This view is supported by Yancey et al.(2006) who claim that participant attitude towards the topic and perceived importance of results affect their determination to enroll in and remain in studies. Kelly and Cordell (1996) suggest researchers make known to the participants any direct benefits to them. Information sessions by the researcher or recruitment person encourage women to participate, particularly if information demonstrates a direct benefit to the women.

In 2006 a review of public health literature was undertaken to identify barriers to and facilitators of recruitment and retention of minority groups in health related research (Yancey et al., 2006). The review focused on recruitment and retention in clinical trials of ethnic/racial minorities rather than culturally dominant socio-economically disadvantaged people, or qualitative studies however; similarities may be drawn as to why socially disadvantaged women do not participate in qualitative research. Yancey et al. (2006) assert that distrust is a barrier to recruitment and that distrust can be eliminated through effective communication between researchers and potential participants as to common goals for both. Community involvement also facilitates participation; recruiting through community based organisations provides a captive audience with the participants trusting the leader of the community group.

Recruitment improvement strategies

The recruiter's gender, focus group scheduling, environment and child minding concerns do not appear to be an issue in the recruitment and participation of women for my study. The Sacc facilitator informed the women of the study. The facilitator is a woman known to potential participants. It was the facilitator who explained that a woman would be undertaking the research and focus groups. I

purposefully went to the environment in which the women usually convene. The SaCC facilitator had arranged child minding facilities with the play group in the next room. The reason I went to the women was to ensure they were in their comfort zone and not inconvenienced by travelling should they wish to participate. I was the outsider visiting the women's familial environment. Discussions were to be held outside any health facilities in which their care may have taken place, or currently occurring. I do not believe I could have improved on any of these issues in relation to recruitment efforts.

The issues of direct relevance and benefit to participants can be difficult to recognize in qualitative research. I cannot guarantee a direct benefit to the participants and reported as such in my ethics proposal. Although I provided information to the SaCC facilitator to pass onto to women, and supplied information statements and flyers, the facilitator told me the women expressed to her that they did not see any benefit for them. I assumed they would gain a sense of empowerment through their collective voice regarding health care interactions during pregnancy. If no women attend the next scheduled focus group I will approach the SaCC facilitator to seek approval to provide an information session to women. By returning to SaCC to explain the aim of my study the women might see that they could potentially benefit as future birthing women; increased awareness following reflection on maternity experiences may empower them to be assertive in future care interactions.

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Appendix K: Glossary

Term	Explanation
Childbearing year	For the purpose of this research the term childbearing year is defined as the period from confirmation of pregnancy up until 6 weeks after having birthed.
Continuity of care experiences	The ongoing midwifery relationship between the student and the woman, from initial contact in early pregnancy through to the weeks immediately after the woman has given birth, across the interface between community and hospital settings.
Fertility rate	The ratio of live births in an area to the population of that area; expressed per 1000 population per year.
High risk	A quantifiable measurement applied to an individual childbearing woman in an attempt to measure the probability of an adverse birthing outcome for either the woman or her baby. A woman categorised as high risk is predicted to have a high probability of an adverse outcome.
Low birth weight	A baby weighing less than 2,500 grams at birth.
Low risk	A quantifiable measurement applied to an individual childbearing woman in an attempt to measure the probability of an adverse birthing outcome for either the woman or her baby. A woman categorised as low risk is predicted to have a low probability of an adverse outcome.
Midwifery context	Context refers to the environment in which midwifery is practised, which in turn influences that practice.
Parity	The total number of pregnancies a woman has experienced.

Postnatal period	The period from 1 hour after the birth of the placenta up until 6 weeks after having birthed.
Perinatal mortality rate	The number of combined stillbirths (babies born deceased) and neonatal deaths (infant deaths occurring within the first 28 days of life) in a population.
Pre-eclampsia	A multisystem disorder with the development of hypertension (not existing prior to pregnancy) after the 20 th gestational week and severe proteinuria.
Pre-term pre-labour rupture of membranes	Rupture of the membranes prior to 37 completed weeks of gestation and prior to spontaneous uterine activity.
Preterm birth	A baby born prior to 37 completed weeks of gestation.
Preterm labour	Labour that begins before prior to 37 completed weeks of gestation.
Woman-centred care	Care that focuses on the woman's individual needs rather than the health professional's or institutional needs. There is recognition that the woman has a right to continuity of care from a known caregiver/s and has choice and control with regards to decision-making.

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