STAYING INVOLVED

'BECAUSE THE NEED SEEMS SO HUGE'.

An exploration of the care processes used by midwives in their work with women living in areas of high deprivation: A grounded theory study.

A thesis submitted in partial fulfilment of the requirements for the degree of

Master of Arts in Midwifery

Massey University
Palmerston North
New Zealand

by
Christine Griffiths

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ABSTRACT

It is estimated that 17-20 percent of New Zealand's population lives in relative poverty (National Health Committee, 1999; Waldegrave, King & Stuart, 1999). Poverty and ill health are closely related- 'with very few exceptions the financially worst off experience the highest rates of illness and premature death' (National Health Committee, 1998, p.8). Although much has been written about the impact of low socioeconomic status (SES) on pregnancy and birth outcomes, there is little written about the actual care midwives provide to childbearing women, especially to those living in socioeconomic deprivation.

Grounded theory was the methodology used to explore the care provided by independent midwives to childbearing women, especially those of low SES. Through a process of theoretical sampling, independent midwives were interviewed about the care processes used in their work with women living in areas of high deprivation.

Initial recruitment for the study was of midwives providing care to women living in thirteen selected meshblocks in a New Zealand city. Each of the meshblocks had been assigned a deprivation score based on the New Zealand Deprivation 1996 index showing them to be areas of high socioeconomic deprivation. Using the constant comparative method of data analysis, categories and properties were elicited which reflected the care processes used by midwives. These were used to develop a conceptual framework that fitted the collected data.

The core category of 'Staying involved 'because the need seems so huge'' was the basic social process which emerged from the data. The midwives stayed involved throughout the woman's pregnancy and childbirth because the woman's need was so huge, to ensure an optimal pregnancy outcome for both the woman and her new baby. Four other categories were also identified; 'Forming relationships with the wary', 'Giving 'an awful lot of support'', 'Remaining close by' and 'Ensuring personal coping'. Details of the conceptual framework have relevance to the midwifery community, specifically to those midwives who work with women living in areas of high deprivation.

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When I first dreamt of completing a Masters degree, it was quite simply to prove to myself that I could do it. To complete such a degree had always seemed to me to be an elusive goal which I had never been sure I was academically capable of achieving. I thought only the brightest of people got a Masters degree- I may now be living proof that this is not true!

I commenced university study at Massey with the goal of enrolling in a MA degree. From the beginning of the MA, I knew that half of my degree would involve undertaking a research study and writing the thesis. I was aware in an abstract way of the challenge and difficulty of the task that lay ahead. It was not until the latter part of this year and the day to day slog of forcing out every word in the writing up stage of the process however, that the enormity of the task I had set myself began to dawn. As writing the thesis became all encompassing on my time, I experienced total frustration and loneliness wondering if I would ever finish. As the thesis finally began to take shape, I began to believe that I would indeed get to the end. Now it is completed and no one is more amazed at this than me.

Many friends and colleagues have given me great support and encouragement at varying stages of my thesis. Being asked by them how the thesis was progressing has been incredibly helpful. Thank you all for your interest and for being available to listen and give comment.

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1.1 Introduction

This grounded theory study provides a conceptual framework of the care processes used by independent midwives in their work with women living in areas of high deprivation. For this research study, initial recruitment was of independent midwives who provided care to women living in thirteen selected meshblocks of high deprivation in a New Zealand North Island city. This chapter describes the background to the study and provides an explanation of the reasons for undertaking research into the chosen topic. Working definitions and descriptions of terms used in this thesis are given. An overview of the focus of the other chapters in this thesis concludes the chapter.

1.2 Justification for the study

The focus of this research was to explore the care provided by independent midwives to childbearing women living in areas of high socioeconomic deprivation. The motivation to explore this topic stemmed from my own experiences as an independent midwife. For six years out of the past eleven, I have provided independent midwifery care to women living in a variety of socioeconomic circumstances. Until recently I worked for four years as one of a team of four midwives employed by a community-based primary health care service whose members are people of low income. The midwives provided total midwifery care to women from within the service. The health service has two centers– each situated in the middle of the community in which its members live. Approximately 40 percent of the pregnant women within the service are Maori, 31 percent are Pacific Islanders, 20 percent are of European descent, with others being Chinese, Cambodian, Iraqi and Indonesian in nationalities (J. Doherty, pers. comm. 8.5.00). The midwives are well known within the community and had often cared for other members of the same family during previous pregnancies and births.

The women are usually unemployed and living on social welfare benefits. Often, a woman's partner is also unemployed. Many of the women have English as a second language, are not well educated and live in poor, usually overcrowded housing, without any transport or telephone. In addition to being at high risk obstetrically due to their general poor health and high parity, my experience has been that there are many social

problems amongst these women and their families. These problems include illicit drug taking, excessive nicotine and alcohol intake, domestic violence and abuse and involvement in other illegal activities. Lack of money is a constant concern. Many of the women have ongoing contact with social support services. A high proportion of these women are teenagers when having their first babies and they continue to have unplanned pregnancies with the associated risk factors. Many women are unsupported and socially isolated from their families. Working as a midwife within this environment was stimulating, frustrating and always challenging.

As my knowledge and experience in caring for these women who live in poverty grew, so had my awareness that in many ways, the care I provided to these women was different from the care that I provided to other, more affluent women. For the pregnant woman living in poverty, pregnancy is just another event in her already chaotic life. This woman viewed pregnancy as a normal life event– so much so that she often continued on with her life, having little chance or time to give thought to the personal contributions she could make to ensure the best outcome for herself and her baby. This woman was generally not interested in attending antenatal classes, writing birth plans, eating healthier food or taking regular exercise. When I called in for a regular antenatal visit this woman may not have been at home. I may have had to call in several times before I eventually got to see her. This woman was often more concerned that she had no food in the house, no clothes for the forthcoming baby, or that her phone had been cut off again, than in having her antenatal check-up performed. Trying to sort out these social issues became the focus of my visits– actual pregnancy care was relegated to a very minor part of the time I spent in the woman's home. This woman trusted me, her midwife, and wanted me to make all the decisions regarding her care.

In contrast, this woman's middle class counterpart is in her mid thirties, a professional who has worked full-time at her career until now, the time of her planned pregnancy, and lives in a long-term relationship with her partner. In my experience, this woman has read a lot about pregnancy and childbirth and is doing everything she can to keep herself and her baby in optimal health. She attends antenatal classes and is always home for her midwife's visits. She has discussed options for her and her baby's care in detail before making an informed decision about what would suit her the best and has written a comprehensive birthplan of her wishes. This woman is totally focused on her

pregnancy. She is interested in all aspects of the antenatal care the midwife provides and has many questions. Her partner takes time off work to be present when the midwife calls.

Although the situations of the women described above are generalizations and of course do not apply to every woman, what they attempt to highlight is my belief that care delivered in a similar manner to these groups of women would be inappropriate to meet their needs or expectations of care. Both women received consistently high quality midwifery care, but they each had differing needs and therefore the experiences I as a midwife have had, of providing care to these two groups of women are, in my opinion, quite different. However, before any analysis can be undertaken to determine if there is a difference in the care provided to these two groups of women, it is necessary to first establish what the care processes provided by midwives to women living in areas of high socioeconomic deprivation actually are. This is the focus of the present research study. Once the care processes provided by midwives to women living in areas of high deprivation are established, it may be possible to decide whether this group of women have care requirements which differ from those of more affluent women.

1.3 Working definitions

In order to ensure that there is shared understanding, definitions of 'independent midwife', 'total midwifery care' and 'poverty' are required.

1.3.1 Independent midwife and total midwifery care

Since the passing of the 1990 Amendment to the 1977 Nurses Act (New Zealand Government, 1990), New Zealand midwives have been able to take responsibility for providing care to women throughout normal pregnancy, labour, birth and the postnatal period, without medical supervision. Guilliland and Pairman (1995) define an independent midwife as a midwife registered under the 1990 Amendment to the 1977 Nurses Act who works on her own responsibility with a woman, providing all the midwifery care the woman requires throughout pregnancy, labour, birth and the postnatal period. The independent midwife under this definition provides total midwifery care. This differentiates the independent midwife from the midwife who

provides fragmented or episodic care (such as care during labour only), and will be the definition used for this study.

The Health Funding Authority (HFA) is allocated funds by the Government to purchase health and disability services for all eligible people in New Zealand. To meet the needs of women throughout their pregnancy and childbirth period, the HFA purchases a range of services. These include primary, secondary and tertiary services. The HFA purchases primary care services from midwives, general practitioners and obstetricians who provide the services as Lead Maternity Carers (LMCs) (Health Funding Authority, 1998). Section 51 of the Health and Disability Services Act 1993 (Health Funding Authority, 1998) provides for a LMC to be nominated by the pregnant woman. The LMC is responsible for the care provided to the woman throughout her pregnancy and postpartum period, including the management of labour and birth (Health Funding Authority, 1998). In 1997 midwives were the LMC for 53 percent of women in New Zealand (Guilliland, 1998). By 1998-1999, the number of women having a midwife LMC had risen to over 71 percent (Guilliland, 2001). Section 51 (Health Funding Authority, 1998) outlines the service specifications of the maternity services the HFA will pay for. It also lists the items to be covered in documentation of the care plan and the education content to be provided for individual women and their families. Details of the actual care to be provided by LMCs is not given in the document.

Recent legislative changes have meant that maternity services now form part of the New Zealand Public Health and Disability Act 2000 and the Maternity Notice formally known as Section 51 has been renamed Section 88 (Ministry of Health, 2001). Proposed changes to Section 88 are currently being discussed in a draft document circulated to the relevant professional organisations, all maternity facilities, maternity consumer organisations and practitioners who claim under the Section 88 Maternity Notice (Ministry of Health, 2001). Proposed amendments to the Section 88 Maternity Notice are expected to be effective from the beginning of May 2002.

1.3.2 Poverty

There is no general agreement about how poverty should be defined or measured and New Zealand does not have an official poverty measure (National Health Committee,

1998), however a distinction between relative and absolute poverty can be made. Absolute poverty occurs when people do not receive sufficient resources to support a minimum of physical health and efficiency, often expressed in terms of calories or nutritional levels (Abercrombie, Hill & Turner, 1988). Absolute poverty is the term used to define poverty occurring in developing or Third World countries.

Relative poverty is defined by the general standards of living in different societies and what is culturally defined as being poor rather than some absolute level of deprivation (Abercrombie et al., 1988). People are considered poor by the standards of the country in which they live. The extent of relative poverty within a country is reflected in the degree of inequality in income and wealth distribution (National Health Committee, 1998).

A relative standard of poverty attempts to define poverty in terms of the median standard of living in a society (Balivens & Anderson, 1988). If a relative standard were to be used, the poor might be defined as those who earn 50 percent of the median income for family size (Balivens & Anderson, 1988). In New Zealand, real disposable income for salary and wage earners at the bottom end of the income scale declined over the last decade and the subsequent effect of this growth in income inequality is an increase in relative poverty (National Health Committee, 1998). People of low income in New Zealand are eligible to apply for a Community Services Card, which gives access at a reduced cost to several services, including transport, medical visits and prescription charges. Eligibility for the card is income tested. A single adult living alone must earn less than $19,689 per annum. A two-person family (two adults, or one adult and one child) must earn less than $29,398 per annum. A three-person family (two adults plus one child, or one adult with two children) must earn less than $34,243 per annum in order to be eligible for such a card (Work and Income New Zealand, pers. comm. 30.4.00).

Waldegrave et al. (1999) have recently published the results of their research of low-income New Zealand households. For this study, a 'low-income' household was defined as one with a combined annual household income of under $25,000 with any children under 15 years of age. In selecting a national random sample of 400 low-income households to participate in the study, all households had to fall below the poverty line

previously set by the researchers at 60 percent of the median disposable household income. Two examples of this are that to be eligible for the study, a household of one adult and one child must have an annual disposable income of no greater than $17,000 and a household of two adults and two children no greater than $26,000 per annum. Waldegrave et al. (1999) identified that using this threshold, 18 to 20 percent of New Zealand households– those at the lowest end of the national distribution of income, were defined as living in poverty and thus eligible for the study. From their research Waldegrave et al. (1999) identified that many low-income New Zealand households are substantially deprived of essential household items and services and confirmed the reality of poverty for many New Zealanders' lives. Another current study (National Health Committee, 1999) alludes to 17 percent of women being in the lowest socioeconomic bracket. This figure was found through measuring the deprivation score of the census area in which the women live (National Health Committee, 1999). It would be expected that a proportion of the women living in poverty in these households would be of childbearing age.

The NZDep96 index (Salmond, Crampton & Sutton, 1998) is an area-based measure of deprivation that combines nine of the variables measured in the 1996 national census to determine levels of socioeconomic deprivation. These variables are communication, income from a means tested benefit, employment, income below a preselected income threshold, transport, support, qualifications, owned home and living space. A meshblock is a geographical unit defined by Statistics New Zealand, containing a median of 90 people (Salmond et al., 1998) and each meshblock in New Zealand is allocated a deprivation score by the NZDep96 index. The NZDep96 index has a scale of deprivation from 1 to 10 and therefore divides New Zealand into tenths e.g. a value of 10 indicates that the meshblock is in the most deprived 10 percent of areas in New Zealand (Crampton, Sutton, Blakely & Howden-Chapman, 2000). It was decided to use the NZDep96 index as the measure of deprivation for the present study.

The streets in the New Zealand North Island city selected for the study were defined and the specific meshblock number for the 13 selected areas obtained (Statistics New Zealand, pers. comm. 18.5.00). The NZDep96 score was then allocated to each meshblock (Hutt City Council, pers. comm. 19.5.00). Eleven of the meshblocks had a NZDep96 score of 10. Of the remaining two meshblocks, one had a score of 9 and the

other a score of 8. These scores confirmed that the childbearing women in the selected area are amongst the most deprived in New Zealand. While it cannot be assumed that all the women living in each individual meshblock are as deprived as each other, throughout this thesis any reference to women living in areas of high deprivation refers to the majority of women in each meshblock who are living in deprivation.

1.4 The focus of the other chapters

Chapter Two details the literature review that was undertaken prior to the commencement of the study and explains the place of the literature review in a grounded theory study.

Chapter Three provides an explanation of the historical development of grounded theory methodology and its theoretical and philosophical underpinnings. Procedures for recruiting participants, data collection and analysis methods and ethical considerations as they were addressed for the study are detailed.

Chapters Four to Seven are data chapters. Each chapter introduces one of the categories which emerged from in-depth analysis of the data obtained from the study participants. The sub categories which together merge into each of the categories are defined and discussed in terms of their properties, conditions, strategies and consequences. The theoretical linkages by which each category is linked with the other categories developed from the study's data analysis are detailed.

Chapter Eight draws together the preceding four chapters by presenting an overview of the conceptual framework which was developed from analysis of the data. Limitations of the study and implications of the study findings for midwifery practice, education and research are presented.

A reference list and appendixes are provided.

1.5 Summary

This chapter has described the background to and an explanation of the reasons for undertaking research into the chosen topic. Working definitions and descriptions of

terms used in this thesis have been given, followed by an overview of the focus of the other chapters.

Chapter 2: Literature Review

2.1 Introduction

This chapter explains the place of a review of the literature within a grounded theory study. The literature reviewed initially to aid in formulation of the research question and to assess the amount of research previously undertaken on the chosen topic is detailed. Specific areas covered are health and poverty, social support intervention, social effects of high deprivation, suggested midwifery intervention and working towards the Government health strategy.

2.2 Literature review in a grounded theory study

Although an extensive literature review is seen as an important part of many research studies, in a grounded theory study literature is not extensively reviewed at the beginning of the study. This is to ensure that the researcher allows the categories, their properties and theoretical codes to emerge from the data without having preconceived ideas about what concepts may seem relevant (Glaser, 1992; 1978). Glaser (1992) warns about the possibility of the researcher's ideas being 'derailed' from reading associated literature prior to theory development taking place by the formation of assumptions of what ought to be found in the data.

> ...the mandate of grounded theory is to be free to discover in every way possible. It must be free from the claims of related literature and its findings and assumption in order to render the data conceptually with the best fit. Grounded theory must be free from the idea of working on someone else's work or problems. It need make no bows to the existing literature... (Glaser, 1992, p.32).

In grounded theory, the data are collected, analysed and the theory is generated. Once the theory seems sufficiently grounded in a core variable and an emerging amalgamation of categories and properties, the associated literature is reviewed and the developing theory is related to the literature through the integration of ideas (Glaser, 1992; 1978). Reviewing the literature is seen as an ongoing process that is conducted to fulfil analytical needs. Literature is a source of data in a grounded theory study and

therefore the literature used is determined by the categories that emerge during data analysis, helping to enrich a developing theory (Glaser, 1992; 1978).

While Glaser (1992) purports the need not to review any of the literature in the area under study, a literature review was undertaken initially in order to help in the formulation of the research question and to assess the amount of research previously undertaken on my chosen topic. Literature, both from within NZ and worldwide, was initially reviewed from 1985 until the year 2000 on the Medline, Cinahl, MIDIRS and Cochrane databases. These years were specifically chosen to ensure that literature surrounding the events in midwifery leading up to the change in New Zealand midwifery legislation (1990 Amendment to the Nurses Act 1977) was captured.

2.3 Literature review

The literature reviewed centred around the themes of the relationship between health and poverty, the effects of social support intervention, the social effects of high deprivation, suggested midwifery intervention and the link to the NZ Government health strategy. The literature related to each of these themes is discussed.

2.3.1 Health and poverty

'The link between poverty and ill health is clear: with few exceptions, the financially worst-off experience the highest rates of illness and premature death' (National Health Committee, 1998, p.8). A social gradient of health is evident no matter how prosperous a population or a country is; those lower down in the socioeconomic hierarchy are likely to have worse health than those above them (Crampton et. al., 2000). Poverty is an important determinant of ill health and income is the single most important determinant of health (National Health Committee, 1998). In order to improve the health status of a population and reduce health inequalities, it is important to first identify and understand the main factors, known as the determinants of health, which protect and promote good health (National Health Committee). In an industrialised country such as New Zealand, the general key determinants of good health are; a household income which is not markedly below the average income, employment, safe working conditions, education, an adequate diet, warm dry housing, family support and the absence of smoking (Howden-Chapman & Cram, 1998).

Income is the single most modifiable determinant of health and is strongly related to health and wellbeing –there is a persistent worldwide correlation between low income and poor health (National Health Committee, 1998). Household income after-tax in New Zealand fell between 1981 and 1993, with single parents, Maori and Pacific Island people experiencing the greatest income reductions (National Health Committee, 1998). There is a considerable disparity in the distribution of socioeconomic deprivation across the European, Maori and Pacific Island ethnic groups in New Zealand with most Maori and Pacific Island people having the highest deprivation score on the NZDep96 index (Crampton et. al., 2000). Given the relationship between socioeconomic factors and health, the differences in the distribution of deprivation between ethnic groups is of profound social significance – much of the poor health experienced by Maori and Pacific Island people is a consequence of the way in which society structures itself regarding access to material and social resources (Crampton et al., 2000). It is estimated that about 80 percent of the most important causes of death across all age groups are more common in low socioeconomic groups (Crampton et al., 2000).

In 1996, 26 percent of all children aged under 15 in New Zealand were living in households in the bottom income quintile and another 23 percent were in the second to bottom quintile. At the same time, 41 percent of Maori children aged under 15 were living in families with an income of less than $20,000 per year and more than 55 percent of children in one parent households were in the lowest income quintile (Statistics New Zealand, 1998, cited in New Zealand Network Against Food Poverty, 2000). From their survey of low income households, Waldegrave and Stuart (1996) found that 77 percent of households had problems paying for food, 64 percent were missing meals due to lack of money, 68 percent were unable to pay their power bill by the due date within the previous year, 59 percent had gone without necessary clothing and shoes and 43 percent could not afford a doctor for at least one person in the household in the previous six months.

Although there is a lot of literature surrounding the negative effects of poverty on pregnancy and pregnancy outcomes, there is little specifically written on midwives' experiences of providing care to women living in poverty. No New Zealand literature surrounding this topic was found. This was somewhat surprising given that Waldegrave

et al. (1999) define 18 to 20 percent of New Zealand households as living in poverty and the National Health Committee (1999) alludes to 17 percent of women being in the lowest socioeconomic bracket. Despite this percentage of households living in poverty, New Zealand midwives are yet to document their experiences of providing care to childbearing women living in areas of high deprivation. Hence the gap in the literature and the need for this research to take place. From the literature review two key research studies were identified which have relevance to the chosen research topic. These benchmark studies by Oakley, Rajan & Grant (1990) and Davies (1988) are often referred to in later articles about midwives working with women living in poverty.

2.3.2 Social support intervention

In the United Kingdom, Oakley et al. (1990) considered the effects of poverty and also attempted to measure the benefits of midwifery care. For this study 509 socially disadvantaged women with a previous history of a low birthweight baby were recruited from the antenatal booking clinics of four hospitals and randomised to receive either standard antenatal care plus social support intervention from a research midwife, or standard antenatal care only (Oakley et al., 1990). The group receiving social support had 24-hour telephone access to four research midwives and a programme of home visiting during which time the midwives provided a listening service for the woman to discuss any subject of concern to her (Oakley et al., 1990). The research midwives also gave practical advice and information when asked and carried out referrals to health professionals and social agencies when required (Oakley et al., 1990).

Pregnancy outcomes were measured using information collected from case notes and postal questionnaires. The women in the social support group had heavier babies, fewer low birth weight babies and fewer admissions than the control group in pregnancy. More women in the social support group experienced a spontaneous onset of labour, normal deliveries and used less epidural anaesthesia than the women in the control group (Oakley et al., 1990). The numbers of babies requiring resuscitation at birth in the two groups were similar, but the social support group babies required less invasive methods for resuscitation, less neonatal care, and were significantly healthier in the early weeks (Oakley et al., 1990). Women's attitudes to the social support intervention

were very positive with the majority of women highlighting the fact that the midwives 'listened' to them, to be of most benefit (Oakley et al., 1990).

Jean Davies, a community midwife in the North of England, wanted the poor women in her area to be better served by midwives. Davies was one of a group of four midwives plus a research worker initially funded for three years to research the effect, if any, of giving enhanced midwifery care to women in low socio-economic groups in two areas of Newcastle. The study was titled 'The Newcastle Community Midwifery Care Project' and has been the subject of several reports and book chapters in addition to many journal articles, including those reviewed as part of the literature review undertaken for the current study (Davies, 2000; 1997; 1993; 1988; Davies & Evans, 1991; 1990; Hughes, 1992). In addition to the women in the study who were to receive enhanced midwifery care, there were also two control groups in the study; one a concurrent, prospective, matched group and one a retrospective control group of women from the study area who had delivered a year previously. Data were collected through both pre and postnatal semistructured questionnaires, the review of case notes and through interviews with the professionals involved.

In the study area unemployment levels were high, 99 percent of the people were on the housing benefit and there was a lot of vandalism, burglaries, long-term depression and despair particularly in one of the areas chosen. As part of the study, the midwifery service became neighbourhood based and the midwives were easily accessible. Enhanced midwifery care involved midwifery continuity (but not midwifery continuity as practised in New Zealand)– at least four home visits, setting up antenatal classes, visiting women if they were admitted to hospital antenatally, hospital visiting either during labour or postnatally, the occasional attendance at a delivery, and postnatal visiting for at least four weeks. The women attended their GPs and the hospital for antenatal care as was usual. The midwives each had a caseload of 50 women and there was close liaison with the Social Services.

The main result of the study on 263 women from the impoverished areas was that the women liked having a known midwife who would see them throughout their pregnancy. There was a slight decrease in analgesia used and a reduction in preterm deliveries compared with the control group and a tendency for women in the study to have fewer

low birthweight babies. The women in the study who had enhanced care modified their diet during pregnancy and were still eating better than the control group at six weeks postnatally. The midwives involved experienced enhanced job satisfaction and enjoyed working in an autonomous way in an area in which they became known as the midwives within the community. Unfortunately the funding was decreased following completion of the study and the number of midwives working in the areas reduced to two, despite the positive findings of the research project. No reason for this reduction in funding is given.

2.3.3 Social effects of high deprivation

In one article, Davies (1993) draws a graphic picture of the situation facing the midwife working with women in an underprivileged urban area. While this article is not based on a specific research study, it is a culmination of the years of experience Davies has had working with childbearing women living in poverty, including working on The Newcastle Community Midwifery Care Project, and therefore is relevant as an informative piece of literature. Davies (1993) writes of the effects of long-term unemployment, often second or third generation, and the social effects, not just the lack of money that results from this, but also lifestyle issues such as nutrition, smoking and leisure activities such as attending bingo or going to the pub. Overwhelming debt is the reality for many of these women, also the constant vigilance needed when living in a poor area because of fear of burglary, the bailiff, the police, the constant night noise and the inability to move out of the area due to rent arrears (Davies, 1993). According to Davies (1993, p.32) 'low expectations lead to low self-esteem and low self-esteem to low expectations', as demonstrated in the breakdown of family relationships exacerbated by unemployment. The men, rather than fostering a closer relationship with their children as a result of being out of work, shun domesticity, as shown by overt neglect of the children and covert control of the women. The partner leaves the woman alone with the children while he comes and goes as he pleases. Single parenting by women is common either through choice or because of feeling better off financially and socially (Davies, 1993).

Violence in all its forms is a common experience for many women as often the only control the men can achieve is within their homes, so as a consequence, many women

prefer to live on their own than put themselves under this kind of domestic pressure (Davies, 1993). The frequency of burglary and vandalism creates an undercurrent of criminality and people have the expectation of losing what little they have (Davies, 1993). O'Campo, Gielen, Faden and Kass (1994) researched the occurrence of verbal abuse and physical violence during pregnancy for 358 low-income women attending a hospital antenatal clinic. Each woman was interviewed three times during her pregnancy using a tool previously utilized in addition to tools especially developed for the study. O'Campo et al. (1994) found overall that 65 percent of the women in the study experienced either verbal or physical violence during their pregnancies, supporting Davies' (1993) view that violence is a common experience for many of these women.

Davies' (1993) main point is that due to the frequent absence of the men, the women are central to the community; the families are organised around the mothers and frequent contact with the grandmothers. It is therefore essential that health care is accessible to the women because if their health expectations can be lifted, it should affect the whole family. In The Newcastle Community Midwifery Care Project, Davies (1988) found that the health problems of these women related mainly to reproductive issues. Davies believes that if these mothers' birth experiences are of feeling out of control, this will exacerbate the women's already diminished sense of worth, but that midwives can promote the woman's emergence from birth feeling able to cope with confidence. Davies also believes that if underlying problems related to health are to be addressed, midwives need to provide continuity of midwifery care to the women who are most likely to smoke, have poor diets and take little exercise. According to Davies, midwives have an important part to play in health education and ensuring it has a positive effect on health outcomes. Midwives need to understand the social and psychological situations of these pregnant women's lives.

In a discussion paper surrounding caring for women in poverty in Britain, Salmon and Powell (1998) make the point that although poverty affects significant numbers of women, the voices of these women have often not been heard above the voices of their more affluent counterparts in influencing the midwifery agenda. For many of these women, concepts such as continuity of care and choice are viewed as secondary to the daily reality of managing poverty (Salmon & Powell, 1998). For those families struggling to manage their weekly budget, payment of fixed costs such as rent, credit

and electricity come first and the residual pays for the remainder of the family's needs, such as bills and food (Salmon & Powell, 1998). Food is regarded as residual as it can be cut down on if finances are low. Mothers have been reported to cut back on their own food consumption in order to protect their family's dietary needs contributing to maternal malnourishment in pregnancy resulting in small-for-dates babies and the development of chronic diseases such as hypertension (Salmon & Powell, 1998).

2.3.4 Suggested midwifery intervention

According to Salmon & Powell (1998) midwives working with these women need to be sensitive to the realities of their difficult lives and not give inappropriate advice that may reinforce an already vulnerable situation. Midwives also need to adapt their care to these women by understanding the ways in which individuals' health choices are limited emotionally and financially by poverty (Salmon & Powell, 1998). Cardale (1992) emphasises this point stating that it is essential that the midwives' objectives meet the mothers' perceived needs. For example, for the pregnant woman living in poverty, the issue of antenatal classes may pale into insignificance next to concerns about where the next meal is going to come from.

Thompson (1999), a community midwife, gives details of a thriving parent and toddler support group established in an area of enormous deprivation. The group's success is attributed to it being community-based, targeted at those most in need and relevant to the context of the women's lives. Early on, realising that traditional parentcraft teaching sessions would not work in this environment, Thompson (1999) decided to have low-key sessions with an emphasis on fun. Women lost their inhibitions and began to talk about the things that most mattered to them, resulting in the sessions becoming almost cathartic for the families involved (Thompson, 1999). The group developed with the women forming a self-directed and self-motivated social club, empowering them to achieve and to develop a kinship with other women and families in the community (Thompson, 1999). Four years later not only is the group a vital part of the local community with regular speakers, but some of the original members have gone on to further education and obtained qualifications leading to paid employment. The group has had an immense impact on the women who participate in it through sharing the experiences of parenthood and supporting one another (Thompson, 1999).

If the health status of socioeconomically deprived people is to be improved, primary health workers, such as midwives, need to focus specifically on the needs of those people.

2.3.5 Working towards the Government health strategy

A strong primary health care system is central to the current NZ Government's overall health strategy in an attempt to improve the health status of New Zealanders (King, 2000). The aims for the future health system will be achieved by reducing the disparities between the health of different groups, meeting the needs of the communities, involving communities in decisions about their local health services, giving priority to promoting health and preventing disease and making sure that health resources are used effectively (King, 2000). One way of assessing the needs of these people is to explore the care they currently receive.

2.4 Summary

Given that 17-20 percent of the New Zealand population can be considered to be living in poverty (National Health Committee, 1999; Waldegrave et al., 1999) there is a large gap in the literature regarding the care provided by midwives to the numbers of childbearing women these figures represent. From the literature review it is apparent that there is a need to undertake research studies exploring the care processes used by midwives in their work with women living in areas of high deprivation. Midwives' experiences of this have only been briefly covered in discussion papers and only two research studies related to the chosen topic were found. Due to the absence of available literature it was decided to use grounded theory to answer the research question '*what is the care provided by midwives to women living in areas of high deprivation?*'

Chapter 3: Research Methodology

3.1 Introduction

This qualitative research study uses grounded theory to explore the care processes used by midwives in their work with women living in areas of high deprivation. This chapter provides an explanation of the historical development of grounded theory methodology and its theoretical and philosophical underpinnings. Procedures for recruiting participants and data collection and analysis methods are detailed. Ethical considerations as they were addressed for the study, are described.

3.2 Grounded Theory

Grounded theory is a highly systematic research approach for the collection, organisation and analysis of qualitative data for the purpose of generating explanatory theory that furthers the understanding of social and psychological phenomena (Chenitz & Swanson, 1986). For this reason, grounded theory has been well utilized in previous midwifery, nursing, psychology and other social science studies. Grounded theories are guided by the belief that people sort and make sense of their environment although their world may appear muddled and/or not make sense to observers (Hutchinson, 1993). Grounded theory is a process of inductive theory building based totally on observation of the data themselves (Crotty, 1998). The purpose of grounded theory research is to explain a social situation by identifying the central and subsidiary processes operating in it (Chenitz & Swanson, 1986). Grounded theory appears to fit the research question well and is an appropriate process for investigating areas where little research has previously been undertaken, so was therefore deemed suitable as a methodology for this study.

Grounded theory methodology, like other qualitative research methods, has clearly defined theoretical and philosophical underpinnings. Grounded theory is based on the idea that people give meaning to experiences they are exposed to throughout their lives (Glaser & Strauss, 1967). As the self and the world around the self are socially constructed, they are ever changing through processes of social interaction, therefore individuals and their actions cannot be understood out of their social context (Hutchinson, 1993). This is known as symbolic interactionism. George Herbert Mead

(1934) is credited with first laying the foundations of the symbolic interactionalist approach between 1920 and 1950 at the Chicago School of Sociology. Herbert Blumer (1969) later redefined this approach and Glaser and Strauss (1967) developed this approach for generating theory further, renaming it as grounded theory.

According to Blumer (1969) symbolic interactionism is based on three assumptions or premises. The first premise is that human beings act toward things on the basis of the meanings that the things have for them. The second premise is that the meaning of such things is derived from, or arises out of, the social interaction that an individual has with other people. The third premise is that these meanings are handled in and modified through an interpretive process used by the individual in dealing with the things which are encountered. The symbolic interactionist studies behaviour on two levels –an interactional level and a symbolic level. For the researcher to gain an understanding of what is happening in a situation, the researcher needs to look at the interactions that take place between individuals to discover the basic social and structural processes of a situation at both the symbolic and interactional levels (Wuest, 1995). People sharing common circumstances experience shared meanings and behaviours which are not necessarily articulated- this is resolved by identifying the basic social psychological process (Hutchinson, 1993).

Crotty (1998) describes symbolic interactionism as the putting of oneself in the place of the other. To be able to gain an understanding of a particular group of people Crotty (1998) argues, we have to see ourselves as social objects and adopt the standpoint of others. This role taking is both an interaction and a symbolic interaction as it is only possible because of the significant symbols such as language, that humans share and through which they communicate (Crotty, 1998). Due to its theoretical importance, the interaction that takes place between individuals is the focus of observation and interview in grounded theory research (Glaser & Strauss, 1967). Early research based on these assumptions were in the form of field studies in which the researcher would observe, record and analyze data obtained in a natural setting (Robrecht, 1995). The final product would be a theoretical explanation of the studied events with no reference to the analytical process undertaken to arrive at the theoretical explanation, the resulting lack of explicit methodological procedures being a cause for receiving criticism from the scientific community (Robrecht, 1995).

In the early 1960s Barney Glaser, a researcher from Columbia University and Anselm Strauss, from the School of Pragmatism at the University of Chicago, began working together on explicating a method of developing theory from qualitative data obtained by field methods. In 1967 Glaser and Strauss published their book presenting their new method for the discovery of theory from qualitative data; *The Discovery of Grounded Theory: Strategies for Qualitative Research*. Grounded theory is a method of constant comparative analysis of data, based on the idea that theory can be developed from data obtained systematically in a social setting whereby data collection and theory generation are seen as two parts of the same process (Glaser & Strauss, 1967). Over the next 20 years, Glaser and Strauss wrote books and articles explaining the method further, until Strauss and Corbin (1990) deviated from the original model by suggesting a new coding process. Glaser responded to this by stating that what Strauss and Corbin had developed was not grounded theory and went on to present his version of generating grounded theory emphasising 'emergence' (Glaser, 1992). As a consequence there are now differing viewpoints on how data gathered for grounded theory research should be examined and the researcher using this method must choose which one is to be followed throughout the study. For this study, I adhered to the principles expressed in the publication by Glaser and Strauss (1967) and Glaser (1992).

Once the study methodology which appropriately suited the research question had been chosen, the next stage was to decide who potential participants for the study would be and how they would be recruited. This necessitated the writing of a research proposal, which was written prior to the commencement of the study and presented to a research review committee at Massey University, Palmerston North. The committee's brief was to review the proposal to ensure the proposed research was ethical, methodologically sound, and of sufficient scope to meet the academic requirements for which the research was being undertaken (Appendix A). Recommended changes were made to the proposal. An ethics application was then presented to the Massey University Human Ethics Committee and a regional health ethics committee. Both committees gave unconditional approval for the study (Appendix B). Support for the study had also been sought from Kuini Puketapu: a Maori Health Advisor (Appendix C), to meet the requirements for National Ethics Committee approval of a research project. An

explication of how various ethical issues were considered in this study will be given as the steps in the research process are presented.

3.2.1 Participant Selection and Data Collection

Participants in a grounded theory research study are those who have experience of the phenomenon under study. For initial recruitment into this study the participants were independent midwives who provided total midwifery care to women living in one or more selected meshblocks of high deprivation in a city in the North Island of New Zealand. As recruitment in grounded theory studies is an ongoing process that continues throughout the data analysis, not all the participants were recruited at the beginning of the study. Midwives were recruited as the data analysis identified a need for their experiences to be explored. The initial three midwives interviewed for the study had each had extensive experience working with this group of women and proved to be very articulate in describing the care they provided. Data analysis of the interview transcripts of these initial participants identified several categories and their properties common to these midwives which warranted further exploration. An attempt was then made to interview midwives with varying experience of working with this group of women. The subsequent four midwives interviewed had varying experience of working with these women. In total, seven participants were interviewed for the study.

The initial recruitment process took the form of speaking over the telephone and sending a letter to the midwifery manager of a maternity unit in a North Island city, asking for permission to place a notice (Appendix D) outlining this study with an accompanying board of maps, in a prominent position within the delivery suite. Permission was granted and the notice and board were prominently displayed for a period of time. A notice was also placed in a New Zealand College of Midwives (NZCOM) regional newsletter. The researcher also attended a NZCOM regional meeting to briefly outline the study and give interested potential participants an information sheet (Appendix E). Details of what consent to participate in the study would mean were clearly outlined in the information sheet. This sheet was given to potential participants to peruse for a period while considering whether they wished to be involved in the study or not. Initial recruitment also happened through midwives telling

their colleagues about the study and the colleagues contacting me for an information sheet.

Five potential participants contacted me by phone initially (within a week of each other) and all were sent an information sheet. Two of these potential participants phoned the researcher again within a couple of days of each other to say they wished to participate in the study, so a time and place was arranged with the first potential participant to discuss the study and the researcher made arrangements to contact the second potential participant again once the initial transcript from the first interview (if it went ahead), had been received. In hindsight, this was probably a mistake. The second participant could have been interviewed at any time after the first without waiting to look at the data received back from the original interview first. Data analysis using the constant comparative method means that data is constantly being compared with other data, so there was no advantage in waiting for the return of the first transcript until the second participant was interviewed this early in the data collection. For this meeting the researcher who was unused to undertaking research interviews had developed an 'interview format' sheet (Appendix F) to ensure that a set process was followed leading up to the participant being asked the research question and that no important part was overlooked. At this meeting the researcher briefly went through the purpose of the study with the potential participant, as well as what participation in the study would involve and the participant's rights.

Written informed consent from potential participants was obtained prior to commencement of the study, prior to the first interview being conducted by the researcher. This was because the midwives may not have finally known how they felt about participating in the research until the time of the proposed interview (Massey University Human Ethics Committee, 1999). The potential participants had the opportunity to have any questions answered prior to written informed consent being given (or refused). The consent form contained the following specific elements.

- A statement that the study involved research
- An explanation of the purpose of the research including expected duration of the midwife's participation
- An explanation of the procedures to be followed

- A statement describing the extent to which anonymity and confidentiality of the records identifying the midwife will be maintained
- An explanation of who to contact for answers to questions about the research and the rights of participants
- An explanation of how the completed research will be disseminated and to whom, e.g. publications, conference proceedings
- A statement that participation was voluntary (LoBiondo-Wood & Haber, 1998).

The researcher informed the potential participant that additional data in the form of written notes may be made of observed participant behaviour during the interview by the researcher, for example, gestures used and emotions expressed. All this information had previously been given to the potential participant in the form of the information sheet. Any questions the midwife had about the research were answered. The potential participant was still keen to be interviewed so the consent forms (Appendix G) were signed. Each participant retained a copy of the signed consent form and the researcher retained a second copy. All participants agreed to the interview being audiotaped. In this study all consent forms were signed immediately prior to the interviews taking place and a copy was kept by both the researcher and the study participant. The exception to this was the first participant interviewed, who the researcher returned to for a second interview to explore points raised at the first interview, to ensure the transcript reflected the initial interview and to clarify any points which were still unclear. As this participant had already signed a consent form prior to the first interview taking place, it was considered unnecessary for a second consent form to be signed prior to the second interview, however verbal consent for the second interview was obtained prior to it taking place.

The researcher told each participant that when the tape recorder was turned on to ensure anonymity they would be asked to choose a pseudonym, or if agreed, the researcher would choose one for them. This would ensure the audiotape was not identifiable. The transcripts from the tapes and any quotes in the final report use the pseudonym. No other information from which the participants could be identified are included in the thesis or will be included in any publication arising from it. The participant was informed they would then be asked some demographic data prior to being asked the

question 'could you please tell me what care you provide to women living in areas of high deprivation?' The dictaphone was then turned on. For the first two interviews, the researcher, concerned that she may inadvertently delete an audiotape recording and therefore lose valuable data, took along both a dictaphone and a regular tape recorder. As the researcher's confidence in the equipment grew, it became unnecessary to take along two modes of recording, so the dictaphone alone was used. This proved to be adequate. After data analysis of the first two interviews, four possible other questions relating to the emerging categories were prepared and placed at the bottom of the 'interview format' sheet to ask each successive participant. Glaser and Strauss (1967) support the asking of direct questions relating to the emerging categories in this way; '...when interviews and observations are directed by the emerging theory, he can ask direct questions bearing on his categories' (Glaser & Strauss, 1967, p.76).

Once the first interview was completed, field notes were written as soon as possible in a large exercise book specifically devoted to the researcher's research and the audiotape was listened to usually in the car on the way home. While the audiotape was being listened to at home, additional field notes were made. The audiotape was then given to a transcribing typist who had previously signed a confidentiality agreement (Appendix H). The transcribing typist typed the interview from the audiotape onto a computer disc, which, along with the audiotape, was then returned to the researcher with an accompanying hard copy. It was considered necessary to use the services of a transcribing typist due to the researcher's slow typing speed. As it transpired, there was often a two or three week delay until the transcribed audiotapes, disc and hard copy were returned from the transcriber, and this time delay was the cause of much angst for the researcher. On their return the researcher checked the transcript against the original audiotape, made any changes necessary especially deleting any identifying information, made corrections to punctuation and grammar, added any other details like laughter, and filled in any gaps in the interview transcript that the transcribing typist had missed, which commonly included misspelt or misheard midwifery or medical words. This process took a large amount of time and often up to a week to complete. The researcher then arranged to give the hard copy to the relevant participant to ensure the transcript reflected the initial interview and to enable them to make any changes they wished. Several participants deleted short comments or words on their original transcripts, however these did not detract from the meaning of what they had said. All participants

commented on how they felt they sounded inarticulate on reading through what they had said at their interviews! Getting the transcripts back from the participants often took at least another week, which meant it was now four to five weeks since the original interview had taken place. When the transcript was returned from the participant, any changes they made were integrated into the transcript, before the transcript was then ready for analysis.

Information was handled in a way that protected and safeguarded the confidentiality of the midwife participants. All audiotapes, computer discs and transcribed scripts were identified by a code number only and kept in a locked cabinet accessible to the researcher only. A master list linking code numbers with names was kept by the researcher in a separate locked cabinet. Also kept here were the signed consent forms. At the completion of the research the midwives will be offered the audiotapes, computer discs and transcripts of their individual interviews to keep, archive or alternatively the data will be kept by the researcher for five years in case they are required for auditing purposes. If they are required for auditing purposes, they will be available for viewing on site only. If the audiotapes, computer discs and transcripts of the individual interviews are kept by the researcher, the researcher will destroy them after five years. As this research was to be used to write a Masters thesis, participants were informed that the researcher, the researcher's supervisor, the transcribing typist and possibly the examiners, would have access to the information contained in the interview tapes, computer discs, transcripts and written notes. However, use of pseudonyms ensured that confidentiality and anonymity of the participants was maintained. The information sheet contained details of where research results could be published on completion of the study, conferences in which the results could be presented and where to obtain a copy of the completed thesis. A summary of the results will be offered to participants.

Potential benefits to participants were the opportunity to talk and reflect on their practice, and also to be able to contribute to research that explores the care processes used by midwives in their work with women living in areas of high deprivation. These experiences had not been documented within New Zealand before. Due to the nature of this research it was highly unlikely that participants would suffer any harm during this study. However, if any ethical issues arose, I planned to discuss these immediately with my research supervisor. Possible avenues of support in these instances would be the

Resolution Committee processes within the NZCOM and/or offering participants professional supervision. In any event, this was not required.

I was, until the end of June 2000, employed as a full-time midwife by a community based primary health care service. Thereafter, I was employed as a midwife manager within a woman's health service for the duration of the research study. There were ethical reasons directly relating to this study that were important in respect of my decision to change employment. I wished to ensure I would have no conflict of interest were a former midwifery colleague to volunteer to be a participant in my research. I also wanted to ensure that the participants were aware of my role as researcher rather than midwife during my interaction with them and my change of employment aided this recognition by formally separating me from my former midwifery practice. Another reason for changing employment was that I hoped that by coming off being on call for 24 hours per day I would have more time to devote to the research study.

The first participant was interviewed a second time two weeks after the first interview. As has been previously stated, this was to clarify some issues primarily due to the researcher's interview inexperience. The interview with the second participant took place two weeks after the first using the same process as that previously outlined. The third participant was interviewed two and a half weeks later. It was necessary to begin to analyze the data obtained from the first, second and third interviews and the field notes taken simultaneously in order to get some feel for the data obtained from the transcripts and to begin to identify similar properties and sub categories before interviewing the fourth participant. The fourth interview did not take place for another six weeks due to the time it took to begin to analyze the three preceding transcripts, then two weeks later the fifth participant was interviewed. The fifth and sixth interviews were held three and a half months apart and the seventh a week later. In all, the eight interviews with the seven participants took place over a period of six and a half months from mid-August 2000 to the beginning of March 2001.

At the beginning of the interview process, the researcher did not anticipate that the process of interviewing the midwife participants, receiving the transcripts back from the transcribing typist, ensuring they were correct and then sending them and receiving them back from the participant and simultaneously analyzing the data would take so

much time. Two more potential participants had indicated their willingness to be involved in the study, however due to the time the interview process was taking, the decision was made, on the research supervisor's advice, to bring a halt to the interview process to enable the researcher to focus on data analysis from the seven participants and therefore the two other potential participants were not interviewed.

Six of the interviews took place in participants' homes. One interview took place at a participant's work setting and another interview took place at the researcher's place of employment. The eight interviews varied in length, lasting from half an hour to one and a quarter hours each. The first two interviews particularly were nerve-racking for the researcher. Having no idea what the participants would say, yet hoping they would be able to articulate the care they provided to these women was stressful initially. As the participant interviews progressed, the researcher had to keep very focussed and listen carefully to what the participant was saying during the interview and at the same time, compare what was said to what previous participants had said and decide whether a particular point made by the participant needed to be elaborated upon or indeed, whether to ask about another issue altogether. The researcher also had to be aware of not leading the participant down any particular line of inquiry, particularly when the researcher was able to identify with much of what was said by the midwife participant due to the researcher's previous midwifery role. Balancing all this was at times not always easy and the researcher was aware of the importance of ensuring vigilance was maintained throughout the interview. However, finding that the first two participants were very articulate enabled the researcher to relax more during the following interviews. It was apparent to the researcher when a really good interview had been held.

Not all things go to plan however, no matter how much time is spent in preparation, and this was certainly the case in the present study. With one participant, the researcher had explained the purpose of the study, what participation in the study would involve and answered the questions posed. The interview then commenced with the researcher having forgotten to get the consent form signed. This was then done immediately after the interview. At another interview, the researcher spilt a cup of tea on the carpet. Fortunately this was easily mopped up and was not seen by the participant to be a major problem. One of the participants who volunteered to be in the study was not currently

working as an independent midwife having recently moved into another area of midwifery after several years of recent independent midwifery practice in the area under study. It was decided to include her as a participant as she had experience working with these women and was keen to support the researcher's study. Major panic ensued when the researcher went to make corrections on the computer disc between a participant's original transcript and that transcribed by the transcribing typist, only to find that the transcribed transcript had not been saved by the transcriber on to the computer disc! Several hours later when the transcriber was finally contacted it transpired she had saved the transcribed transcript onto another disc from that returned to the researcher.

3.3 Data Analysis

In accordance with grounded theory research, the nature and direction of the research study was developed from the data as they were collected. In grounded theory, theoretical sampling is used to obtain as varied a participant population as possible. Theoretical sampling means that the researcher collects the initial data, analyses them and then uses the results of the analysis to decide on the next area of data collection. Theoretical sampling is an ongoing part of data collection and is determined by the emerging theory and cannot therefore be predetermined (Becker, 1993). Multiple and diverse perspectives are sought to illuminate the theoretical properties of emerging concepts in the theory (Glaser, 1978). Diversity must be explained and integrated to enrich an emerging theory (Wuest, 1995). Theoretical sampling is a critical component in the collection, coding and analysis of data, which are happening concurrently in a grounded theory research study. While going through the process of research, the researcher writes field notes and memos noting events, actions and interactions and to trigger thinking processes (Holloway & Wheeler, 1996). Eventually memos become integrated into the writing up of the study and may influence other data sought e.g. literature.

Using a method of constant comparative analysis, the researcher analysed the transcribed interviews line-by-line, along with the written memos and field notes to answer the question 'what is happening here'. The four stages of the constant comparative method involved comparing the incidents applicable to each category, integrating categories and their properties, delimitation of the theory and writing the

theory (Glaser & Strauss, 1967). The data analysis is the search for patterns, processes and one or more central themes which would lead to the development of a theory from the data. 'Categories elicited from the data are constantly compared with data obtained earlier in the data collection so that commonalties and variations can be determined' (Polit & Hungler, 1995, p. 530). Each concept is vital for the development of a theory that fits the underlying data. Theoretical sampling is based on the need to collect more data to examine categories, their properties and their interrelationships to ensure that the category is representative of the sample population. Analysis of the data identified ideas and gaps in the data, which gave direction for further development, i.e. theoretical sampling. For example, the sub category of losing women to the secondary care clinic was identified in data analysis as an issue of concern to the initial midwife participants. Exploration of the different properties making up this sub category was undertaken in subsequent participant interviews to obtain as much information as possible about this sub category. Data collection continued until the decision was made to focus on data analysis. Normally the criteria for judging when to stop theoretical sampling the participant groups relevant to a category is the category's theoretical saturation (Glaser & Strauss, 1967). 'Saturation means that no additional data are being found whereby the [researcher] can develop properties of the category' (Glaser & Strauss, 1967, p.61). While it is not possible to state that saturation of data occurred from analysing the transcripts of the seven midwife participants, no new properties or categories were seen to emerge from data analysis after the fifth participant was interviewed. Glaser (1978, p.53) does state however that 'when one is in the field and feels he has saturated a category in one situation, he probably has'. Further theoretical sampling would have assisted in establishing whether this was true in the present study. This possibility was limited by time constraints.

Once a transcript was complete the pages and lines were numbered chronologically and the transcript was printed using double spacing and only half the available width of the page. The transcript was then printed onto coloured paper– each participant having their own separate colour primarily to avoid confusion and to ensure the researcher knew which words were attributed to each participant. A column was then drawn in pencil on each side of the page; one to be used for data analysis and the other to be used to write theoretical memos as the transcripts were analysed. The transcripts were then analysed line by line trying to answer the question 'what is happening here?' looking for patterns,

processes and one or more central categories which would then be used to develop the conceptual framework. Initial sentences were broken down into single words or small phrases by analysis and these properties, in the participants' own words, were written on the transcript by hand. By constantly reading and rereading the eight transcripts, which together totaled 247 pages of data, these properties were then 'taken up' into groups of sub categories, of which initially there were 99. The transcripts were cut up into pieces at this point, each piece consisting of a property with the attached relevant piece of transcript and care was taken to ensure that each piece was labeled with the participant's number and the transcript page number. The properties relevant to each sub category were placed in 99 separate snap-top plastic bags and each bag labeled with the sub category name. Each bag also contained catalogue cards headed with the relevant sub category and with the properties within the snap-top bag listed. This was to aid further immersion in the data by the researcher and to act as a double check that all the properties within the bag were related to the same sub category. Twelve categories were eventually developed from merging the 99 bags of sub categories into more abstract units (and bigger plastic bags). With further analysis, which included the bags containing the categories and the snap-top bags containing the sub categories being laid out on a table for a long while to enable them to be looked at easily and regularly and changed around if relevant, 8 categories consisting of 25 sub categories and their properties emerged.

The aim of data analysis was to discover the core category or central process, which in grounded theory is the major category linking all others. The core category is the basic social-psychological process involved in the research and demonstrates the ideas that are most significant to the participants (Glaser, 1978). The core category (or core variable) is what in the midwives' view is the main concern or problem in the setting, what sums up the pattern of behaviour, the substance of 'what is going on' in the data, what it is that brings about process and change (Glaser, 1978). The basic social process is one type of core category, which may or may not be present. It is processural, having two or more clear emergent stages which occur over time and which involve change over time, and the stages should differentiate and account for variations in the problematic pattern of behaviour (Glaser, 1978). Identifying the core category and the basic social process took some time and the researcher waited impatiently for an 'a-ha' experience when these would suddenly appear and make themselves known. Eventually

'staying involved 'because the need seems so huge'' was identified as both the basic social process and the core category. The reasons for this will be elaborated on in Chapter Eight. Following further data analysis and collapsing of categories, four categories emerged. These categories became the basis of the developing conceptual framework.

To be credible, the theory that is developed must have explanatory power, linkages between categories and specificity (Holloway & Wheeler, 1996). It must also have fit, understanding, generality and control (Glaser & Strauss, 1967). A theory has fit when the categories fit the data (Glaser & Strauss, 1967), and when the theory is acknowledged as representing the reality of all those involved in the study area; the theory is understood by them and because of its relevance to them has credibility (Cluett & Bluff, 2000). As the categories emerged from the data and became more dense, these were taken back to three of the study participants separately several times to ascertain how applicable to their working reality they felt they were. The three midwives all felt the developing categories were representative of the care processes they used when working with this group of women. The theory should be able to be applied in other situations where the phenomenon under study can be found- generality. The theory should also offer control, which means 'it must allow the user partial control over the structure and process of daily situations as they change through time' (Glaser & Strauss, 1967, p.237). Cluett and Bluff (2000) explain control further as meaning that midwives should be able to use the theory, adjusting it to the current circumstances or in response to the effects or consequences it has on mothers and babies. Whether the developed conceptual framework demonstrates all these qualities will be discussed further in Chapter Eight.

The process of data collection is controlled by the emerging theory. Once categories have been found researchers search the literature to place the research findings into the context of current knowledge and to assess other literature which may support these categories. Glaser and Strauss (1967) state that two types of theory could be produced – substantive and formal. The aim of the present study was to develop a substantive theory or at least a conceptual framework. As due to the small number of study participants it cannot be stated that theoretical saturation of categories was reached, a

substantive theory could not be developed. Instead, a conceptual framework was developed from analysis of the data to explain the phenomenon under study.

3.4 Summary

This chapter has provided an explanation of the historical development of grounded theory methodology and its theoretical and philosophical underpinnings. Procedures for recruiting participants and data collection and analysis methods have been detailed. Ethical considerations as they were addressed for the study, were described. After an introduction to the data, Chapter Four introduces the first of the categories that emerged from data analysis.

INTRODUCTION TO THE DATA

Profile of the midwife participants

The midwives who participated in this study were all female. Five of the seven participants had completed their initial midwifery education in New Zealand. At the time of being interviewed, the participants had been registered as midwives for between six and thirty-one years. The participants had been practising as independent midwives for between five and ten years each. Each of the participants provided total midwifery care for between twenty and eighty women per year. The participants considered the percentage of their annual caseload of women who lived in areas of high deprivation to be between twenty and ninety-five percent.

Each of the participants had a contract to access the maternity facilities of the same hospital in a North Island city. The participants were from five different midwifery groups working within the study region. All participants were known to each other prior to the research study taking place.

At the time of the study, three participants had, since gaining midwifery registration, completed an undergraduate degree related to midwifery. One participant who had gained an undergraduate degree, plus two of the other participants had gained or were currently enrolled in papers towards a Masters degree in Midwifery. All participants were Registered Nurses prior to undertaking their initial midwifery education.

Key to interview abbreviations

The following key has been developed and utilised within the data chapters.

italics -participant's speech

bold -researcher's speech

... -material edited

[ ] -insertion of additional material by researcher, usually explanatory

All participants in the study have a pseudonym. Following each participant's speech are brackets containing the participant's pseudonym, transcript page number(s) and transcript line number(s) e.g. (Jane p4 L23-30).

Throughout the data chapters 'family', in addition to meaning the woman's nuclear and extended family, also refers to her friends and support people.

Since the writing up of this thesis began, Section 51 of the Health and Disability Services Act 1993 (Health Funding Authority, 1998) has been subsumed under Section 88 of the New Zealand Public Health and Disability Act 2000 (Ministry of Health, 2000). For the purposes of remaining true to the data however, 'Section 51' (Health Funding Authority, 1998), the section of the 1993 Act which has direct relevance to midwives, will be the title used, as this is what was referred to by the study participants at the time of data collection.

Chapter 4: Forming Relationships with The Wary

4.1 Introduction

In this chapter the first of the four categories which emerged from in depth analysis of the data obtained from the participants in the study is introduced; 'Forming Relationships with The Wary'. The sub categories of 'becoming comfortable', 'providing total midwifery care' and 'losing women to the secondary care clinic' were identified from the data. These sub categories merge into the category of 'Forming Relationships with The Wary'. The sub categories are defined and discussed in terms of their properties, the conditions under which they occur, the strategies for how the action takes place and the resulting consequences for all involved (Chenitz & Swanson, 1986). Conditions, strategies and consequences form the theoretical linkages between the sub categories making up the category of 'Forming Relationships with The Wary' and also the linkages by which these are related to the other categories developed from the study's data analysis and to the core category. Figure 4-1 provides a diagrammatic representation of the properties and sub categories which together make up the category of 'Forming relationships with the wary'.

4.2 Becoming comfortable

The properties which emerged from the data as together forming the sub category of 'Becoming comfortable' are 'developing a trusting relationship', 'encouraging self responsibility', 'being accepted into her life' and 'taking on her family'. In order to become comfortable with each woman, the midwife needed to develop a trusting relationship with her while encouraging self responsibility. It was also crucial to develop a positive relationship with the woman's family. Midwife participants felt they were accepted in a special way into the woman's life through the relationship that was formed.

Midwife participants in the present study had given some thought to partnership and the individual meaning that it held for them.

> *...what I see in partnership is that there is an equality between us, and even though we come from totally different backgrounds, and possibly even totally different perspectives that equality is still there and it's a*

respect and an acceptance of the other's point of view. That's part of it. And the partnership thing is not equal, but you acknowledge that it's not equal, and you still have to acknowledge that the woman...has her own knowledge, her own experiences, and her own rights to do what she wants to do, as long as they are not damaging to her or the baby. But I also have a right and I also have a knowledge...(Lisa p7 L11-22).

Here Lisa is acknowledging the central point of the partnership for her, this being respect, an acceptance of the other's point of view and an acknowledgement that the partnership is not equal. Recognising these points enables Lisa to work with the individual women, having an understanding of the basic tenets of the relationship and therefore enabling its further development.

Guilliland and Pairman (1995; 1994) define midwifery as being the partnership between the midwife and the woman and believe that it is this partnership which underpins the practice of midwifery in New Zealand. 'The Midwifery Partnership', as Guilliland and Pairman (1995; 1994) have called their model, is seen as a relationship of sharing between the woman and the midwife, which involves trust, shared control and responsibility, and shared meaning through mutual understanding. Establishment and maintenance of the partnership depends on individual negotiation, equality, shared responsibility and empowerment, and informed choice and consent (Guilliland & Pairman, 1995). That partnership is considered to be a basic premise of the midwife-woman relationship, is also reflected in the New Zealand College of Midwives (NZCOM) philosophy which states that 'midwifery takes place in partnership with women' (NZCOM, 1993, p. 7) and again in the Code of Ethics, 'Midwives work in partnership with the woman' (NZCOM, 1993, p. 10).

Although Guilliland and Pairman (1994) acknowledge that 'The Midwifery Partnership' was a model for practice which they expected would evolve over time, since its inception there is a sense of it having been held up as the only way to practice midwifery 'properly' in New Zealand. According to Pairman (2001, p. 7) it is 'the midwifery model that underpins the New Zealand maternity services'. Midwives therefore, have in general been loath to debate the model in any public forum. Fleming (2000, 1998a) challenges 'The Midwifery Partnership's' (Guilliland & Pairman, 1995) assumptions that normal birth is something which all women should strive for and that midwives only function properly as midwives when they alone provide total care to

individual women. Fleming (2000; 1998a) is of the view that these assumptions make the model narrow, self-limiting and exclusionist. Tully, Daellenbach and Guilliland (1998) make the point that midwives may place different interpretations on the meaning of partnership depending on where and how they choose to work. Guilliland and Pairman's (1995; 1994) model therefore, provides the philosophical basis for the practice of some midwives only- that is only those midwives providing total midwifery care throughout pregnancy, labour and birth, and the postnatal period on their own responsibility.

'The Midwifery Partnership' (Guilliland & Pairman, 1995) has undergone some refinement by Pairman (2000; 1999) in an effort to advance an understanding of the relationship between the midwife and the woman. Pairman (2000; 1999) has further defined 'partnership' as meaning 'professional friendship' to describe the unique nature of the midwife-woman relationship. In a British study undertaken to explore women's experiences of having a known midwife throughout their pregnancy, labour, birth and early postnatal period, Walsh (1999) found that women's perceptions and experiences were mainly influenced by the relationships they had with their midwives who the women described as 'friends'. A study by Kennedy (1995) attempted to understand the midwifery process from the woman's point of view. Women talked about a relationship grounded in respect, trust and alliance, with the qualities and behaviours of the midwife laying the foundation for how the women perceived the experience (Kennedy, 1995).

Skinner (1999), a midwife working with low income families, is concerned that the partnership model fails her practice for several reasons; it does not explicate the power imbalance between the woman and the midwife especially with regard to their different knowledge bases, it presumes that informed consent is always possible, a presumption which can leave the midwife and the woman extremely exposed litigiously, and finally it assumes that all women want partnership and control which in Skinner's experience in working with low income families, is often not true. Benn (1999) in providing comment on Skinner's (1999) paper describes 'The Midwifery Partnership' (Guilliland & Pairman, 1995) as an attempt to prescriptively describe the childbearing experience in which midwives are the LMCs, and sees the model as an ideal, a goal to strive for and also a description of the way some midwives currently practice. Benn (1999) believes the key to understanding the parameters of partnership depends on how partnership is

defined, and that the important issue and what midwives should be focusing on is not what the relationship is called, but instead how the woman and the midwife work together and the difference this makes to the woman, her baby and family, and to the midwife involved.

It is Lauchland's (1996) assertion that as the authors of 'The Midwifery Partnership' have not undertaken an analysis of what partnership means in actual midwifery practice, the model represents an unresearched model of the professional status of midwives rather than their clinical practice. Lauchland (1996) points out that the childbearing woman's viewpoint is a major element missing from discussions about partnership in clinical practice and that more research is needed on the midwifery partnership in clinical practice.

That some women do not identify the interaction between themselves and their midwife to be an equal one nor call the interaction a partnership, was a finding of Vague's (2001) study. This was particularly apparent when the midwife worked with women from different cultural groups, when it seemed the woman's expectations did not allow for a sense of partnership because their cultural background or self-image had conditioned them to seek a more passive role in relationships (Vague, 2001). This was especially noticeable when there was a need to make decisions about care (Vague, 2001).

It is Strid's (2000) opinion that most NZ midwives have totally forsaken the principles inherent in the partnership model which promote the provision of women-centered care by midwives, birth being seen as a normal process, midwives being the guardians of normal birth, and the significance of midwives' active participation with consumer groups. Instead Strid (2000) believes midwives are exploiting women's fear and uncertainty of their body's ability to give birth normally in the same way that doctors have, as reflected in the fact that NZ now has more autonomously practising midwives than ever before and also the highest rates of intervention in childbirth. A similar view had previously been expressed by Cole (1994) who was concerned that women were feeling disillusioned and betrayed by midwives who seemed to be replacing the medical model with a midwifery model which placed the midwife, rather than the woman, at its centre. This view was supported by the amount of fragmented care which midwives

were undertaking and midwifery caseloads far in excess of the 50-70 per year recommended by the NZ College of Midwives (Cole, 1994). Strid (2000) defines partnership as being when both parties agree there is a partnership and implores midwives to work towards returning power to women giving birth rather than to professionals to control birth.

In a study investigating the relationship between midwives and consumers in NZ, Fleming (1998b) found that the beliefs which underpinned the practice of midwives were not always the same as those of the women they were working with. In another study which aimed to develop a research based conceptual model of midwifery practice in both NZ and Scotland, Fleming (1998c) articulates the term 'reciprocity' to represent the essence of successful midwife-woman relationships, defined as ideas being exchanged and developmental goals being achieved, and/or the bringing together of aims and aspirations to create the reality.

Though all participants in this study provided total midwifery care and were therefore practising according to the principles inherent in 'The Midwifery Partnership' (Guilliland & Pairman, 1995), the majority of the participants, referred to the 'relationship' that developed between the woman and themselves rather than to the 'partnership'.

> *...she's happy and it just feels good. The relationship feels good, and it's good with her partner, it feels good with her children. And that's how I go with the relationship. It's comfortable. It's comfortable for her and it's comfortable for me and I think that's what makes it work (Rose p10-11 L29-1).*

As the midwife participants in this study referred to the 'relationship' that was developed between the woman and themselves, to remain true to the data this word will be used throughout this thesis. Becoming comfortable was one of the consequences of developing a trusting relationship.

4.2.1 Developing a trusting relationship

Midwives found that a lot of their initial involvement with each individual woman was focused around developing the beginnings of some sort of relationship with her. The midwife however was often faced with obstacles to break through from the woman's

previous encounters with health professionals and/or social support agencies, before this relationship could develop.

> *From the beginning antenatally they are very untrusting and that lack of trust is totally justified often by the treatment that they've had in the past, and that they get in the hospital system...and it's because they're Maori or they're Samoan, or they're smokers or they're obese or they drink a lot, or whatever reason (Anne p17-18 L30-2).*

> *I find they often feel quite threatened with anyone that comes in from health type things just because of what may have happened in the past.... ...some of the women that I see, they've had children taken off them and things like that so they're a little bit wary. Or sometimes their partners might be involved in some of the local gangs or things like that, so they're just a bit wary of me (Carmel p3 L19-31).*

> *...partly I think there's a fear of income support –that I'm gonna dobb that woman in that the father of the baby is living with them and they try and not involve me too much in their personal circumstances because they don't trust the system (Linda p27 L15-20).*

A mistrust of health professionals can stem from previous maternity episodes as well. Previous experience of caregivers during childbirth has a significant effect on how women anticipate their subsequent pregnancy and birth (Walsh, 1999; Fleming, 1998b). Dyehouse (1992) found that women seeking health care are often offered care based on stereotypical sex-biased responses and her symptoms trivialised as she is offered unnecessary or inappropriate treatment. Many of the women in Walsh's (1999) study were left with an intense dislike of hospitals and the care they received there following their first births. This contrasted greatly with their next pregnancy when the women in the study choosing to have midwifery care, found their experience underpinned by the significance they placed on the relationships they developed with their midwives, who they came to describe as friends (Walsh, 1999).

Merchant (1993) followed a panel of 18 women living in areas of deprivation through pregnancy, birth and the early months of their babies' lives. The study results showed that most women felt excluded from appropriate antenatal care by deprivation, poor communication and insensitive procedures (Merchant, 1993). This is supported by the results of a study exploring barriers and motivators to prenatal care among low-income women which found that psychosocial, structural and sociodemographic factors were the barriers and the woman's beliefs and support from others were important motivators

in accessing antenatal care (Lia-Hoagberg, Rode, Skovholt, Oberg, Berg, Mullett & Choi, 1990).

A New Zealand study which aimed to determine the rates of utilisation and expenditure on primary medical care and related services for Maori and low income New Zealanders confirmed there is gross underutilisation of and expenditure on primary medical care and related services to Maori and other New Zealanders living in poor circumstances (Malcolm, 1996). Malcolm (1996) recommends a radical review of the current problems of financial access for low income populations to health services and the associated barriers they face such as poor access to public transport and isolated populations living in rural settings as well as low expectations of the benefits of primary health care and therefore deferring treatment until problems become emergencies necessitating hospital admission.

In their evaluation of a project which provided enhanced pregnancy care to women living in areas of social and economic deprivation, Davies and Evans (1991) describe how the women had found their previous encounters with some health professionals to be inappropriate usually because there had not been adequate recognition of the poverty in which the women were living. The midwives in Davies and Evans' (1991) study coped with the initial lack of trust the women had in them by not having any preconceived ideas on topics to be discussed, by letting the women determine the speed with which the relationship began to develop, and by trying to establish some sort of relationship of trust.

The midwives in the present study considered it important that the relationship that developed between themselves and the women be based on mutual trust.

> *...I know that they do trust me, and I've just sort of accepted that.... So yeah I guess it is a trust. But the other thing too is that they know that I will trust them to comply as well as possible with the suggestions that are made and that makes it really good. ...There is a huge sense of trust. But it has to work both ways (Lisa p8 L22-30).*

Lisa's statement above could also imply that if there is no compliance from the woman then there will be no trust from the midwife. This interpretation may need addressing.

Davies and Evans (1990) found that during the process of providing/having antenatal care and preparing for childbirth and parenting, trust builds up between the woman and her midwife. In the current study, the development of trust in the midwife, by women, was a process which often took a long time to develop. Once established however, it was seen as being one of the most satisfying aspects about working with this group of women.

> *And so it takes a long while to build up that trust and it's one of the really satisfying things about the job, is that you know when you have a first antenatal visit and everyone in the house is looking at you really really suspiciously and by about the second or third one...you've made them smile or you've made them crack a little bit (Anne p18 L9-16).*
>
> *[They are] just very quiet at first, just tell you exactly what you ask, nothing else. But once you develop this relationship with them then you develop the relationship within the street, within their friends and they come back to you and they really trust you (Jane p7 L1-5).*
>
> *But it is something that actually happens over time, so each visit I find that I get to know a little bit more...and sometimes I might look after her for more than one pregnancy and it's the second pregnancy where you find that the woman will have developed that trust and so she actually will tell you heaps more (Carmel p4 L1-7).*

When commenting on aspects of the one to one relationship with the midwife which they particularly appreciated, Davies and Evans (1991) found that the aspect most frequently mentioned by the women was trust. The women trusted the midwives, not only throughout the pregnancy, but long term as well (Davies & Evans, 1991).

Flint (1995, 1994) alludes to the importance for the woman of having a known midwife whom she has come to know and trust throughout her pregnancy. In building a relationship with the woman, the midwife has spent time 'getting to know her'. According to Page (1995), the key to ensuring women receive individual, sensitive care throughout their pregnancy, labour, birth and the early postnatal weeks, is for midwives to get to know the women and families in their care as individuals, thus developing a relationship of trust. Ralston (1998) believes that the key to being able to engage in a close and trusting relationship with women is good communication skills, with communication either facilitating the development of a therapeutic relationship or serving as a barrier to its development.

According to Kirkham (2000) the relationship women build with their midwife is about them being made to feel safe and able, and that a relationship can only develop between the woman and the midwife if they continue to meet regularly together. Therefore, with continuity of midwifery care and the consequent development of the relationship between the midwife and the woman, a trust is formed and the woman's agenda is then able to be addressed as the midwife's response to the woman becomes the primary purpose of care and of the relationship. In a relationship where the midwife is aware of and able to offer respect and support for the woman's values and priorities, the woman feels that she is acknowledged and valued and feels safe in the relationship (Kirkham, 2000). The midwife is then able to give what the woman seeks and defines, rather than what the midwife defines as being best for her (Kirkham, 2000).

In a study exploring the processes involved when women make choices regarding their care and how midwives try to help them to make choices, one of the central issues which emerged concerned the importance of trust (Levy, 1999a). Depending on the quality of the information the midwife provided to the woman, and the woman's perceptions of the midwife's expertise and interest in her personal circumstances and needs, Levy (1999a) found the woman made a judgement as to whether the midwife was deserving of her trust. Equally important, she also found that midwives gatekept information to protect women and themselves, and the degree of trust the midwives placed in the women to use the information appropriately affected the degree of gatekeeping of information by the midwives.

A study undertaken to examine women's experiences of midwifery care during their labour and the birth of their baby found that women trusted their midwives to know what care was best for them because of their expertise (Bluff & Holloway, 1994). This trust in the midwife remained intact no matter what happened during the labour and birth process and even when the midwife disregarded the woman's wishes (Bluff & Holloway, 1994). This trust in the midwife's expertise is supported in an example from the data collected for the present study:

> *...I was looking after a woman.... It will be her third baby that she's had with me.... This was a completely new partner, and he'd never met me before. But he'd obviously heard about me and trusted me and he was actually quite concerned about the baby because he'd used IV [intravenous] drugs and things like that in the past. So that was quite*

good that he mentioned it to me on the first visit...it was obviously because he knew that this woman trusted me...and then we went on to talk about the risk of HIV and things, which again he was reasonably open about but I think only because of the previous relationship that I'd had with the woman (Carmel p9 L5-25).

In a study exploring the way decisions were made in the midwife-woman relationship, Calvert (1998a; 1998b) found that as a consequence of spending time together a relationship between the midwife and the woman develops. This relationship was based on a foundation of trust, which was essential if there was to be a successful working relationship. Calvert (1998a; 1998b) also found that women often spontaneously handed over their decision making responsibility to their midwife and looked to the midwife for help, assistance and professional guidance throughout the relationship, especially when they were in situations which they didn't fully understand or when help was needed. Having formed a trusting relationship with the midwife, the woman then trusted the midwife to ensure the safety of herself and her baby (Calvert, 1998a; 1998b).

In the present study, midwives found that in the trusting relationship that was formed between themselves and the women, the women often trusted them unquestioningly. Once this trust was established, the women often chose not to be involved in any of the decisions that needed to be made regarding their care. They preferred instead to abdicate this responsibility to the midwife.

...because they trust you and they don't have this care plan. If you say 'I think it will be great if you get in the water' they'll jump in the water...'is it all right if we put the monitor on?' They are not going to want the far end of 'well what happens if we don't monitor' –'yep you can put the monitor on'. Not that I'm knocking women who do that at all, but...you don't have this 'well we were hoping to go for another hour's walk before you did that again'.... These women just trust you if you believe that they need that...(Jane p10 L15-27).

This is supported by Creasy (1997), who found that in order to be able to abdicate responsibility for decision making to the midwife, the woman must first trust her carer. As a familiar carer will be more likely to understand the individual woman's circumstances and beliefs, trust is more likely to occur within the confines of a previously developed relationship (Creasy, 1997). Levy (1999b) found that information sometimes poses a threat to the woman by causing worry and/or distress and so some women prefer not to have this information given to them as they felt unable or did not wish to influence events. Levy (1999b) cautions midwives to be sensitive to the cues the

woman gives and respond in an appropriately sensitive way. Richards (1997) comments that the woman is not expected to suddenly become an academic, a competent practitioner or an experienced professional overnight. It is more important that she feels guided and supported by the midwife in her decision-making (Richards, 1997).

Exploring the attribute of 'warmth' as the defining characteristic which allows some midwives to establish a relationship with women which sets them apart from their midwifery colleagues, Vague (2001) interviewed three New Zealand midwives about their philosophical approach to midwifery care and what they actually did when providing labour support, as well as interviewing three women who had been cared for by each of the midwives. Promoting a sense of security and trust emerged as a common theme in each of the midwives' practice and this was articulated by each of the women involved in the study (Vague, 2001). The establishment of trust was considered to be essential in the relationship between the woman and the midwife.

> *And it's kind of, once they do trust you, you know it's going to take them a long time to trust anyone else still. So often when you offer other services they're reluctant to use them, and they often cling hold of you as well because they've found someone they trust (Anne p18 L20-26).*

As Anne points out, having developed a trusting relationship with the midwife and as a consequence, abdicating the responsibility for decision making to the midwife, the women were reluctant to use other services when they had already chosen who they wished to have involved in their care. This was a mark of the trust these women had in their midwives.

Occasionally there is a down side to the relationship that has been formed however, and this centers around the times when the midwife knows she will have to break the trust which has been built up between herself and the woman in her efforts to be honest with the woman and to ensure the safety of the woman and/or her baby and/or her other children. These times are a source of anguish to the midwives, even if they feel sure of the need to speak out to protect those for whom they are providing care.

> *...we try and be up front and tell women what we are doing. We try not to sneakily do it behind people's backs. We say to them 'look I need to tell CYFS [The Department of Children, Youth and Family Service]'. I always think that is the right thing to do but, sometimes I can't quite get the words out of my mouth when I try and tell them that (Anne p15-16 L28-2).*

In these situations, the action the midwife decides she has to take may directly threaten the relationship that has developed between the woman and herself. The decision to act such as in the above quote from the interview with Anne, has to be balanced with the necessity of taking the action in the midwife's mind. Decisions which may directly threaten the midwife-woman relationship such as this are never easy, nor undertaken lightly.

Other difficulties arise when the midwife becomes aware that she is not being trusted with information, which, if she knew, would potentially make a positive contribution to her relationship with the woman.

> *And I have had one woman tell me her whole pregnancy that this guy in the house was her flatmate, and I knew he wasn't because he was very interested in all the antenatal stuff that was going on, and he came to the labour and I thought well there's not many male flatmates that come to the labour! And then her mother said something about oh something or other 'dad' and I could see the daughter glaring at her mother like 'don't do that. [Linda] doesn't know he's the father,' whereas I did the whole time, and afterwards her mother said 'she hasn't got stupid written on her forehead'...afterwards I said to her 'you know, I can only help you if you let me help you' and she apologised and said she should have trusted me more than she did (Linda p27-28 L20-4).*

The midwives endeavoured to ensure the trust the women bestowed in them was utilised appropriately. Care needed to be taken however to ensure the relationship the midwives fostered with the women was one of self-responsibility rather than dependency.

4.2.2 Encouraging self responsibility

The midwives took great care to ensure the developing relationship was not one of dependence, with the woman relying on the midwife to make all the arrangements and decisions regarding the woman's care, but instead one which encouraged some self-responsibility on the part of the woman.

> *I think that one of the things you have to be careful of is not to make them dependent on you though, that's really important. I don't want people to be dependent on me...I don't want them to get to the point of saying 'oh [Lisa] will come and do that' because I want them to be able to do it for themselves (Lisa p27 L8-16).*

I think generally the answer is that women shouldn't be particularly dependent upon one person. But that's a very easy thing to say and a hard thing to do...(Anne p17 L26-29).

Encouraging the women to take some of the responsibility for their care was often something the midwives learnt they had to do following some of their experiences while working with these women, rather than something they had initially set out to encourage. This could take the form of the midwife not being available for the woman 100 percent of the time due to having days off, study or sick leave, or this became apparent when midwives wanted women to get such things as blood tests done, or to organise their own transport to attend a scan.

...she needs to be responsible enough to go (Lisa p15 L15-16).

...I don't think that you should do everything for people and that people are quite capable of organising things for themselves (Linda p18 L14-16).

This raises the issue of whether mutual trust is part of self responsibility within the relationship that has been formed between the woman and the midwife. Kirkham (2000) sees the trust that is formed within the midwife-woman relationship as being a two way process. The woman trusts the midwife that the blood tests and/or scan that the midwife has recommended, needs to be done. The midwife trusts that the woman will go and get the blood tests done, or is capable of organising transport to attend a scan. The woman's part of the relationship therefore is to take responsibility to ensure the recommended tests are done by organising to get herself to wherever they are to be performed.

4.2.3 Being accepted into her life

Midwives felt that the relationship that was formed was one of them being accepted in a special way into these women's lives.

I remember one day being down at Kentucky Fried...having lunch, and the family of one of the women said 'come and eat with us, come and share our food,' but we had just finished our food, so we didn't, but they do embrace you as part of the family and it's nice that way (Theresa p17 L9-15).

Once you get to know them you kinda fit in...(Jane p13-14 L33-2).

...being accepted into those women's lives is actually huge. And in the...years that I've been working in these areas...I've felt very much as if the families down there have accepted me and I know they do because

they come back to me time and time again, and time and time again...you build up a confidence with them (Lisa p5 L17-18).

Midwives also mentioned being referred to as the woman's midwife. This was another way in which the relationship formed between themselves and the woman was acknowledged.

...and I think to be 'my midwife' as you often are for these people when you meet them downtown 'oh mum here's my midwife' is actually a really big step (Lisa p24 L5-8).

Being identified as 'their' midwife, was also identified by Davies (2000) who found that many of the women in the Newcastle study commented on how the midwives were 'just like one of us', whereas economically and professionally this was not so. In trying to find an explanation for this phenomenon, Davies (2000) concluded that it probably resulted from the way the midwives were working, in that the midwives were working on the women's territory and were making a conscious effort to break down some of the barriers between the women and themselves. By meeting a woman in her own environment, the woman was made to feel that her unique identity was understood (Davies & Evans, 1991).

From time to time though, being thought of as the woman's midwife was given different interpretations by the woman, compared to what the midwife expected out of the relationship with the woman.

...they do turn up, even if you don't see them for the whole pregnancy, they turn up at the hospital at birth and tell them that you're their midwife...I mean I've had people who have turned up and told the hospital that I am their midwife and I've never met them but I looked after the sister (laughs). So they felt the pregnancy and birth was under control. Yeah, they had it arranged.
So what would you do in that situation if you got called in for something like that?
I would attend that birth just because chances are I did look after her sister and if I had that link with the family then I would certainly come in. Yeah if she believed I was her midwife then I would be (Anne p29-30 L17-7).

...I saw her once her whole pregnancy and then she presented again at term. And that was because the baby hadn't been born yet and she was getting towards being post mature and it was like 'I'm back now' and 'will you still look after me?'...I saw her a couple of times and once I knew the baby's size was okay and that her blood pressure was alright, I

thought well, if she's well, she's well, and I thought, she needs some form of continuity so it might as well be me...(Linda p45 L6-25).

Agreeing to take on the woman's care as in the above situations, was seen by the midwives involved to be just part of the everyday reality of working with these women. Providing the women with some form of continuity by a midwife who has some understanding of the circumstances the women live in was seen as the priority.

The commitment to both maintaining a full caseload and looking after themselves, meant the midwife was not always able to take back and continue the care of a woman who had disappeared for the majority of the pregnancy and turned up again near the baby's expected date of delivery expecting to be taken back on. When this happened the midwife usually handed the woman on to one of her team midwifery colleagues.

...you have to look at your numbers [of women] and your own safety as well. And it doesn't always happen that you can look after her.... And if say she's gone and she's been gone for a few months and I've taken another woman, because you've still got that space, you can't just chop and change [women], so I think the beauty of working [as part of a midwifery team] is that you've got other midwives and they will be able to take her. A woman may be disappointed because she had you last time. It's really really hard, but when you look at the numbers and you think you just can't take anymore with looking after yourself and looking after her, so that she has to go with someone else (Rose p13-14 L24-8).

Occasionally the relationship does not work from the midwife's and/or the woman's perspective and for a variety of reasons. This may be because either party does not feel a relationship is developing, or it may be that the midwife feels she is being lied to.

I think that you struggle...[with] always believing that the woman is telling you the truth and I don't know that that's always true. Some women are quite deceitful, and I think that you're naive as a care giver if you always accept everything a woman says as being the whole truth, and that you have to protect yourself as a care giver and reflect on that. Maybe she's telling you what you want to hear because she wants to look good in your eyes and she doesn't want you to be a judgmental care giver. ...maybe there's a bit of guilt attached to some lifestyle behaviours and they won't tell you or be totally honest with what's happening (Linda p29-30 L31-18).

When this occurs either of the parties involved may decide to terminate the relationship.

Because from what I've learnt, sometimes you can go along and you can feel that the relationship isn't quite going to gel and at some time it will just bottom out, so you're better if you feel that, to not take it on. You give it to someone else...it's better to let them go because you end up

being hurt, which I find really really hard, but it's just part of the job...and it's not something wrong that you've done...It's a skill as well don't you think? I know where this is going and I'm not going to, I'd be better to give her to someone else (Rose p9 L4-31).

They have no hesitation in firing you if they're really stroppy, or if you challenge their lifestyle in any way. I had one woman, who all I did was ask her if she smoked and how many, and gave her the top 10 tips on how to quit, who rang me up and fired me and said that she thought I was judgmental about her lifestyle. And I said that I was sorry that she felt that way but I had an obligation as a care giver to assess her health history...and to point out the risks of smoking and that I wasn't trying to be judgmental. So we came to a parting of the ways and I think she just felt threatened, that she felt guilty about smoking one and a half packets of cigarettes a day and that I had mentioned it and how dare I and I just said 'oh well, that's fine' (Linda p29 L8-22).

No literature was found on what happens when midwives and/or women end the midwifery-woman relationship. Do the women find other caregivers whom they form a satisfactory relationship with for the remainder of the pregnancy, or do these women receive no pregnancy care and turn up at their local delivery suite when in strong labour, or alternatively, do these women have homebirths without midwifery or medical supervision? This is a subject warranting further research.

4.2.4 Taking on her family

The building of a relationship between the midwife and the woman did not occur in isolation however. A consequence of being accepted into the woman's life was that of taking on the woman's family. Most of the women had family members and a group of friends around them, who provided them with support throughout their pregnancy. The development of a positive ongoing relationship between the midwife and the woman's family was seen by the all the midwives in the study as being crucial to their ongoing interaction with the woman. Over the woman's lifetime, the midwife is with the woman for a very short period and it would be the family who would nurture and support the woman and her baby once the midwife's role was completed.

...my belief and feeling about it is that if it goes really well and it feels really functional and they all pull together, and...the baby is born and everyone is really happy, there is a very bonding special moment for the whole family, and my belief is that may be an impact on that whole child's life and the family life because of it. It feels like a healthy, right system (Anne p25 L12-19).

...you don't just take on the woman; you take on the whole family...I think that's because we get to know the women so well because we're going into their environment, and when we do that we are taking on that- the whole of the woman because that is her isn't it (Rose p8 L14-24).

Here Rose is acknowledging how important it is that the midwife realises the necessity of trying to establish a relationship not only with the woman, but with her family as well and in building on that relationship in all subsequent encounters that the midwife then has with the woman. Acknowledging the importance of other family members as providers of social support and assisting partners in recognising their potential positive contributions is a view espoused by Schaffer and Lia-Hoagberg (1997). From their study of the effects of social support on prenatal care and the health behaviours of low-income women, Schaffer and Lia-Hoagberg (1997) found that social support from partners correlated positively with adequate antenatal care and social support from others correlated positively with antenatal health behaviours. Bright (1992) studied how expectant parents and grandparents prepare for and respond to the arrival of the firstborn infant in the family from the beginning of the third trimester until the child's first birthday. The data revealed the evolution of a family process which began before the birth and allowed for the inclusion of the new baby into the family's ongoing life (Bright, 1992). Bright (1992) concluded that it is crucial that nurses (read midwives) recognise the importance of the extended family's relationship, their response to the infant's birth and their contribution to the quality of family life including the importance of including grandparents in the birth experience.

So I really like to incorporate the family into what we're doing and I'll often bring it up and say 'what did your mum do, what did your grandma do?'...if you don't get them on side you have a hell of a job at the time of labour (Lisa p20 L17-26).

Midwives found that because they had been given access to the woman's home and therefore to her family life, they were often called upon to give advice on matters not necessarily pertaining to the pregnant woman.

Often they want you to look at the other child's sores on their legs, and do other things as well (Anne p18 L27-28).

I had a woman the other day and she rang me and she is pregnant but her 18 year old daughter is in an abusive relationship and she was ringing me for care for her 18 year old daughter who isn't pregnant you see (Rose p8 L10-14).

In this situation the midwives would give the woman information on appropriate community groups which the woman could refer her daughter to and may end up going with the woman or organising for someone else to go with her, to support and advocate for the woman and her daughter.

The midwives noticed that the woman's partner often had little involvement in the antenatal checkups the midwife performed in the woman's home.

> *And the partners...might stick their head in to listen to the heartbeat, but they shoot through [leave] as soon as you talk about anything. They're not very involved...(Linda p27 L1-5).*

As mentioned previously, this may be due to previous negative encounters with health professionals and/or social support agencies and the consequent lack of trust that these experiences have engendered, or it may be due to cultural aspects. In her work with socioeconomically disadvantaged women, Davies (1988) found that amongst these women, childbirth and childcare are accepted as being exclusively women's work and that men are excluded. This is despite many of the men being unemployed with little to do and women with children having too much to do. An alternative explanation may also be that the woman's partner often had little involvement in the antenatal check-ups the midwife performed in the woman's home because this is simply not important to them.

4.3 Providing total midwifery care

One of the conditions of being eligible to participate in this study was that the midwives provided total midwifery care. This meant the midwife was the woman's Lead Maternity Carer (LMC) and therefore took total responsibility for providing the woman's antenatal, labour and birth, and postnatal care for up to six weeks following delivery of the baby.

> *My care [is] the total midwifery care (Lisa p5 L1-2).*

> *I provide...antenatal care plus education and I provide labour care and postnatal care up to four to six weeks (Rose p2 L15-17).*

> *I do midwife only care – complete midwifery care. I do all antenatal, labour care and all postnatal care until discharge to Plunket, with specialist referral, as indicated (Linda p2 L21-24).*

I do antenatal care and labour and birth care and postnatal care (Anne p2 L26-28).

The reasons why the midwives chose to provide total midwifery care to women rather than fragmented care was not a focus of this study. Linda however gave one reason for practising in this way.

I figure if I'm going to make a mistake it might as well be my own. I think it's too confusing to have too many fingers in the pie about making decisions about people's care (Linda p2-3 L31-1).

Midwives talked about the midwifery care they provided at antenatal visits being similar to the care which they and other midwives provided to other, more affluent women.

I do antenatal visits at home, the routine antenatal visits which are four weekly, two weekly and then one weekly and at those visits I do the routine stuff that everyone does; the blood pressures, and wees and things and the normal education around health and pregnancy and birth (Anne p2 L1-6).

...I always check the urine for protein, sugar and then take their blood pressure and check for oedema, and also palping the woman and listening in to the baby usually. And at that time it's a good opportunity to find out where the woman's actually at with the pregnancy – how she's feeling about it, how her family are coping (Rose p6 L16-21).

After I've done a health assessment I check their blood pressure, I do a urine analysis; glucose and protein, ketones just in case they're vomiting, and I don't routinely weigh women because there's not a lot of clinical evidence to support that...I'll listen for a fetal heart and check the fundal height (Linda p8 L18-27).

Linda's comment about not weighing women is supported by the lack of research evidence to support the stance that routinely weighing women during pregnancy is likely to do more good than harm (Chalmers, 1993).

The midwives believed that they gave similar midwifery care to all the women they worked with, that is, both women living in areas of high deprivation and more affluent women.

Well I try as much as possible to provide the same care for every woman irrespective of where they live (Jane p2 L20-21).

I don't think I treat them differently. I don't want to treat them differently (Lisa p26 L6-7).

Probably I provide the same care that I provide for all my women (Theresa p2 L10-11).

From analysis of the data however, it became apparent that the midwives in the study believed that women living in areas of high deprivation had additional requirements to more affluent women, which also needed to be addressed if these women were to be assisted to have the best pregnancy outcome for themselves and their babies. Providing total midwifery care, meant more than just the provision of pregnancy, labour, birth and postnatal care, which was similar to that provided to more affluent women. In addition to requiring the usual midwifery care that all women received, these women had other requirements.

So, a certain amount of my care is actually to do with meeting needs that are not directly maternity (Anne p3 L29-31).

...those women need more in the way of 'propping up' (Lisa p3 L30-31).

They are absolutely very different demands. Yes, yes very different and they're not their demands. They're their needs, rather than demands (Theresa p16 L23-29).

...so you've got to target your care at the individual woman (Jane p3 L29-30).

The additional requirements the midwives recognised these women had are the focus of Chapter Five.

4.3.1 Taking on women other midwives don't want

A consequence of working with women living in areas of high deprivation was taking on women that other midwives did not want to provide care for. The midwives in the study felt that due to the complexities of these women's lives, midwives who worked primarily with more affluent women were usually not keen to commit to becoming involved with these women as well. This meant that women considered to be 'more difficult', were often referred on to these midwives for midwifery care. And the midwives would take them on.

Yeah, I suppose it's the philosophy of our practice...that we take women that other people won't have (Anne p30 L26-28).

The most common reasons for women being considered more difficult were that the women were non-residents or late attenders.

Until just prior to this study taking place, maternity hospitals had charged women who were non-residents for the care they received during their hospital stay. This was because there was no provision in the Government funded facility fee paid to maternity hospitals to cover this cost. The repercussions of this were huge, particularly for the women. They were usually Samoan or Tongan and living with their extended families in areas of high deprivation. These women were usually on a very limited income as were their families. If possible, most would come into the hospital late in labour and take an early discharge following the birth of their baby to avoid the escalation of costs of over $700 per day they would be charged in relation to their care if they continued to stay in. Other women would have homebirths because they did not want to go to hospital and have to pay.

> *And they were really undesirable homebirths, because they were...women who didn't want homebirths. They wouldn't have actively chosen [one]...sometimes their houses were cold, and they could be in big blocks of flats that were hard to access and...not really suitable (Anne p42 L6-19).*

As the local hospital no longer charged non-residents, the problem of them being charged for care, being unable to pay and then being followed up by debt companies and consequently disappearing, had stopped. The ongoing problem however, was that there continued to be no payment for antenatal care for non-resident women within Section 51 (Health Funding Authority, 1998) so many midwives did not want to provide these women with midwifery care as the option of charging the women for the care provided was minimal given the woman's financial status. However some of the midwives in the study would provide these women with care even though they would not be paid for doing this.

> *We don't charge them [the women] and we don't get paid, neither. ...so it means that any antenatal care we give these women is not, there is no payment for it (Anne p43 L23-28).*

While not being prepared to accept these women from other providers because of the unlucrative nature of providing the care, midwives who were prepared to provide care to these women became known within the community.

> *What happens in some ways I think is in some communities, like the Tongan community, they know that we will accept those women [for midwifery care], so the community directs them to us at times and yes, we don't turn them away (Anne p44 L7-11).*

In addition to taking on non-residents, the midwives also took on women who presented late in the pregnancy who for a variety of reasons had not received any antenatal care.

> *I did have a woman recently who's 35 weeks [pregnant] and we have just recently...had women turning up, mainly Maori, at 35-36 weeks with no antenatal care. [One] was promised by a midwife that they'd be visited and the person never came round to see them. And so they came to us at about 35 weeks and [had received] no antenatal care whatsoever (Rose p24 L18-25).*

Sometimes the woman had had midwifery care from the midwives they eventually accessed during previous pregnancies, but had initially gone to a provider who had referred them onto a different midwifery group. Being unhappy with the care they were now receiving the women had decided to return to their previous midwifery provider/s for their remaining pregnancy care. If the midwives were then unable to take on the care of the woman, the woman would need to be referred on to the secondary care clinic. The midwives would prefer to try and accommodate the care of the woman, rather than allow this to happen.

> *...they would be handed over to the secondary care clinic, which really to me isn't good care (Rose p25 L31-32).*

Occasionally a woman for whom the midwife was providing care, displayed behaviour which was difficult for the midwife to deal with.

> *Occasionally we've had women who have been really outrageously awful actually you know, and shrieked things and thrown things [at the midwife]... because they've been using solvents or they're really drunk or they're in the middle of a relationship problem...(Anne p30-31 L28-3).*

Rather than 'sack' the woman, the midwife would try to keep contact with her, knowing that if she didn't, the woman would end up receiving no midwifery care at all.

> *...and we've usually persisted to try and if possible, keep contact with them just on the basis that if we don't have them then nobody will (Anne p31 L3-6).*

If the woman refused to have the midwife provide care however, the midwife had no option but to stop her involvement in the pregnancy.

> *...if they refused [care] then we won't but...I have gone back...to a house and tried to talk to the woman again about her care to see if she would have us, if she would stay with us, if she would see me as her midwife. Not because I wanted her because she seemed extremely problematic and I didn't want her, but just because she seemed so desperate and isolated*

and unwell that I wanted her to have care very badly. ...in fact what happened was she rejected my care so ended up with no care (Anne p31 L11-25).

This was hard for the midwife who had a strong commitment to ensuring these women had access to quality midwifery care. Ensuring these women had access to midwifery care from midwives who had some understanding of their social circumstances appeared to be a huge motivator for the midwives in the study to work with these women.

4.3.2 Assessing

At her first contact with a woman requesting midwifery care, the midwife began what would turn out to be an ongoing assessment of the woman's pregnancy and her life in general. The place of first contact varied depending primarily on the woman's preference, but also on what suited the midwife. It may have been by phone, it may have been at the woman's home, it may be at the midwife's clinic rooms or it may be at some other venue. Wherever this first contact happened, the midwife would undertake an initial assessment of the woman and begin to give her the information she would require to make decisions throughout her pregnancy.

Well to start with, normally my first contact might be a phone call with the woman and over the phone I will do an initial assessment about where they live, what their age is, just so I can straight away in my mind know about the timing of the first appointment.... I send an information pack.... So if they're under 12 weeks then I'll want to know whether or not they're taking folic acid and if they're not then I'll send them a script. ...So if they're feeling unwell or if they've had any problems I would schedule an early check up otherwise my first appointment's at about 12 weeks (Linda p3-4 L11-5).

...initially on the first visit I usually go to them and I talk to them about what midwifery care is and how it's different and I also go through the choices that they could have [for care]. ...And then I talk to them about my midwifery experience and how I practice as a midwife, and who my back up midwife is.... Then I go through what they can expect in their pregnancy; so their visits, how often I would visit, and when we will do blood tests and scans and talk about arrangements that are there if there are any complications (Theresa p2-3 L23-7).

And then they come to us at the clinic and then you go through what you do, the education; all the options for care. Because we're working in a group then they need to know who the [other] midwives are and how we work (Rose p2-3 L29-1).

At the beginning stages of the development of a relationship with the woman, the midwife gave the woman a lot of information about many things the midwife considered important for the woman to know. As a relationship of trust developed between the woman and the midwife as the pregnancy progressed however, it became apparent that many of the women didn't want to make decisions related to the pregnancy and instead choose to abdicate the decision making to the midwife, as previously discussed.

At this or the next visit, the midwife undertook an antenatal booking with the woman.

4.3.3 Booking in women

The aim of an antenatal booking is to gain a complete history of events in the woman's life relevant to the pregnancy (Hickman, 1981). A full antenatal history includes the woman's personal details, family history, medical and surgical history, contraceptive, fertility and menstrual history, obstetric history, current pregnancy history, social factors, a general and obstetrical examination, investigations e.g. blood tests, and advice (Hickman, 1981). The Midwives Handbook for Practice (NZCOM, 1993) lists the topics to be covered at this booking visit which normally occurs before the woman reaches 16 weeks gestation.

> *And then we do what's called an antenatal screening and booking...(Rose p2-3 L29-2).*

> *So it's just your basic information like what number pregnancy this is, all the usual stuff that you ask... . And sometimes even on the first visit I won't necessarily get that because it just might not be the right time to ask it so that I might defer getting that stuff until the second visit (Carmel p4-5 L32-9).*

> *I do a complete booking history at their first appointment because I don't feel that you can decide how to look after someone unless you know all about them, so I don't wait to book them in until later. So I do their medical health history and their family history and the father of the baby's health history and family history and their obstetric history. I make sure that they understand what my role is as caregiver and that they've chosen the kind of care that they want to have and what the boundaries of my care are. ...I send them off for their first labs.*
> ***That's the blood tests?***
> *Yes, VDRL and blood group and you know...(Linda p6-7 L9-14).*

...and then of course it's the normal pregnancy history...just going through their history and all that sort of stuff. And finding out their last period and calculating their due date, and family history and social history and we talk about smoking, alcohol and drugs if that's relevant. And then depending on their gestation, you know if they're very early pregnancy, I'll just palpate the uterus if there is anything there, blood pressure, urine and arrange for their bloods (Theresa p3 L12-26).

In a study exploring what happens between independent practitioners and women during the first antenatal visit, Sylvester (1999) identified that the midwife and the woman were meeting for different reasons; the midwife was setting the scene for future care, while the woman was wanting to get to know the midwife. Midwives were found to be giving women a lot of information, much of which they may not need or be able to absorb. Sylvester (1999) suggested that as continuity of care allows ongoing meetings between the woman and the same midwife, booking notes could be completed later rather than at the first antenatal visit. Methven (1995) investigated how effective the traditional history taking booking interview was for obtaining information relevant to the provision of midwifery care. Methven (1995) found that midwives in the study effectively controlled the interview by using closed questions, which controlled or blocked the development of conversations. Midwives also used leading questions which suggested or encouraged the women to respond in a certain way (Methven, 1995). By using these techniques midwives frequently failed to gather important information relevant to planning care for the ongoing pregnancy and to developing the beginning of a relationship with the woman. Sylvester (1999) suggests that midwives assess what is happening at the first antenatal visit and review their practice according to the individual needs of the woman.

Part of the booking interview involved deciding whether there were any other risk factors involving the woman or her unborn baby that the midwife would be prudent to screen for or which required referral to an obstetrician or other specialist.

4.3.4 Working within boundaries

The 1990 Amendment to the Nurses Act 1977 (New Zealand Government) allowed NZ midwives to practice independently and take responsibility for the care of women throughout their pregnancy, labour, birth and postnatal period (Donley, 1995; Hedwig & Fleming, 1995). It also reflected the reality of the maternity services where the

responsibility for the majority of any woman's care in labour rested with the midwife who was attending her (Guilliland, 1998b). The law change required the amendment of five Acts of Parliament and nine Regulations and by doing so enabled midwives to prescribe medication commonly used in pregnancy, order routine laboratory tests, make direct referrals to consultants and have access to public maternity hospital facilities on the same basis as general practitioners (Donley, 1995).

Midwives were well aware of their mandate to work within their legislated scope of practice. Working within the boundaries of their midwifery practice meant midwives referred women on to allied health professionals as necessary, when their health deviated from normal.

> *...I'm not a paediatrician or an obstetrician etc. If they have a sore throat or an earache they go to their doctor (Linda p6 L19-20).*

> *...the other thing that's really important is that I can't be all things to all people and...there are always going to be incidents when I have to refer people to...secondary care and stuff like that because you just can't [treat these things yourself] and these are the women who do often have things like intra uterine growth retardation and other health related problems. So I mean I can't deal with those things because...they're not within my scope of practice and you have to be aware of that (Lisa p28 L22-32).*

In New Zealand, the Transitional Health Authority Maternity Project (THAMP) (1997) published the Guidelines for Referral to Obstetric and Related Specialist Medical Services, colloquially called 'the national guidelines'. The national guidelines (THAMP, 1997) act as a guide for assessing the need for referral of a woman to a specialist for a consultation as soon as a problem is suspected or identified at any point in a woman's pregnancy, labour, birth, or the postnatal period. For the midwives in the study, having to refer a woman to an obstetrician or other specialist for an antenatal consultation meant getting the woman to attend an appointment at the secondary care clinic at the local hospital. The need for referral was dependent on the grading category different medical and obstetric conditions were given in the national guidelines (THAMP, 1997). Usually only a single referral for consultation was required and the woman remained with her midwife LMC.

> *A lot of our women get at least one antenatal clinic appointment. Often they have a risk factor of some sort.... So it might just be a one off, a previous c[aesarian] section...(Anne p45 L17-22).*

And now there is the [secondary care] clinic where you can send them and hopefully they won't be taken off you (Jane p22 L28-31).

Sometimes however the reason for the referral was graded as a '3' in the national guidelines (THAMP, 1997), which meant that the LMC must recommend to the woman that the responsibility for care be transferred to a specialist. Health professionals at the secondary care clinic would then assume ongoing responsibility for the woman's care.

4.4 Losing women to the secondary care clinic

In the area in which this study took place, the obstetricians had recently entered into a contract with the Health Funding Authority and the local maternity hospital about the care of women requiring secondary care. At the time the midwives were being interviewed, this system had been in place for between 16 and 23 months. Under this contract, if a woman was graded as being a '3' under the national guidelines (THAMP, 1997), the woman was encouraged to transfer responsibility for her care to the hospital secondary care team who would then act as her LMC. The secondary care team consisted of obstetricians, and hospital employed midwives who worked eight-hour shifts. The terms of the contract meant that the woman's midwife no longer had any official professional involvement in either care provision or care planning.

4.4.1 Being unable to provide midwifery continuity

The midwives in this study agreed that a woman who was obstetrically high risk required secondary care and therefore needed to have care in consultation with, or even led by, an obstetrician. Their main objection to the hospital secondary care team was that under this local system, women who were handed over to secondary care were also required to give up their independent midwife and instead have their midwifery care provided by hospital midwives whom they did not know. These midwives had set out to provide complete midwifery care to women primarily because they believed that continuity of midwifery care resulted in better pregnancy outcomes for women and their babies. This stance is supported by an abundance of research evidence, both from New Zealand and overseas (Guilliland, 2001; 1998b; Homer, Davis, Brodie, Sheehan, Barclay, Wills & Chapman, 2001; Biro, Waldenstrom & Pannifex, 2000; Davies, 2000; 1991; Kirkham, 2000; McCourt & Pearce, 2000; Pairman, 2000; National Health Committee, 1999; Rowley, 1999; Shields, Turnbull, Reid, Holmes, McGinley & Smith,

1998; Tinkler & Quinney, 1998; Waldenstrom, 1998; Turnbull, Holmes, Shields, Cheyne, Twaddle, Gilmour, McGinley, Reid, Johnstone, Geer, McIlwaine & Lunan, 1996; Page, 1995; Enkin, Keirse, Renfrew & Neilson, 1995; Rowley, Hensley, Brinsmead & Wlodarczyk, 1995; Waldenstrom & Nilsson, 1993; Flint, Poulengeris & Grant, 1989).

However, the results of the above studies are in contrast to the outcomes of two recent studies; one a Scottish study conducted by Shields, Holmes, Cheyne, McGinley, Young, Gilmour, Turnbull and Reid (1999) and the second an Australian study undertaken by Waldenstrom, McLachlan, Forster, Brennecke and Brown (2001; Waldenstrom, Brown, McLachlan, Forster & Brennecke, 2000). Shields et al. (1999) compared birth outcomes of women cared for by a known midwife during labour with birth outcomes of women cared for by an unknown associate midwife during labour. Results of the study showed that there was no obvious clinical or psychosocial benefit for women from having a known midwife during labour, although a proportion of the women in the study identified having a known midwife as something they liked about their care and all women expressed high satisfaction about the care they had received (Shields et al., 1999). Shields et al. (1999) conclude that more research needs to be undertaken into this area particularly examining clinical, psychosocial and economic outcomes and I would add, for both the midwives as well as the women involved.

Waldenstrom et al., (2001) conducted a randomised controlled trial with 495 women randomised to team midwife care being compared to 505 women randomised to standard care. Standard care referred to care mostly by doctors or care mostly by midwives with delivery at either the public delivery suite with doctors and midwives or at a birth center with predominantly midwives. Team midwife care (Waldenstrom et al., 2001) included a team of eight midwives who provided antenatal and intrapartum care for a group of women in collaboration with medical staff. The women in the study were of lower socioeconomic status and 60 percent were expecting their first baby. Data from the study found no statistical differences in the average number of antenatal visits, medical procedures during pregnancy, procedures during labour, complications antenatally or during labour and delivery, mode of delivery, episiotomy rates or infant outcomes between the women receiving team midwife care and standard care (Waldenstrom et al., 2001). Continuity of midwifery care was found to increase

women's satisfaction with care received (Waldenstrom et al., 2000). The researchers give some possible explanations as to why other trials have suggested that team midwife care is associated with a reduction in medical interventions. Possible explanations include differences in philosophy of care between midwives electing to work on the team compared to those providing standard care, the model of team midwifery care utilised, whether the team midwives are on call so providing continuous labour support or rostered onto shifts, the size of the team affecting the potential for a shared team philosophy and systematic reviews of models of midwifery continuity having dissimilar elements (Waldenstrom et al., 2001). An additional explanation is whether the team midwifery philosophy encourages more family member involvement especially during labour and birth, compared to standard care, and as a consequence whether the woman therefore feels more supported so labour is able to progress naturally. The importance of comparing 'like with like' appears evident from the above study and this may need to be the primary focus of future studies evaluating the outcomes of midwifery care.

The midwives in the current study had built up a relationship with the woman and wanted to continue to provide her midwifery care, even though she also required secondary care consultant input due to being high risk.

> *It's a problem in a number of ways. One is that we don't want to let them go, because we believe in continuity and it's not just continuity for that pregnancy, it's [that] often we've looked after them for other pregnancies or we've looked after other people in their family, and they can't understand why we suddenly drop this person who has the most needs, in this pregnancy (Anne p45-46 L32-6).*

> *I don't think the women understand what secondary care means and most of my women that have signed over have had no idea that that meant that I relinquished my role as caregiver and were expecting a shared care type scenario (Linda p18-19 L31-5).*

> *...the women get taken over by the secondary care team and lose the person they've come to trust and it's a big thing I think that how we are we can't continue the care. That's probably the biggest thing because those women are high risk and they lose our care (Theresa p13 L12-17).*

> *I'm not saying that the [hospital] staff don't care.*
> ***No.***
> *It's just that it's so awful for the women that they don't have that follow through, somebody that knows them, knows her, knows their family, knows their expectations and knows what they want (Rose p29 L21-28).*

According to Section 51 (Health Funding Authority, 1998), hand over of a woman to a secondary care LMC is only supposed to take place following discussion and agreement between the woman, her current LMC and the consultant involved. The discussion should include the reasons for recommending hand over, what hand over of care would mean for the woman, and the formulation of a clear plan for the woman's ongoing obstetric management. Details of the discussion should be clearly documented in the woman's clinical notes. This would ensure the woman had a clear understanding of what handing over to secondary care would entail and would therefore be able to make a decision on whether she wished her care to be handed over based on knowing all the facts. It is important to emphasize that the handover of care is for obstetric management of the woman only. At no time does Section 51 (Health Funding Authority, 1998) stipulate that the midwifery management must be handed over to anyone. In fact in a Maternity Services reference document, the HFA (2000) stipulates that any funding model for the maternity services needs to encourage women to remain under the care of the primary LMC, receiving specialist consultations when necessary and only transferring to the secondary service for the period that is considered essential (HFA, 2000). The document goes on to say there should be no financial incentive for the secondary service to obtain a transfer to their care (HFA, 2000). It is only a local hospital policy that the midwifery management is handed over also. Most of the midwives in the study responded to the unique needs this group of women had by continuing to staying involved in the women's care despite the women having been handed over to the secondary care team. They felt that this was the only way of ensuring that the many complex needs these women had could be met.

4.4.2 Keeping 'tabs on what's happening'

For women who were under secondary care and were therefore having all their antenatal appointments at the hospital secondary care clinic, difficulty with transport and/or not having a phone often meant they simply did not turn up for their clinic appointment. The hospital did not provide transport or assistance with transport costs for these women to attend, nor did the clinic actively follow non-attendees up, especially if they were not on the phone.

> *And so if they don't get there the hospital doesn't, well very often doesn't provide the facility where they can chase the women up (Theresa p14 L1-3).*

This meant

> *...that the women who really need the care the most can end up with no care or minimal care (Anne p46-47 L33-2).*

In an effort to ensure women did not miss their hospital antenatal appointments, the midwives often transported them to the hospital clinic themselves, even though they were not the LMC and that doing this took up a lot of their time for which they were not now being paid.

> *And so if you have someone who's going for a 10 o'clock appointment, by the time you pick them up from home and they muck around getting the other kids ready, and then you get to the hospital and you wait an hour and a half to see the consultant and then you get them home again afterwards, it can take a whole morning to do one appointment. It's a nightmare. And sometimes you can drop them at the hospital and go somewhere else, but often you actually want to be with them because you want to keep tabs on what's happening with them. I want to keep good communication with the obstetrician. I want to advocate for the woman if she needs it, and mostly for the woman. They don't like the clinics and going there, so it seems really mean to drop them off and leave them on their own (Anne p44-45 L30-12).*

Staying involved socially in the woman's care enabled the midwife to ensure the woman was getting to her secondary care appointments. It also meant the midwife could meet other needs, both midwifery and non-midwifery, which the secondary care clinic staff did not see as their role.

> *...certainly we stay in touch quite a lot and continue to do antenatal visits and be the contact person if things are not going right (Rose p15 L23-16).*

> *There are a few of the women who want us there for all of the care...and there's...another group of women where we'd pop in and out and go and see them and visit and see if they need anything (Anne p48 L3-7).*

The midwives would have much preferred to have been able to continue to provide the midwifery care for these women, within the relationship they had built up together.

4.4.3 Being appalled at secondary care

The midwives felt that the care the women received from this secondary care 'team' was less than optimal for a number of reasons.

...It's very difficult and basically our relationships with the hospital are reasonably good, it's done in a fairly friendly manner, but it's very frustrating and the care seems immensely inferior to the care that we would normally give them. ...not because the midwives or the obstetricians are bad, it's just because they lose that continuity. They get 10 minute obstetric appointments. They don't have a midwife to talk to. They don't know their midwife in labour (Anne p47 L10-23).

...I've watched the care that some of our women have had at the secondary care clinic and I have a big issue with it (Rose p26 L3-5).

Rose goes on to give an example of why she is unhappy with the care women receive from the secondary care clinic.

I've had a primip who was taken off us. And then just watching, she didn't have continuity of care in the antenatal period. She'd see a consultant, and then another different consultant again who she'd get 10 minutes with. When she came into labour, she happened to see me. She'd had no antenatal education. She did not have a clue why she was being induced. She was induced. Nobody stayed with her in the labour. They didn't believe she was near to delivery. Then the baby's head came out and she was screaming, trying to get someone to come and help her (Rose p26 L10-20).

Rose feels that had she been able to continue to provide the midwifery care this woman required, even though the secondary care clinic were taking overall responsibility for her pregnancy, the woman's experience of receiving care from the health professionals involved would have been much more positive. Being unable to continue to provide midwifery care to women who had been handed over to the secondary care clinic was a cause of great grief for the midwives affected. Given that these women were a specific group who had highly complex lives and who had historically been poorly treated in a number of ways by health professionals and therefore had often received less than optimal health care, it seemed ironic to the midwives that at the very time these women needed the support of a midwife they had come to know and formed a relationship of trust with, the women were required to relinquish the continuing involvement of this person.

Several of the other midwives in the study were keen to give examples of what they considered to be suboptimal care that women they had previously been responsible for, had received while under the auspices of the secondary care clinic. These stories were not only distressing for the midwives to tell, they were distressing for me to hear.

[It's as] if the woman's been thrown to the wolves, not that they've been thrown to the wolves in the sense that they're not going to get good specialist knowledge and things...it's the twins that are the most upsetting. I've had a twin woman recently hand over and I understand she may have been booked into [a regional] hospital now to have her twins because [hospital's] too busy to accommodate her...I don't know because I'm not in the loop (Linda p20 L20-33).

...the baby died. And I always felt really bad that she didn't ring us, even though we weren't getting paid for her care at that point. Yeah so I felt like we handed over the care of her to someone else and they gave her not good care. ...they kind of brushed her off and that was why the baby died. So high risk women are such a real concern for us, that we end up having lots of input, because we are anxious that if we don't have input the hospital won't meet their needs. But they're not paid for...(Anne p49 L15-26).

The midwives felt that had the women been able to retain them as their midwifery care giver, even though the women were under the secondary care clinic, the quality of care provided and therefore the subsequent outcome for the women and their babies may well have been different.

Walker (2000) used grounded theory to explore the experiences of women who were transferred from a midwife-led maternity unit to a distant consultant obstetric unit before and during labour. The core category discovered was loss; loss of control and choice over the desired type and location of birth, and loss of caregiver continuity and support (Walker, 2000). For the women, the losses were accompanied by feelings of unfairness which were associated with anger, resentment, and sadness (Walker, 2000). While Walker's (2001) study has a different focus from the current study, the results support the feelings expressed by the midwives in the current study of when they had to hand their women over to the secondary care team and the experience of being unable to continue to provide midwifery care.

Being forced to hand over the midwifery care of women who required LMC transfer was a local rather than a national issue for the midwives in the current study. In her thesis, Hunter (2000) analyses the experiences of midwives who provide labour care in both small and large maternity settings. Although the experiences for the midwives involved were somewhat different depending on the practice setting, when a woman was transferred to the larger maternity setting because she had moved out of the realms

of normal, the midwives were able to continue to provide the woman's midwifery care. Midwives experiences had they not been able to continue to provide the woman's care, would be useful to explore.

4.4.4 Coping with handing over to secondary care

Midwives had several solutions to the secondary care handover issue and the disruption it caused to both women and their midwives.

> *My choice would be to continue to provide the midwifery care while getting the obstetric care they need (Anne p48 L12-14).*

> *...I think it's much wiser if they don't have to be transferred (Lisa p13 L32-33).*

Some of the midwives had had women refuse to sign over responsibility for their care to the clinic. In these cases, the woman had retained the midwife as the LMC and seen the obstetrician at the secondary care clinic when referred there by the midwife based on each woman's individual need for consultant assessment. The midwife then maintained the overview of the plan for the woman's care and then provided the labour, birth and postnatal care to the woman. Midwives also had women who, after their secondary care team experience, said they would refuse to hand over their care in a subsequent pregnancy.

> *They're not coping with it well at all. It's actually really quite bad. And I've just recently had a couple of incidents where the woman was transferred, and medically and obstetrically it was sensible that she was transferred, but from a social perspective it was really rotten for both of those [women] and for that very reason we've both decided (the two women and I), that if it ever crops up again we shan't transfer and that's that (Lisa p13 L14-23).*

Midwives ensured they talked with women early on in the relationship about what would happen if they required secondary care.

> *...we talk over this issue. We talk about that at the very first visit about the involvement there is if they do go to secondary care and how much I can stay involved if they do sign over (Lisa p15 L19-22).*

Midwives also became more selective for whom they became LMC.

> *...I haven't had as many women taken over lately as I did when it [the secondary clinic handover policy] first came out. Because I guess possibly because I am screening my women quite aggressively in the beginning and if they sound like they've got severe asthma or any of*

those things, I'm not even taking them on now, I just straight away say 'you need to go through secondary care'...(Linda p18 L24-31).

Choosing to not take on the LMC role for high risk women as Linda states in the above example however, does not address the need high risk women have for a midwife they have come to know to care for them through their pregnancy, labour and birth and postnatal period, in conjunction with a secondary care provider. Several meetings had been held with representatives from the midwives practising independently in the local area and hospital management in addition to meeting with HFA representatives, to attempt to resolve the ongoing problems that both midwives and women were experiencing as a consequence of losing midwifery care with handover to the secondary care clinic. Both the hospital management and the independent midwives working in the area in which this study took place had also sought legal opinions. At the time of writing, a resolution had not been found.

4.5 Summary

In this chapter the first of the four categories that emerged from analysis of the data has been introduced; 'Forming Relationships with The Wary'. The midwives in the study spent time forming relationships with the pregnant woman and her family. It took time for the women to become comfortable enough with the midwife for a trusting relationship to develop. The women were often wary of the midwife initially due to previous bad experiences with other health care providers. The midwives were careful to ensure that the relationship with the woman encouraged self-responsibility rather than dependence. Midwives felt they were accepted in a special way into a woman's life and into the life of her family.

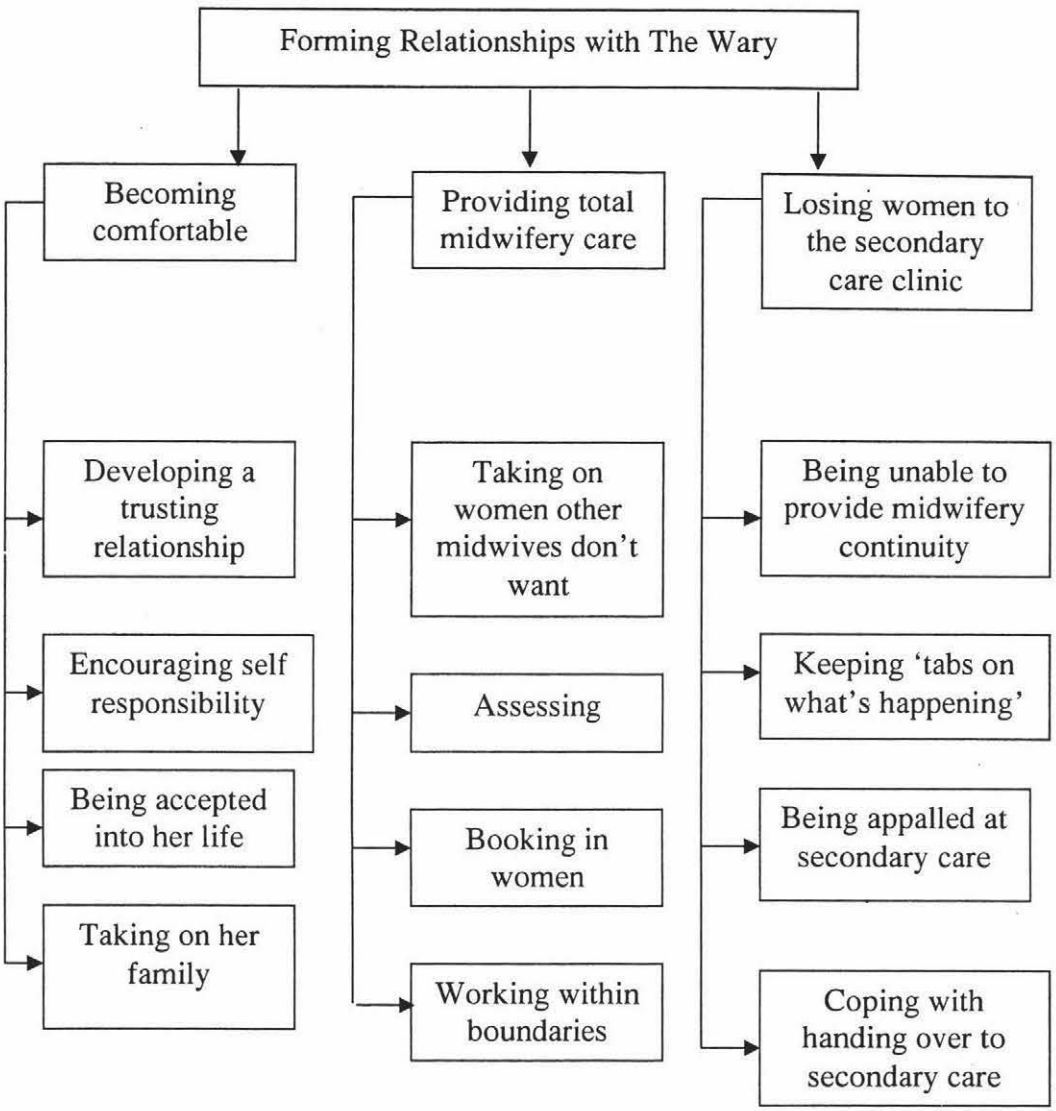
To be eligible to be in the study, all the midwives provided total midwifery care. Analysis of the data revealed that providing total midwifery care meant more than the provision of pregnancy, labour, birth and postnatal care. The midwives identified that these women had additional requirements. The midwives took on women considered to be problematic by other providers because they wanted them to have care during their pregnancy. The midwives assessed and booked in women antenatally, working within their defined scope of practice.

When a woman's care was transferred to the local secondary care clinic, the midwife continued to stay involved with the woman, despite being unable to continue to provide midwifery care, to ensure the many complex needs the woman had would be met. This was also as a consequence of observing the care women had received from the secondary care clinic staff previously. Midwives were attempting to address the mandatory handover of midwifery care to the local secondary care clinic in a number of ways.

Throughout the midwife stayed involved because the woman's need was so huge.

The sub categories which together merge into the main category of 'Forming Relationships with The Wary' have been defined and discussed in terms of their properties, conditions, strategies and consequences. The theoretical linkages by which the category of 'Forming relationships with the wary' is linked with the other main categories developed from the study's data analysis has been detailed. In Chapter Five, the category 'Giving 'an awful lot of support': Dealing with social, emotional and physical issues' is introduced.

Figure 4-1 Forming Relationships with The Wary



Chapter 5: Giving 'an awful lot of support': Dealing with social, emotional and physical issues

5.1 Introduction

In this chapter the category of 'Giving 'an awful lot of support': Dealing with social, emotional and physical issues' is introduced. The sub categories of 'meeting individual needs', 'constantly educating' and 'dealing with different abuses' were identified from the data. These sub categories merge into the category of 'Giving 'an awful lot of support''. The sub categories are defined and discussed in terms of their properties, conditions, strategies and consequences. The theoretical linkages (conditions, strategies and consequences) by which the sub categories identified from the data make up the category of 'Giving 'an awful lot of support'' are detailed. For example, as a consequence of assisting women with transport and ensuring women had adequate clothing for the forthcoming baby, midwives ensured they were meeting the individual needs of the women. 'Meeting individual needs' was one of the processes the midwives used when 'Giving 'an awful lot of support'', the category this chapter discusses. The linkages by which this category is linked with the other categories developed from the study's data and the core category are discussed. Figure 5-1 provides a diagrammatic representation of the properties and sub categories making up the category of 'Giving 'an awful lot of support''.

5.2 Meeting individual needs

It was apparent to the midwives that apart from the routine antenatal care that they provided to the women, there were many issues pertaining to this group of women only, which had to be dealt with if the most optimal outcomes for both the woman and her baby were to be achieved. Trying to ensure that these issues, many of which were not maternity related, were dealt with in addition to the routine midwifery care that the midwives provided, became a focus of the midwife's relationship with the woman especially during the antenatal period. It is in this aspect of the midwife's care more than any other, that the uniqueness of the care these midwives provide, compared to that provided to more affluent women, becomes apparent.

I think with the [labour] and birth I would say it mostly is, more similar to other people's care. It tends to be in the hospitals and it's not usually particularly complicated socially although it can be. And afterwards it's kind of too late in a way, but in fact probably the biggest difference is with the antenatal care (Anne p5 L10-17).

...the care is personalised to the uniqueness of each individual woman which is probably something not previously experienced [by them] (Lisa p24 L30-33).

The midwives felt a great sense of responsibility towards these women to be available to assist them in problem solving.

And I think that if they have a problem and are concerned then they know that it's okay to come to you. That they'll do that so you may be able to meet a problem earlier than if it's left 'til much later. So that that's going to make a difference for them (Lisa p24 L20-25).

...but I think really we just have to try and adapt to them as midwives, try and do our best for them (Jane p20 L24-26).

I think the difference is that social problems do come up and emotional problems I think do come up with all women, but other women have more resources to deal with them themselves. ...I think for the women who I see, the lower socioeconomic women, often they don't have the resources. There's no one they can go to and pay [for counselling] because they don't have the money and often the families are so distressed in a variety of ways that there's not the resources within the whanau or the extended family either necessarily. Yeah so often then I feel that the onus is on me to actually try and solve the problem in a way that it wouldn't be with someone else. That isn't necessarily realistic because I can't solve everyone's housing problems or relationship problems (Anne p6 L13-33).

In order to assist the women with problem solving, the midwives had to first identify the issues each individual woman had. These were not always apparent at the beginning of the relationship.

...there are things like meeting basic needs, like paying for prescriptions and getting things for the baby. It's very basic kind of material needs around the pregnancy and birth. But other things emerge like housing problems, no heating in the house, the house being cold with the young children in it (Anne p3 L20-26).

I think it's an awful lot of support...your input is being there and supporting them through this experience (Jane p21 L19-22).

I think they probably have different needs to a point, but then on the other hand, the needs of these women are the same but perhaps couched differently to other women (Lisa p25 L23-26).

The identified issues needing to be addressed by the midwives appeared to be divided into three groups: social issues, emotional issues and physical issues. These issues were often but not always, directly related to the degree of deprivation in which the women lived.

The main social issue identified by the midwives was a lack of money. All the other social issues the midwives came across while providing care to this group of women had their origin in this lack. Because the midwives knew the women had little financial resources, the midwives found they were giving the women various forms of material support out of their own pockets.

> *They'll get a lot more physical support from me, and more material support. I mean I have a family over in [local suburb] at the moment now and I've probably fed them for three weeks because...they just haven't got any money, and she's got like baby, baby, baby and I've had to deal with her for [several] years.... And so materialistically they depend on me more when, maybe that's foolish to get into that thing. My colleague sometimes says 'don't start that' and I see her doing it too sometimes (Lisa p26 L13-30).*

> *I always remember getting a phone call in the middle of the night one night, because somebody knew I was going round and they didn't have any toilet rolls and they were scared stiff in case I was going to go to the toilet and they didn't have any toilet paper...they called me out and I said I would come and then [the husband] rang back and said 'don't come unless you bring a toilet roll because you might want to use our toilet'. I never forgot that and God... and also I remember going into a house one Easter and offering to bath the baby because the mum wasn't very well, and they kept saying 'no, no' and I knew this baby hadn't been washed for a few days and sort of said 'look I'm going to have to do it tomorrow' because the dad didn't want to do it and there was only a little three year old and 'you really need to you know,' and the reason was because they [had] spent the money on an Easter egg and the family didn't have any soap. So I used to take some out of our cupboards (Jane p6-7 L25-13).*

The midwives provided these 'extras' in addition to the provision of midwifery care. The midwives were not reimbursed by the Health Funding Authority for them, nor did they mention expecting to be. Having little money also affected the transport the women had available for their use.

5.2.1 Assisting with transport

Working with women who do not have easy access to private transport brought certain challenges to the efforts of the midwives to ensure those women received optimal pregnancy care. Often the midwives found they were transporting women themselves.

> *Transport is a really big issue, getting to clinics, getting to scans, blood tests...because they don't have transport. Coming to the hospital in labour –that's a total headache. ...I live 30 kilometres away from where I practice and I get phoned from somebody who lives 20 kilometres the other side of that to say that she is in really strong labour and has no way of getting to the hospital. If I thought it was really urgent she could just go in an ambulance, but in fact often I pick people up to take them to hospital for the labour. ...that's part of my job. I'm really happy to do that (Anne p32 L9-28).*

> *I think my main concern about transporting somebody is that if somebody that I know won't attend a clinic then I will take them. There are the ones who can't get home after they've had their baby, so I've had to take them home and other things like they haven't got a [baby] car seat, so I'll go and get them one and take it to the hospital (Rose p23 L17-23).*

> *Well I don't actually see that [transporting women] is not in my role and I don't have to do it for everybody (Lisa p12 L28-29).*

> *Sometimes for transport reasons they're waiting for their ride to come, so they don't have any choice but to be labouring away at home maybe for an extended period of time. I've actually gone to women's houses and picked them up if I've thought that that was happening. Or for fear of transport...they'll come in really early because their neighbours brought them in and they don't want to put them out in the middle of the night...which is quite difficult. ...most women in the end find their way around those things with neighbours and friends and family. And if transport is a real problem they'll ring an ambulance...(Linda p15-16 L17-8).*

Not all the midwives however, felt that transporting the women themselves was part of their midwifery role. Instead they tended to encourage women to arrange alternative sources of transport.

> *I don't take them along [to hospital appointments]. I don't go that far (Theresa p5 L2 8-29).*

> *No, I used to do it more I think but I do it less often now.*
> ***And why do you think that is?***
> *Probably that's something in me, in that I probably try to encourage them to do things more for themselves rather than thinking that I can actually do all these things, because I don't think physically that you can. I mean, you like to think that you can (Carmel p7 L24-33).*

But I often talk to them and make sure they've got transport (Linda p16 L8-9).

At the time this study was being undertaken, the only independent midwives in New Zealand who received any form of transport allowance were rural midwives and those midwives belonging to groups who had negotiated contracts separate from Section 51 (Health Funding Authority (HFA), 1998). The majority of midwives in New Zealand, who practised independently therefore, receive no financial reimbursement for their transport costs. This is in stark contrast to the period prior to the introduction of Section 51 (HFA, 1998) when midwives were receiving $1.50 per kilometre for using their own vehicle to visit women. When this reimbursement was claimable, midwives were possibly more keen to transport women to appointments or to the hospital as it was not such a direct cost to themselves.

...the care that I provided had to change in that respect as the Health Funding Authority [funding] changed. ...when I could claim individually for women and individual petrol, then I would go and cart them everywhere because I could get reimbursed for it. Once the ...individual [modular] packages came in and you'd get 'x' amount no matter where the women lived or what you actually did for them, then I couldn't afford to just truck them around. Because it wasn't that I wouldn't have done, it's just that I couldn't afford to do it (Jane p4-5 L27-7).

As a result of not always providing transport for women, midwives potentially ran into problems with women who did not give tests the same priority as the midwives did, and therefore did not bother to arrange the transport to attend them. When this happened midwives had to decide whether to take the woman to the test themselves or not.

...once we stopped picking them up and taking them and relied on them to get themselves there they would turn up [for the scan], but not necessarily at the time or on the day that they were supposed to be there.... Not all of them, really only a few, particularly if they thought it would help with the baby. They really cared about the baby (Jane p5 L22-29).

The scanning's a real catch isn't it because a lot of them want to go for the scan (Rose p24 L17-18)?

..the other thing is making her responsible for her care, and she needs to be responsible enough to go. If they don't go [to the consultant visit], I will go and pick them up (Lisa p15 L14-17).

...they'll go [themselves to scans]. Blood tests can sometimes be an issue and I'll often do them. If it's a real issue and they haven't done them by

about 28 weeks, I'll do them myself yeah and take [the blood] down [to the laboratory] but obviously I'd prefer if they go [to the laboratory themselves]. And I talk to them about sort of being open to take a little bit of responsibility themselves...(Carmel p8 L7-13).

Other problems arose when the midwives, while being happy to transport women to tests and appointments, were then asked by the women to be transported to other locations for social reasons.

Sometimes it's a problem with the women. I'm happy to take them for scans and blood tests and specialist appointments and to the hospital. I find it really hard when they have an expectation that I will transport them for other things. ...I'll do an antenatal visit and then they'll say 'where are you going next? Can you drop me at...?' I find that extremely difficult. ...Even if it's not out of my way often they've got young children and no car seats and I am so unhappy putting them in my car and I find those situations really hard (Anne p32-33 L28-14).

However, there were some pluses to being prepared to transport women if necessary. These include having the tests that a midwife feels are necessary.

...I think I get women to more blood tests and consults and scans because I take them. 'Cos certainly they are not going to pay for a taxi to go to a scan. ...so if I think they need the scan then I also have no choice but also to provide the transport. If I think they don't need the scan then that's fine. It's the same with a specialist visit or whatever it is. If I want them to do it enough, then I want it enough for me to provide the transport (Anne p34 L12-25).

Overall the midwives felt it important that they encourage women for whom lack of transport was a problem, to begin planning their transport for labour early in their pregnancy.

Mostly I get them to start to explore those things early on in preparation for labour. So I'll talk to them and say 'is there someone that you know that has easy access to a car?' And if we have to go down to the hospital for something I'll always ask them have they got transport down. ...mostly I think they've usually got someone in the extended family somewhere that is around [who] will have a car and if not then I'll go and pick them up and take them to the clinic or whatever (Carmel p17 L7-19).

Preparing women this way was in an effort to minimise the amount of transporting the midwives would be expected to do throughout each woman's pregnancy.

5.2.2 Ensuring clothing

Ensuring women had adequate clothing and baby equipment by the time the baby arrived, was an aspect the midwives frequently became involved with. Having knowledge of community groups such as Pregnancy Help from which women could access clothing and other baby gear was seen by the midwives to be a necessary part of working with these women. Often the midwives were given baby clothing from their own friends to pass on to these women, or they had clothing from their own children that they gave away. Driving around with a car boot full of baby clothes tended to be considered by these midwives to be just a normal part of their job.

> *Often they don't have clothes for the baby and you carry some around in your car, or you know somewhere where they can get them like Pregnancy Help, or groups attached to church groups –things like this. Sometimes other midwives are able to provide you with stuff (Jane p3 L7-12).*

> *...a certain amount of my care is...either helping directly with getting baby clothes or actually putting women in contact with people in...other organisations (Anne p3-4 L29-1).*

> *...because they all come from families within the area anyway they tend to have, or are able to collect, a lot of stuff from family. But if they don't then we do certainly have different resource areas where they can get things from if they want to, including Birthright, or Pregnancy Help, or stuff that people have given to us as well we can give them (Rose p5-6 L29-2).*

> *I do have a lot of clothing sitting in the cupboard that people give me to give to other women. So if I can see that they haven't got much stuff, I say 'look, someone's given me this nice bag of babies clothes' and I give it to them. But I often channel women in to Pregnancy Help (Linda p18 L1-6).*

> *Well I usually send them through to people like Pregnancy Help. Sometimes I know people that are wanting to get rid of baby clothes and things like that. I might give them some stuff myself, but mostly I'll direct them through to something like Pregnancy Help. They are quite good usually and most of them [the women] will hire their baby seats and things from Plunket usually or borrow them off a friend (Carmel p6-7 L27-2).*

Theresa makes a relevant point when she states the importance of being careful when giving women clothing not to make the women feel beholden in some way through not having the resources to be able to provide the clothing for their babies themselves.

> *...often I'll ask around friends or women. Often middle class women will, when you visit them, say '...I've got this clothing'. I've passed on my*

older children's clothes to other children and they love it. I'll come next time and they're wearing one of my son's T-shirts and they're so proud (laughs). But I think too you have to be a wee bit careful with that because you don't want to be putting them down by giving them things. ...I think you probably try and steer them to some other support people you know like perhaps Pregnancy Help and things like that (Theresa p14-15 L31-27).

Ensuring women had an adequate amount of baby clothing and other equipment could sometimes take up a considerable amount of the midwife's time. Accessing clothing was not always limited to the needs of the forthcoming baby. Equipment was also accessed for other children in the household as well.

I think I probably spent more time looking for equipment for them than I did carting them backwards and forwards for appointments. Well sometimes clothes but they had other toddlers at the house as well and they wouldn't have a cot (Jane p6 L18-25).

While accessing equipment for other children was not within the midwife's role/scope of practice, it was still seen by the midwives as just another aspect of the care that was required and that they gave when working with these women. This was also linked with the acceptance of taking on the family as part of taking on these women, as previously discussed in Chapter Four.

Another reflection of the lack of money this group of women had access to became apparent when they required prescriptions during their pregnancy.

5.2.3 Giving prescriptions

When the amount of income in a home is not sufficient to meet the basic everyday needs which would be considered essential by more affluent income earners, any extra demand on financial resources is prioritised, and whether considered necessary or not, may never be given enough priority to justify allocating financial resources to it at the expense of some other immediate need. This was apparent when a woman required medication during her pregnancy which was not considered by the woman to be essential.

Things like iron are really annoying because women certainly see it as really low priority and it's not subsidised so the last thing they're going to do is pay out six dollars for the month's prescription for iron. Antibiotics I would often pay for. Usually with a Community Services Card it's three dollars...(Anne p35 L8-16).

I'll do a lot of shopping; I'll do a lot of purchasing of vitamins and spirilina (Lisa p5 L6-7).

While paying for prescriptions is not considered to be within the midwife's normal scope of practice, these midwives do this to ensure women receive the medication they required in an effort to stop potential complications from developing.

I certainly see it as part of my role to make sure they get the medication by hook or by crook, otherwise again what's the point of me going there? I may as well not go. I may as well not respond to that call if I'm not gonna take that next step and ensure they get it (Anne p37 L4-8).

That women did sometimes develop complications through not taking prescribed medication and that this was linked with being unable to say to the midwife that they couldn't afford to purchase the medication became apparent in the data. This was a cause of distress for the midwife involved.

...for lots of women three dollars [prescription charge] is not practical. Often the women will say to me that they will pick [the prescription up] and that they do have the money [to pay for it]. Yes the problem with prescriptions is not me paying for them, because I'm happy to do that if people need them. The problem is more that I will say to people 'I want to give you this prescription because...you have a urinary tract infection and you need an antibiotic' and...I say 'and you can pick it up today and you've got the money and you can get to the chemist?' And they say 'yes, yes'...and I go away feeling very happy about it and I come back two weeks or four weeks later and the situation hasn't changed. They still have the thing or they present three days later at the hospital with a really acute urinary tract infection. And I'll say, 'so what happened, did you take the medication?' And they'll say 'no' because they had no money. So women...don't want to ask for the money, they don't want to take it off you (Anne p35-36 L24-11).

It would appear that these women might often not get the medication they require because they cannot afford it. Potentially this has serious implications for their own health and the health of their families.

Communication barriers such as lack of phones were another hurdle to overcome if the midwife was to meet the individual needs of the woman.

5.2.4 Communicating

The midwives often had communication barriers specific to this group of women to overcome if they were to work effectively together. Working with women who did not

have home phones and/or working with women for whom English was a second language, presented challenges for both the woman and the midwife.

5.2.4.1 Getting around women having no phones

Finding ways of working around women who had neither home phones nor easy access to one was another challenge that both the midwives and the women faced. Usually some form of contingency plans were developed for use in various situations. Making arrangements for contacting the midwife when the woman went into labour or if the woman felt there was a problem with the pregnancy and she needed to be seen by her midwife, was essential.

> *...occasionally they have no phone, yes. So you have to talk to them about 'well you haven't got a telephone. That's okay. If it's daytime, you can go to the neighbours'. I wouldn't expect them to go down to the public telephone, five blocks away or anything and then we usually just make plans that well they'll just go to the hospital and I'll just be in shortly (Theresa p6 L17-23).*

> *What I did find was they would front up to delivery suite rather than ring you at home, and again that was 'we'll try your house phone' and if you weren't there a lot of them had toll bars on so they couldn't get you on your cellphone. But I just used to tell them to ring the hospital and get the hospital operator to get in touch with me, but if they didn't do that for whatever reason they used to just front up to delivery suite. And sometimes that was a bit of a problem because they weren't actually in labour and if you'd been able to go to their house, you could have kept them there (Jane p5-6 L29-7).*

> *I usually get them to either arrange something with a neighbour or occasionally some of them will actually rig up a cellphone for a few weeks before they're due –they'll borrow a friend's cellphone. And if they're really desperate, they know just to go straight down to the delivery suite and I have had several women do that. But mostly I think they're quite good at trying to get a friend or neighbour or someone and they'll send the partner out [to ring me] if they think that they're in labour. You know it is a bit of a hassle for them, but I think that they do the best that they can do really given their resources. Some will actually put the phone on for a month before, from about 36 weeks, and that's at their suggestion. They'll go down to Income Support and get a bit of extra help to be able to do that (Carmel p10 L1-16).*

> *I think if they've got a genuine problem, they find a phone. A lot of them have cellphones actually, which is kind of ironic in the sense that cellphones are very expensive to make phone calls with...I guess the reason why they have them is because you can receive phone calls free, so they're contactable. ...when they page me they only have to pay to*

ring that phone number, and then I ring them back on their mobile, so I wear most of the expense in that regard. Having a mobile is easy if you're of no fixed abode also (Linda p16-17 L27-18).

Ensuring arrangements were made to enable the woman to contact the midwife when necessary was essential.

Difficulty arose when the midwife was called to delivery suite or some other venue when she had previously booked an appointment with a woman who did not have a phone so could not be easily contacted. The midwives usually made plans for this eventuality also.

My problem was that if I was called to delivery suite and couldn't keep the appointment – but then usually one of the other[s in the] group would go (Jane p5 L11-14).

Another issue I thought about with women who haven't [got a] phone is you contacting them if you are busy with another woman in labour. I usually say on my first couple of visits that if I am not at an appointment within half an hour just to carry on with their normal day and I will contact them [the] next day (Theresa p20 L24-29).

Planning ways of getting around the problems of working with women who had no phones was an essential part of the care these midwives provided to the women. This was because a large number did not have their own home phone. Being able to be contacted by women required contingency planning and occasionally some assistance from others. Jane found that despite women being encouraged to ring the delivery suite midwives who would then contact Jane, when women rang the hospital the hospital telephone operators, rather than connecting the women to delivery suite, would often contact Jane themselves for the women.

And I have to be honest and say that nobody at the hospital [complained] –I know I used to tell them to ring delivery suite, but they'd just get through to the [hospital] operator and the operators never complained (Jane p6 L14-18).

Communication barriers caused by women not having either good spoken English as their first language and/or a good understanding of English also presented challenges to the midwife attempting to provide individual care.

5.2.4.2 Communicating with language difficulties

A reasonable percentage of the women the midwives worked with did not have English as their first language. Ensuring specifics of pregnancy care were communicated between women and families who were speakers of other languages and spoke and understood minimal or no English, and the midwife, was challenging. Using the woman's family members for translation, employing a formal interpreter or managing with sign language were the methods utilized by the midwives to cope with the difficulties of getting and relaying information. Each of these methods however had their down side.

> *In the situations where I've actually used real interpreters it's incredibly difficult, almost unmanageable. It's almost easier to use sign language. It feels like there is so much lost in the interpretation and the kind of formality and it's incredibly awkward. ...[using family members] still complicates the conversation. ...they only interpret the task type of stuff. You miss the whole dimension of chatting and casual conversation (Anne p40-41 L11-3).*

> *...you'll often use their relatives. There's usually someone. ...But it is quite difficult. I guess you just use a lot more sign language and just showing. You know, point to the breasts and [say] 'how's it going?' And hands sort of things. I think you're probably more intense with all of them in some ways in the care that you're giving. ...Time wise you probably spend a little bit more, I think. Just so that you know they're understanding. I think that's probably what it is.... Yes I think it's just the time in explaining (Theresa p8 L1-29).*

> *I did know little bits of words that we could get through and there is usually plenty of support around and somebody speaks English. But with the refugees –very very difficult because they didn't speak English. The interpreter couldn't always be there and it was sign language you know and sign language is the same in any language isn't it. You just had to hope that they understood. If you wanted to feel their tummy and see how baby was growing they understood that, but if you wanted to go in-depth like if you had an iron problem which I did have with one woman, trying to explain to her about diet, was impossible. I just had to wait until I got the interpreter (Jane p14-27).*

> *...you do sometimes [have problems with language difficulties], but mostly I can make myself reasonably understood. ...mostly I think you can make yourself understood with sign language and some English (Carmel p19 L9-21).*

Issues surrounding the gaining of informed consent from non-English speaking women were not mentioned by the midwives in the study. Language and communication barriers are amongst the most common factors which negatively affect the standards of

care many ethnic minority women receive which affects them from stating their preferences and from making informed choices (Baxter, 1995). It would be difficult to establish whether true informed consent had been obtained for the tests and procedures essential to the provision of midwifery care. In the midwives' defense it could be said however, that the trusting relationship built up between the women and the midwives themselves (as previously discussed in Chapter Four) meant that the elements of informed consent, while not specifically addressed as separate entities, were imbedded in the trusting relationship that had been formed.

Payment for formal interpreters was also not mentioned in the data obtained from the study. Unless the midwife worked in a group that had negotiated extra funding from the HFA for interpreting costs, the cost of an interpreter would be expected to be borne by the midwife as there is currently no provision for extra payment for the use of interpreters in Section 51 (HFA, 1998). The current charge rate for a trained interpreter of around $130 an hour would preclude many midwives from accessing the interpreting service. This has implications for the care women receive. Essential information may be missed or misinterpreted by the midwife and/or the woman which may lead to misdiagnosis and mismanagement and therefore compromise the care the woman and her baby receive. It is also worth considering that if a family member is used as an interpreter, certain problems e.g. domestic violence, may not be disclosed.

In the United Kingdom, employment of bilingual workers in the health service to specifically provide language support has been implemented over the last 15 years as an attempt to address the inadequacies of using a woman's family members for interpreting (Baxter, 1995). Bilingual health advocacy schemes have been found to reduce obstetric interventions during labour and birth and increases the satisfaction of women (Baxter, 1995). Given the increasing amount of refugees and immigrants who are gaining entry to New Zealand and who do not have English as their first language, this issue requires further investigation and action at Government level. Discussions surrounding the possible establishment of a Government funded free telephone interpreting service are currently in progress. It remains to be seen whether such a service, if established, meets the interpreting needs of women and midwives.

One of the roles of the midwife is to provide information to women on a wide variety of topics pertaining to pregnancy and childbirth.

5.3 Constantly educating

Throughout the duration of each woman's pregnancy and postnatal period, the midwives used any available opportunity to provide her and her family with information and education on a variety of topics. This was usually, but not always, directly related to the woman's pregnancy and the birth of her forthcoming baby. The education was given to ensure each woman had enough information to enable her to make choices regarding decisions about the care she wished herself and her baby to have. All the midwives felt that educating women was an important part of the care they provided.

> *I educate them on what to expect and what's going to happen so that they know. And I think that's really important. Education is the big thing (Lisa p17 L6-12).*

This education was not dependent on whether the woman had attended antenatal classes. If they had attended antenatal classes, much of the education they would have received there was repeated by the education the midwives gave. If they had not attended classes, it was dependent on the midwife to provide the education the women needed.

> *They do need more education and information too, than perhaps somebody who has the advantage of knowing they can go to a library and so they've read more (Lisa p3-4 L32-2).*

5.3.1 Having a plan

The midwives generally had a plan for ensuring each woman received education that was appropriate to the different stages of her pregnancy as the pregnancy progressed.

> *Every antenatal check I normally have a set topic that I normally would talk about with them (Linda p10 L13-15).*

> *...each month I sort of have a routine that I go through about what I'm going to talk about next. It depends on whether it's the first baby or number ten. ...So I would gradually sort of work through most of those things like diet and planning for baby and antenatal education (Theresa p3 L13-23).*

> *I do...the normal education around health and pregnancy and birth (Anne p3 L1-6).*

By having a plan, the midwives sought to ensure they provided education on a variety of topics relevant to the requirements of the women they were working with. This also ensured they met the contractual requirements of working under Section 51 (HFA, 1998) which stipulates the content of the education women/families are expected to be provided with during the woman's pregnancy.

Interestingly the topic of exercise for pregnant women was only mentioned by one midwife in the study.

> *As far as exercise goes we don't talk about that because I don't do any exercise. We just say yes it's good to walk blah blah blah...(Lisa p18 L13-15).*

Lisa's advice is contrary to current research recommendations such as that from Campbell and Mottola's (2001) case control study which found that women who engaged in structured exercise e.g. aerobics, of at least 15 minutes duration five times or more a week in the third trimester had a substantially increased risk of giving birth to a low birth weight infant, and women who exercised two or less times a week had a modestly associated risk of having a baby with low birth weight. Campbell and Mottola's (2001) study therefore, recommends counseling women to exercise three or four times per week. Once controlled for, maternal height, prepregnancy body mass, pregnancy weight gain, smoking in the third trimester and nulliparity were not found to be statistically significant interactions (Campbell & Mottola, 2001). In contrast, Kramer (2001) in a systematic review of the effects on physical fitness, labour and delivery and the outcome of pregnancy, of advising healthy pregnant women to engage in aerobic exercise two or three times a week concluded that although regular aerobic exercise during pregnancy appears to improve or maintain physical fitness, the data are insufficient to exclude important risks or benefits for the mother or infant. Midwives are in a pivotal position to give information to women about physical activity during pregnancy.

The education the midwives gave to the women was a combination of giving information, building on information the women already had and reinforcing that information once given.

> *...quite a few of them won't go to classes and then you just build blocks. You just talk a bit more each time you go. But they're the sort of things*

I'm talking about. I do that usually from about 20 weeks (Theresa p4-5 L33-4).

And I've got a big information folder that I give them at about 28 weeks and I just tell them 'you don't have to read it all, just flick through'...all sorts of things [are in it]. ...So they have opportunity to be informed if they want to be, ...and I've got a birth video as well, if they want to, and I've got breastfeeding books that I loan them. ...so I feel that when women go to antenatal classes I just reinforce what they've heard. I mean I say it all over again. It's repetition, which is fine that people hear things over and over. But I make sure that they know what their pain relief options are and birthing positions and what they may like to try and do they want their placenta. So to me it doesn't really matter if they do or don't go to antenatal classes (Linda p24-25 L3-9).

I think there's varying degrees of knowledge about their body and their pelvis and I'll speak to them about that and what is happening with the baby. ...I don't go in there with specific things to cover. It just depends on what you bring up in the conversation really and usually by 36 weeks I've made sure that they've had at least one big discussion around labour and birth. The other thing that I'll try and do before the birth is to try and talk a little bit about breastfeeding and things like that, which is sometimes quite hard because they're so focussed on getting through the labour that you can sort of see this glazed over look. And you sort of think well it is better to talk about it really early on and then focus on the labour...because all they're worried about is this labour thing and the pain and how they're going to manage (Carmel p14-16 L24-19).

...we talk about caring for themselves in pregnancy and we talk about all those other things that everyone talks about when they go for their first visits. Now education proceeds at each visit really. In fact each visit is an opportunity for the midwife to teach. There's every opportunity to talk about things and I don't talk about it every time, but you take it [education] when you're not rushed off your feet, you're not too tired (Lisa p18 L15-27).

It's probably a good opportunity to cover things like caring for themselves, exercising and smoking and good healthy eating and generally looking at their lifestyle, and then because of the time frame, then we would go through the labour process. Like what to expect and pain relief, positions for birthing, midwives involved, and when things don't go according to plan. And then what happens to her after she's had baby and where she goes from there.... And then it may be an opportunity as well to talk about other things like BCGs and the hip check and things like that (Rose p5 L8-22).

In this way, women were prepared for the decision-making they would need to do as the pregnancy progressed.

Providing information and education about diet was an important part of the midwife's role, particularly given the financial constraints pertaining to this group of women.

5.3.2 Talking about diet

Early on in the pregnancy, the education tended to focus on lifestyle issues such as eating healthily, while being aware of the constraints of the woman's budget. The midwives were very aware of the women's lack of financial resources and tailored their education to suit.

> *You had to look as far as nutrition goes, at what these women could afford rather than what was actually best and [knowing] they are going to do what they want to do (Jane p3 L21-24).*

> *...I don't like to overload them too much on the first visit so I'd probably give them information about diet, and listeria and folic acid and all those sorts of things (Theresa p4 L9-12).*

> *I mean I'll talk about general health stuff, I think that's the reasonable thing to do and general diet, and I'll advise people to take children to the doctor for imms [immunisations] or talk to the nurse at school or something (Anne p18-19 L32-3).*

> *I focus more on preventing IUGR [intra uterine growth retardation] babies in the lower socioeconomic [women] and making sure they have good nutrition (Linda p41 L4-6).*

> *...early in the antenatal period I'm talking about diet. Looking at ways that you can maybe improve their nutrition without them having to spend extra money. ...I talk to them about making simple things like soups. ...just trying to get them to look at other ways you know, maybe even planting a few veggies out the back (Carmel p2-3 L26-9).*

> *The first visit...that I do with women, we do a huge talk about diet, which I think is really important. I think there is not enough emphasis being placed on educating them on diet, on their food intake. So we do that. and that sort of opens up the path for all sorts of other things like vitamins. ...So on the first visit I talk a lot about diet and in fact one of the things I've started to do is to ask people to give me a week of a diet diary.... So that's been helpful and I've found that we've had people who have had a bit of a think about it...and I'm quite emphatic about the importance of cutting down on things like coke and sugar.... That's important as far as I'm concerned and it's a good opportunity to talk about what the family eats and what the children eat...so that's the biggest thing (Lisa p17-18 L17-13).*

The midwives endeavoured to ensure that the education they gave to the women on diet had relevance to the women's everyday lives. Taking into account the individual woman's circumstances was therefore essential if the midwives education was to be of any benefit. The midwives were aware of the possible consequences of poor nutrition for the woman and her baby.

In an article about the increasing number of Britons living at or below the European Union official poverty line, Leather (1996) states that although families living in the average British household spend 18 percent of their income on food, poor families may spend a third or more (Leather 1996). Although based on the level of income in Britain, this article has relevance to the current situation in New Zealand as apart from New Zealand, income inequality in Britain has risen further and faster that any other industrialised country in the world (Leather, 1996). Considering the most important factor in food choice to be money, Leather writes how food, because it is the most flexible item in the household budget, is being continually squeezed by the increase in costs of other basic needs such as electricity, clothing, transport and housing and is therefore where savings can be made. As a consequence, people buy whatever food items fill them up for the least amount of money, resulting in food that is high in fat and sugar content, rather that nutrients. An example Leather gives is that while we are being encouraged to eat five portions of fruit and vegetables a day, British figures show that the average fresh green vegetable intake of larger, poor families is equivalent to less than ten brussel sprouts per person per week and their average fresh fruit consumption is equivalent to less than two apples per person per week.

While recommending action at Government level to ensure everyone has an income adequate to meet basic needs for good dietary health, Leather (1996) also recommends relearning cooking skills and promoting the consumption of fruit and vegetables. Another aspect Leather draws attention to is the psychological stress of poverty. Food deprivation is not only an issue of inadequate nutrition, it is the pain of going without; of seeing your children go without; of living on too little money for too long; of having a boring diet; of rarely having a decent meal and of no longer getting any pleasure from food.

Finding the cash to buy healthy food was difficult for the women in the present study. A healthy, balanced diet is not possible for most pregnant women who are living in high deprivation (Davies, 1995) and therefore many women are going through pregnancies dangerously undernourished. The primary effect of inadequate nutrition during a woman's pregnancy is the birth of a low birthweight baby. Low birthweight is linked to a range of disabilities including cerebral palsy, blindness and poor cognitive abilities (Davies, 1995). Davies (1995) cites the results of a British research study (National Children's Homes (NCH) Action for Children and the Maternity Alliance (MA), 1995) which investigated the effects of undernourishment on the pregnancy and pregnancy outcomes of 120 women. The study found that more than two thirds of the babies born to mothers in the study had birthweights below the national average, and that a third of the pregnant women were found to be deficient in essential nutrients. Most of the women in the study had a poor diet and regularly missed meals and while 41 percent said they had not received any dietary advice from health professionals, another 20 percent said the advice they did receive was neither sensible nor appropriate for tight budgets (NCT and the MA, 1995, cited in Davies, 1995).

While most women know what types of foods are good for them, the problem is finding the cash to buy a healthy, balanced diet- it is often easier to snack on filling and cheap fatty sugary food, than to maintain a healthy balanced diet when living on a benefit (Davies, 1995). Davies (1995) encourages health professionals to promote healthy eating advice and information. In a study investigating the effect of giving enhanced midwifery care to women living in low socioeconomic areas, Davies (cited in Hughes, 1992; Davies, 1997; 1992; Davis & Evans, 1991; 1990) found that following being given advice about diet, women modified their diet during their pregnancy and were still eating differently and better than the control group six weeks after the birth. Given the results of the literature, it is essential that midwives advise women during pregnancy on the benefits of a nutritious diet as well as giving the women education relevant to their socioeconomic circumstances on how this may be achieved.

Giving information on reducing or stopping smoking was identified as important by the midwives.

5.3.3 Discouraging smoking

A large proportion of the women the midwives worked with smoked cigarettes. How many cigarettes the women were smoking was difficult to ascertain.

> *I notice it with the smoking women...that maybe there's a bit of guilt attached to some lifestyle behaviours and they won't tell you or be totally honest with what's happening. Especially if you ask them in front of their partner and they go 'No you're not. You're smoking a packet a day'. And the woman will look very sheepish and so you will catch women out in that regard (Linda p5 L14-25).*

In the United States a 1997 study found that 30 percent of women living below the poverty level smoked (Centers for Disease Control, 1997, cited in Klesges, Johnson, Ward & Barnard, 2001). Figures for New Zealand are not known. Smoking is a significant issue not only for the health of the pregnant woman, but also for the health of her unborn/newborn baby. Cigarette smoking is considered to be the single most modifiable cause of adverse outcomes of pregnancy (Klesges et al., 2001) and stopping smoking during pregnancy therefore, should have a significant impact on improving those pregnancy outcomes. A plethora of research has shown the adverse effects of smoking on pregnancy, particularly on fetal growth retardation, preterm delivery and perinatal mortality (Klesges et al., 2001). A study by Roth and Taylor (2001) found that women, including those who are health care professionals, showed an exceptional lack of knowledge about the health risks specific to women who smoke. This was particularly apparent with regard to infertility, osteoporosis, early menopause, miscarriage, ectopic pregnancy and cervical cancer. Health care professionals need to ensure they receive adequate education on the risks to women of their ongoing smoking. As stopping smoking in early pregnancy ensures a reduction in the harmful exposure of the fetus to the over 3000-4000 chemical compounds including carbon dioxide and cyanide found in tobacco smoke, and stopping smoking later in pregnancy also has benefits when compared with continued smoking, health practitioners are encouraged to inform women of the implications of their smoking behaviour in terms of the health concerns that relate to them as women (Roth & Taylor, 2001), and to continue to support women to stop smoking throughout their pregnancy (Klesges et al., 2001).

For the midwives in the current study, supporting the women to cut down their cigarette smoking in the first instance and preferably encouraging them to stop altogether became a primary concern.

They are fully aware of the effects that smoking has on the baby and we try and educate them and they will knock down one or two, well they will tell you that they have knocked down one or two (Jane p4 L13-16).

...so many of them smoke and smoke a lot. The smoke free house, the cot death type stuff is a real concern for me and the breastfeeding. Even just the back sleeping, and I will say it to all women but I'm watching for it in the homes, and pointing out the cot death risk and things like that because the babies are just so at risk. ... Trying as much as possible to make sure in the first two weeks that the breastfeeding is going really well, so they actually enjoy it and they find it easy and relaxing just for the public good it would do that child long term, that the women perhaps don't appreciate (Linda p41 L6-20).

...what has been accepted practice within their family, in their whanau, goes on being the accepted practice. And in essence there's nothing essentially wrong with that except that sometimes one can see that if they'd had a greater knowledge there would have been perhaps, a better outcome. So if we look at something as simple as women who smoke in pregnancy, then we're going to find that if they don't realise, and they don't know what happens to these babies because they're smoking, then they're going to have less intention or incentive to stop smoking. But giving them the information doesn't always help them. So you have to then go on and give them more [information] (Lisa p4 L8-21).

The Midwifery Education to Women who Smoke (MEWS) study; a three-year research study investigating smoking education and its relation to breastfeeding in pregnant and postnatal women, was being undertaken concurrently in the area these midwives were working in during the time of this study. In the MEWS study (McLeod, Pullon, Viccars, Benn, Cookson, Dowell, Green, McGrane & Crooke, 2001) independent midwives were randomised into four groups. These groups consisted of a breastfeeding intervention group, a smoking intervention group, a combined breastfeeding and smoking intervention group and a control group. The group the midwives were randomised into, dictated the intervention the pregnant women with whom they worked and who consented to being in the study, received. This also determined whether the women received any extra structured education (in addition to that already routinely provided by the midwives) on the benefits of reducing the amount of cigarettes smoked and/or encouraging breastfeeding. The results of the MEWS study are awaited with anticipation.

Valbo, Thelle and Kolas (1996) investigated the effects of an intense intervention programme on pregnant women who were still smoking at 28 weeks gestation. The

multicomponent intervention the study intervention group received consisted of monthly consultations with an obstetrician at the local hospital, verbal and written information on the detrimental effects of smoking, assessment of daily smoking confirmed by the measurement of expirational carbon monoxide, counseling on behavioural strategies on how to quit or reduce smoking, and an ultrasound examination to estimate the growth and biophysical score of the fetus was performed at each visit (Valbo et al., 1996). The control group received routine pregnancy care by general practitioners. The results showed that 28 percent of the intervention group stopped smoking compared to 11 percent of the control group, 35 percent reduced their smoking compared to 49 percent of the control group, 26 percent did not change their smoking habits compared to 37 percent of the control group and 11 percent increased their smoking consumption compared to 3 percent of the control group (Valbo et al., 1996). 100 percent of the intervention group relapsed to daily smoking within one year after delivery compared to 66 percent of the control group (Valbo et al., 1996). The authors conclude that the resource demanding multicomponent intervention model does not seem to give additional benefits when compared to other models requiring less resources and that most of the women who successfully stopped smoking in pregnancy were light smokers, and therefore were at less risk of directly related pregnancy complications (Valbo et al., 1996). The results of this study have implications when assessing the benefits of allocating large financial resources into encouraging pregnant women to discontinue smoking.

At the time the current research study was taking place, there was a lack of government funded incentives to encourage pregnant women to either reduce their smoking or to become smoke free. This had implications for midwives who lacked the resources required to assist women towards this aim. A strong predictor of continued smoking is nicotine addiction with continued smokers reporting a higher number of cigarettes smoked per day compared with people who successfully stop smoking (Klesges et al., 2001). Since the interviews with the midwives were completed, there has been a NZ Government funded campaign offering subsidised nicotine replacement therapy and telephone counseling support to people wishing to stop smoking. Nicotine replacement therapy is not recommended during pregnancy however, (Novartis Consumer Health Australasia Propriety Limited, 2001; Adis International Limited, 2000) as controlled clinical trials have not been conducted. Small studies are reporting that short-term

nicotine replacement therapy use during pregnancy shows no adverse outcomes for the pregnant woman or fetus (Klesges et al., 2001). As the results of clinical trials become available, health providers including midwives, will be expected to be able to advise women in making decisions about nicotine replacement to aid their smoking cessation attempts (Klesges et al., 2001).

From reviewing the literature it would appear appropriate that midwives incorporate screening and the offering of counseling to assist pregnant women to stop smoking, at each contact they have with women who smoke. This message is not new. Davies (1988) recommends that midwives repeat the smoking message over and over again. Women should be asked about their smoking status and advised to stop smoking (Roth & Taylor, 2001). A knowledge of community and government funded resources available to aid smoking cessation is therefore imperative and an obligation for each midwife.

The midwives in the study used a variety of forums for the provision of education to women.

5.3.4 Using different forums for education

The midwives tended to use a combination of one to one teaching to women, providing education with family members present, holding their own antenatal classes and encouraging women to attend antenatal classes run by other groups in the community.

5.3.4.1 Giving education one to one

The midwives generally held education sessions with antenatal women on a one to one basis in the woman's home. Describing these as being on a one to one basis was not strictly true as much of the home education by the midwives was held in the presence of the woman's family members.

> *Well, as far as antenatal education was concerned you are on a one to one basis basically (Rose p3 L19-21).*

> *One to one stuff in the home works really good, actually it's not one to one, because often, most often, the homes I go into it's not just one person I'm talking to. Mostly you see the women surrounded by extended family. Not always, often perhaps. And especially when you are looking*

at say a young primip who, we identify as often needs most education, her mum or her grandma or her aunties or some of her sisters are hanging around listening to things you are saying, and you know that you have to speak to them as much as to her, if you want to have an impact on what is happening. If you tell her stuff that means nothing to her mum or her aunty or her grandma, then when you go away, that stuff's going to be probably mostly, not accepted once they discuss it. If you can actually get them into the discussion at the time it's really really useful, so...you can have a group discussion (Anne p19-20 L25-11).

Involving the family antenatally in this way had benefits for the woman's labour and birth (as mentioned previously in Chapter Four) and as 'Anne' mentions

...the home works often, not just because it's a place where the woman is comfortable but because she is surrounded by that extended family, and often if you can get that relationship and that knowledge out to the whole family, then the birth and labour is so easy, because they all come in and they know. And my role becomes very little if they're going to do it. If we're talking about what's going to happen at the labour and I'm talking about 'can I run a bath' and that kind of thing...and they're all making suggestions, when it comes to the birth that just kicks in, to happening in a way where if I just did a little one to one conversation on her own and she was talking to them separately, and where none of us had any idea of what each other was saying, then when it came to the birth there could be conflict (Anne p20 L11-26).

Another reason for providing education to women and their families individually was the inappropriateness to this group of antenatal classes available in the area in which the study took place.

5.3.4.2 Finding established antenatal classes inappropriate

Although midwives encouraged the women they were working with to attend the antenatal classes already established in the community, most women did not attend.

...about half of them [go to antenatal classes]. The transport, the money and not really being interested [are reasons why they don't attend]. Also the shyness factor as well, and if their partner's not involved – it's a very couplely thing to go to antenatal classes. There isn't really any more teenage type focus antenatal classes, so I've had some women go to a couple [of classes] and totally not like it and not go again. ...and it's hard to know what exactly they felt uncomfortable about. But the whole antenatal class thing is quite middle class (Linda p23 L19-32).

I encourage them to go to the hospital classes, but a lot of them don't find it the right environment for them do they? They might go once, or they might not go. They don't feel comfortable going, particularly if they're young as well, or they might not understand the language so

there's not much point. ...I don't think transport's really the problem. That might be what they say but I think it's probably more the environment that they're going to is the problem (Theresa p5-6 L10-9).

A lot of them do [go to antenatal classes] but then I'd say that...there'd be 30% that wouldn't. ...they often might feel that either the people in the class are much older than them or vice a versa.... Or the other thing that happens is that they get a whole lot of people that they see as quite middle class so that they don't find it appropriate (Carmel p15 L5-17).

Sending them doesn't work. There's a whole pile of reasons why. Again it's a trust issue, and there's the transport issue. And I think some of the classes are not particularly appropriate. Also they teach stuff that I don't agree with let alone the women (Anne p19 L14-18).

That this group of women does not attend established antenatal classes is well supported by the literature. An English study found that women from social classes 4 and 5 and very young women were almost entirely unrepresented at antenatal classes, both hospital run and private (Nolan, 1995). The irony that those most at risk of poor perinatal outcomes receive the least education is pointed out by Nolan (1995), who expounds the need for research into what kind of antenatal education would be acceptable to women who do not currently receive it. Cliff and Deery (1997) support Nolan's (1995) findings, adding that practical difficulties with transport, inconvenient class times, location of classes, problems with course content and not addressing this group of women's special needs related to poor housing, low income and social isolation as mitigating factors as to why this group of women do not attend. Finding the antenatal classes not useful, or useful as preparation for the birth but not parenting, was an outcome of a study undertaken by Barclay, Everitt, Rogan, Schmied and Wyllie (1997) exploring women's experiences of new motherhood. Murphy-Black and Faulkner (1990) observed ante natal classes as they were taking place and found that the teacher talked for about 80 percent of the time, the mothers contributed less than 20 percent of the time and the remaining time was spent in silence or confusion. Murphy-Black and Faulkner (1990) recommend that those midwives wishing to take classes attend a teaching and groupwork skills training course to increase the interaction between the teacher and the mother. It is apparent from the literature that if women living in areas of high deprivation are to be encouraged to attend antenatal classes, many changes to how they are run currently will be required.

The midwives recognised and were attempting to meet the need for antenatal classes which were more appropriate to this group of women.

5.3.4.3 Holding appropriate antenatal classes

One option was for the midwives to set up their own antenatal classes to more appropriately meet the educational needs of these women. These classes often had a combined social and educational role.

> *We hold classes actually. Classes that are particularly aimed at our population. They tend to be small groups in a reasonable comfortable room...and it's much more chatty and people bring their babies, and yeah, gossipy and nice. They're quite hard to arrange and it can be a real feat to get people to come to those sometimes (Anne p19 L18-25).*

> *But there are still the ones that we provide antenatal classes for...for those who won't go [to other classes] (Rose p3 L26-28).*

Whether the women attended antenatal classes or not, the midwives attempted to ensure that they provided the women with the education they needed during the pregnancy.

One midwife worked within a midwifery group which held monthly gatherings for the women with whom they worked. While these classes were not antenatal classes, they did fulfil both a social and an educational need for the women.

> *...that's just an opportunity for the women to get to know the other team members who are my back up, and also just an informal way of meeting other mothers and also other mothers that have had babies, because they're sitting there breastfeeding and I think that's a good positive influence on the women. ...we get a guest speaker in so it's educational.... ...We just choose an educational topic or on request from [women]. ...It's a good way of extending friendship to your women without breaching the boundaries of trying to take every woman who wants to be your friend into your friends circle, your private friends circle (Linda p4-5 L28-32).*

It would be useful for an evaluation of the variation of classes these midwives held to be undertaken to assess their responsiveness in meeting the requirements of this group of women.

Another area in which the midwives were called upon to provide support was with abuse in many different forms.

5.4 Dealing with different abuses

The midwives spoke of working with women who were living in a variety of abusive circumstances. These included violent domestic situations, women and children who had been sexually abused and women involved with drug and/or alcohol abuse. Supporting women throughout their pregnancy while liaising with agencies to offer additional support to the woman and/or her family as and when required was undertaken in addition to the midwifery care provided.

5.4.1 Becoming aware of physical violence

Domestic violence can be defined as the systematic abuse which takes place within the context of the family structure (Hunt & Martin, 2001). Domestic violence can present in different forms. It may be physical, emotional, sexual, psychological and economic or any combination of these. The violence is often hidden with women remaining silent because of the shame and many women develop a learned helplessness and become dependent on the perpetrator (Scobie & McGuire, 1999). The true level of domestic violence in pregnancy is unclear but research suggests that it is a common occurrence during pregnancy (Scobie & McGuire, 1999). A British report (Department of Health, 1998), estimates that domestic violence affects one in ten pregnant or postnatal women at any given time, having a profound and ongoing effect on all members of the family. In a Swiss study (Irion, Boulvain, Straccia & Bonnet, 2000), 7 percent of women reported being the victims of emotional, physical and/or sexual violence during the current pregnancy. A study conducted to describe mothers' perspectives of the impact of the violence on their children found that 72 percent of the mothers reported negative behaviours in their children that they believed were as a result of witnessing their mother's violent experiences (Lemmey, McFarlane, Willson & Malecha, 2001). In an analysis of other studies, Stenson, Saarinen, Heimer and Sidenvall (2001) found the estimated prevalence of domestic violence during pregnancy to be as high as 19 percent, while McFarlane, Parker and Soeken (1996) found the prevalence of physical or sexual abuse during pregnancy to be 16 percent. O'Campo, Gielen, Faden and Kass (1996) reported the incidence of verbal abuse or physical violence during pregnancy for 358 low income women to be 65 percent. Of these, 20 percent experienced moderate or severe violence (O'Campo et al. 1996). Domestic violence is now recognised to be a contributory factor to maternal and fetal morbidity (Department of Health, 1998).

Many of the women in this study were living in some form of abusive relationships. The domestic violence that the midwives in the study came across while working with these women was frequent and complex. The violence that the women were living with on a day to day basis was a source of great distress, not only to the individual woman, but also to each of the midwives involved. Although physical abuse is only one manifestation of domestic violence and may be the only one readily identified by health professionals, statistically it is highly likely that a significant number of these women were being subjected to other forms of abuse as well.

While abuse crosses the full socioeconomic spectrum (Stenson et al., 2001; Scobie & McGuire, 1999; Steen, 2000; Anonymous, 1999) more affluent women may have more resources to enable them to seek help if they desire. Also, more affluent women usually have more education and therefore more employment and financial prospects, which means they are more likely to have the positive choice of leaving an abusive situation. However they may also be unwilling to leave as they fear not having access to those financial resources. This is in contrast to women living in areas of high deprivation who usually have little education, little or no employment record and therefore have little prospect of finding employment which would give them and their family an adequate standard of living away from the abusive relationship.

The true level of domestic violence within the group of women the midwives work with in the current study is unknown. Rose had her own idea of the percentage of women involved in physical violence.

> *The whole time I've been [in the area] I would say that probably a third of the women are involved. [in domestic violence] That's quite a high percentage but it seems to be quite a bit that goes on. ...Just the physical abuse that we know of and can see it is going on (Rose p6-7 L28-2).*

The midwives became aware of the physical violence in a variety of ways. Sometimes the midwife became aware of the abuse through being told by the woman or through being aware of the woman's surroundings.

> *...they might say to me 'oh I can't talk to them about that or they'll bash me up', or 'I've never thought about that because my partner wouldn't allow me to do that'. It's quite obvious when they say it, but it's quite hard to explain what sort of things that they're talking about and it's something that often will come through more than once. It's something*

that people allude to, rather than, they're not specific about it, unless I know them really well (Carmel p6 L13-22).

At other times, the women were identified due to physical signs of abuse.

[The antenatal visit] is a good opportunity to find out where the woman's actually at with the pregnancy – how she's feeling about it, how her family are coping, and it's usually at that time that you might discover a bruise here and there and it's a good opportunity to find out about the relationship (Rose p6 L19-24).

Some midwives however, were not aware of the women they were working with being exposed to any physical violence.

And have you had any problems with violence in their homes...?
No. I mean I haven't looked after a lot [of women living in areas of high deprivation] (Theresa p20 L16).

In their study, Scobie and McGuire (1999) found that midwives did not routinely screen for domestic violence and were reluctant to do so due to feeling inadequately prepared. In an anonymous article, (1999), the author emphasizes the importance of midwives being sensitive to the signs of abuse and opening conversations which allow woman to feel safe and confident. Development of practices which encourage routine questioning of women antenatally is recommended (Marchant, Davidson, Garcia & Parsons, 2001; Stenson et al., 2001; Steen, 2000; Anonymous, 1999; Scobie & McGuire, 1999). Stenson et al. (2001) and Scobie and McGuire (1999) examined women's attitudes to being questioned by their midwife during and after pregnancy about exposure to violence. Both studies found that there was no difference as to whether the questioning was acceptable between those who reported abuse and those who did not, suggesting that most women do not mind being asked about exposure to violence, by their midwife. In a study exploring barriers to identification and management of domestic violence from the battered women' perspective, Rodriguez, Quiroga and Bauer (1996) found that most participants said they wanted providers to take the initiative and ask them directly about domestic violence, establish a supportive relationship with the woman and refer battered women to appropriate community resources. O'Campo et al. (1994) elaborate further on this by pointing out that antenatal care may be one of the only opportunities that women, especially disadvantaged women, may have to get proper assistance and support with domestic violence, stressing the importance of health care providers screening, counselling and referring women to community services in an effort to address the problems of violence during pregnancy. Price (2001) writes of the

development of policies and guidelines for practice and the instigation of effective training programmes at one National Health Service Trust in England, which were established with the aim of ensuring midwives have the necessary shills and knowledge required to feel confident in screening women for domestic violence during pregnancy. In identifying women's pregnancies which are at risk women can be offered support and utilise measures which may help prevent further abuse (Price, 2001).

Once the midwife became aware of a woman living with physical violence, she had to decide what action to take. The anonymous author (1999) stresses the importance of midwives being able to inform women of the services available, what their rights are and importantly, valuing and respecting the women throughout. Lemmey et al. (2001) stresses the importance of nurses (read midwives) asking women about abuse and being ready to provide information on community resources and education and counselling about the dangers of domestic violence if a woman discloses domestic violence. Overall, the midwife's role was to be there to provide the woman with information, advocacy, safety and support (Stenson et al., 2001; Steen, 2000; Scobie & McGuire, 1999; Anonymous, 1999) when required. The midwives in this study were aware of where the woman could seek refuge.

> *It would depend. ...maybe Women's Refuge where they've got good support groups. But it depends on the age of the woman. Some of them, because they're so young, they don't want to go there. So you find mainly the midwife, that they really are coming back to you all the time (Rose p7 L16-22).*

> *I've taken them to Women's Refuge, I've done all those sorts of things with them, but you know at the end of the day most of them will go back [to the violent relationship] (Jane p6-7 L32-2).*

That most women return to the perpetrator of the violence is supported by the literature. The anonymous author (1999) emphasizes the importance of midwives realising that such a decision is the woman's own choice and that the midwife's role is to ensure that the woman feels supported in whatever decision is made.

Women for obscure reasons may also call midwives as they attempt to escape following an episode of abuse.

> *...in the case of the women that get abused I know they will perhaps call me out with some excuse, saying for instance, 'I believe that I can't feel the baby move' or something like this, they are not prepared to tell you*

on the phone what the real problem is. But when you get there you know there has been a relationship problem –they've been abused...(Jane p8 L6-12).

Sometimes a midwife was rung by the woman in an acute violent situation, to take her away from her home.

...that whole thing of women...ringing in at night for you to pick them up from their husband and take them to Refuge...is another part.... ...you actually need to do transport and even arrange for contact with Refuge.... ...that's another really traumatizing nasty thing [for the midwife]...(Anne p13 L9-17).

Apart from being traumatic for the midwife, this situation also has the potential to compromise the midwife's own physical safety (see Chapter Seven).

Rose focuses on her wish to accommodate and support the woman as much as possible, providing the woman with care.

Now yesterday, th[e] woman was beaten up and the Police [were called]. She ended up having a Police escort for her scan. ...I don't mind being [midwifery partner's] backup going up there making sure that [the woman's] going to be safe. They [the women and her husband] had this big fight. ...And I think that's just the way we are. We will try and accommodate her as much as we can. Not that I don't think anyone else could provide such good care (laughs) but she's obviously come to us because she wants to be part of the [midwifery group practice] and that's fine. If we can give that to her we should (Rose p37 L1-20).

It is a great tribute to each midwife's commitment to the women that they chose to remain involved, endeavouring to provide appropriate support to the woman through the many issues surrounding domestic violence that arose during the midwife-woman relationship.

Steen (2000) has been involved in an educational program in the UK which aims to raise midwives awareness of domestic violence and the issues surrounding it and to provide midwives with knowledge and skills on how they can best support the women involved. As a result of the program, clinical guidelines are being developed to assist midwives to support abused women.

Providing ongoing support to women who were drug and/or alcohol abusers was another area in which the midwives became involved.

5.4.2 Becoming aware of drug and/or alcohol abuse

Drug and/or alcohol abuse were identified by the midwives in the study at various points during the midwife-woman relationship.

> *...trying to get some sort of history of drink or drugs – if they trust you enough I think they usually tell you that that's going on. But I mean you often get a sense of that anyway if you're going into the house. Because not so much due to the woman herself but [due to] the other people around. ...like if you arrive and everyone's sitting around drinking well you can probably assume that the woman does too from time to time. ...I think [I've] probably [had] quite a lot [to do with women who abuse drugs] but more cannabis use rather than hard drugs (Carmel p8-9 L19-5).*

Sometimes however, the woman's involvement with drugs and/or alcohol abuse comes as a complete surprise for the midwife.

> *I had a woman who came into labour who had been to the pub. But before that I hadn't identified any alcohol problem with her (Theresa p12 L28-31).*

A study by Chasnoff, Neuman, Thornton, and Callaghan (2001) found that past use of alcohol and cigarettes most differentiated pregnant women who were current drug or alcohol users from pregnant women who were current nonusers and recommended that pregnant women be asked three risk-defining specific questions related to alcohol and cigarette use as part of a health evaluation, to target those who require further assessment for drug and alcohol use. This would potentially define the risk of drug and alcohol usage for women and enable midwives such as Theresa to identify those women at risk.

Although research shows an association between maternal alcohol consumption and birth abnormalities (Curtis, 1994), none of the midwives in the current study mentioned, apart from the quoted portions from the transcripts as above, working with women who abused alcohol, or the effects of alcohol abuse on the unborn baby, nor why this may be of concern. It is assumed therefore, that issues other than alcohol abuse were more commonly identified in the women that these midwives were working with.

Working with women who abused drugs and/or alcohol took a lot of the midwife's time and energy.

> *So you don't need too many of them on your books (Jane p15 L6).*

And again from Jane,

> *...when I think about it sometimes particularly with girls on the drugs you get, they wear you out. They really wear you out because of all the social problems that go along with the drugs and sometimes the prostitution and things like this, which you do get involved with (Jane p14 L26-30).*

Lewis, Klee and Jackson (1996) examined the experiences of drug-using women during pregnancy and found that all the women in the study wanted to do what was best for themselves and their babies and most were attempting to reduce the intake of their methadone dose. Most women felt anxiety and guilt about the impact of their drug use upon themselves, their unborn babies and on the lives of those people closest to them (Lewis et al., 1996).

Midwives did not always feel they had received adequate education in how to deal with drug and alcohol abuse.

> *...there needs to be ...some special course...to help you understand the huge dynamics behind these people and actually where they come from – what set them down this track. Their behaviour is part of it, and having to cope with that and very importantly when they are in labour to recognise that...they may be off the hard stuff and on the Methadone programme, but they're still having drugs and...they're still feeling pain and they deserve the same treatment as any other labouring woman.... ...there is a deficit in how to actually cope with these people and I don't think you can put it into the normal midwifery training. You can just give a brief overview of it. ...It's a specialty (Jane p2 L6-27).*

Lewis et al. (1996) highlight the need for improving communication and collegial relationships between the drug agencies and the providers of antenatal care. The need for improving these relationships was evident in analysis of the data from the current study, in an effort to provide the midwife with the knowledge and skills required to ensure the pregnant women who was also a drug abuser, and her unborn child, received optimal care.

When women disclosed information such as a history of sexual abuse, providing ongoing support plus deciding what to do with the information they had received, was an issue the midwives were also required to deal with.

5.4.3 Deciding what to do with disclosed information

Sometimes the women would disclose a history of sexual abuse to the midwives. Although they found this situation difficult, the midwives would try to deal with this situation in some way, not always feeling they had the personal resources to do so adequately.

> *So people started disclosing...really incredibly nasty stuff which I was really not prepared to hear and didn't know what to do with and I was also incredibly busy. ...I would be frantically busy and trying to just get the antenatal visit done and...get out of there and a woman would tell me something really huge and really emotional, and I then would be looking at my watch thinking 'I'm already an hour late for my next visit and this woman has just dumped this big ugly thing on the table in front of me and I don't know what to do with it'. And so I would be sympathetic, 'coz there wasn't anything else you can be, but the more sympathetic I would be the more she would tell me and the more she would cry, and I would keep looking at my watch, and think 'how do I end this? She's telling me this thing and I need to solve it...and I need to get out of here because I'm running so late'. I found that appalling and so hard, and in the end I would end up leaving and just walking out saying 'oh well bye, I'll see you in two weeks time,' feeling terrible that I'd mishandled the situation so badly and it felt like every second house I went into this was happening (Anne p10 L8-33).*

Sometimes midwives had some idea of what could be helpful to the woman once a history of abuse had been identified.

> *... if I know that there's been a history of abuse or anything like that, then I'll often spend lots of time talking about what it might feel like to push the baby out and things like that so that that can be hopefully not too shocking for them at the time (Carmel p14 L28-32).*

Feeling inadequate to deal with the information the woman had disclosed was difficult for the midwife. Learning other more adequate ways to deal with the situation became necessary. Referring the woman onto appropriate community resources was one strategy.

> *...I also know now that I shouldn't try and solve the problems personally because I don't necessarily have the resources to do that; time and skill. And it's also not good as a long-term solution. 'Coz it's much better if I can link people into Supergrans or Naku Enei Tamariki (These Are Our Children), or the local community house or someone that can possibly do ongoing things for them (Anne p7 L23-30).*

Referral to an appropriate resource was not always possible however.

And at the moment it's sad to say [the] Social Worker is so overworked that she won't take any more of our women on so we're sort of stuck with them (Rose p7 L2-5).

Lack of resourcing, in both funding and personnel of community agencies who provide long term counseling to enable people to deal emotionally and physically with these issues, is an ongoing frustration the midwives felt and was a refrain repeated throughout the interviews.

Child abuse was another issue the midwives came across during their involvement with this group of women. Supporting the woman while at the same time protecting the child was not easy.

5.4.4 Dealing with child abuse

Some of the midwives regularly dealt with child abuse and as a consequence contact with The Department of Child, Youth and Family Service (CYFS); a government agency, while others had had little involvement. There appeared to be a strong correlation between the number of women living in areas of high deprivation that the midwife worked with and the amount of contact with CYFS that the midwife had. For those midwives who had had involvement with CYFS, their experience had been universally negative.

...the few times that I have [had involvement with CYFS] it's been a very negative experience for me and usually the woman involved...terribly negative (Carmel p6 L1-7).

I have rung CYFS and not had a very good response to my concern.... I felt the whole environment for the woman and baby was really unsafe...and they didn't want to have a bar of it, and said it wasn't anything to do with them and so I flagged it with Plunket and I bumped into her a year later and the baby was under CYFS care. I've had women who have had previous babies already under care of CYFS so they've known when that baby's been born but they haven't been interested in ringing me which I think is quite fascinating (Linda p34 L4-25).

...in a way I'm not very good at telling the difference between what you do particularly for lower socioeconomic women because I don't have a lot of the others, so I don't know. Maybe all midwives have quite a lot of contact with CYFS. I've always assumed they don't (Anne p13 L21-26).

Sometimes the midwife knew a social worker to whom she could refer women who had CYFS involvement, enabling the midwife to not be so personally involved in the proceedings.

> *...she [the social worker] does a lot of the liaising for CYFS, going to meetings there as well. She generally knows the area. She also knows the whanau groups in the area as well. She knows the Iwi links. So she does a lot of that for us, which is good for us. But now that she's not going to be so much involved with us it means that we may have to pick up all that ourselves and get involved again which makes it very difficult (Rose p33-34 L31-6).*

Finding out a woman had previously had children taken in to CYFS care sometimes happened for the midwife only by a process of deduction. This may be because the woman was concerned that should the midwife become aware that a previous child was in CYFS care, the midwife would then have to inform CYFS of the woman's current pregnancy and the woman may end up losing custody of her forthcoming baby to CYFS as well.

> *...and sometimes they'll just talk about their relationship with their partner or other members of the family and if I've known her for quite a long period of time they'll often just start to talk about the other children, especially if they don't happen to be around and I think you can often sort of figure it out; either all the kids will be there or none of them at all, and so they're all either out doing other things, they're much older, or maybe some of them have been put into care (Carmel p5 L19-28).*

For any midwife, having a baby taken into care by CYFS was traumatic. Finding a way to deal with the stress of this situation was essential. Chapter Seven discusses how midwives cope with the personal emotional conflict which results.

> *Oh it was really hard. That I think is when you need your colleagues afterwards to come and talk to. ...[That] put us off wanting to work in that area again. Though you thought, 'it's just that house', it's still...that was hard (Jane p18 L1-8).*

> *But yes it did seem to be huge and stressful at the time. I think I found that emotional stuff more difficult than the directly social and material needs of the people (Anne p13 L5-8).*

The requirements women had as a result of social, emotional and physical issues necessitated the midwives liaising with a variety of community services, including government agencies.

5.4.5 Liaising with community services

Due to the amount and seriousness of the social, emotional and physical issues that became apparent during the midwives contact with these women, the midwives spent time liaising with a variety of government agencies and community services. This was in an effort to ensure the most optimal pregnancy outcome possible for the woman and her baby. Liaising with the different groups took up much of the midwife's time.

> *Probably the Pacific Island Group, Parents As First Teachers (PAFT), Te Whanau Ora and Naku Enei Tamariki. They're the main ones.... ...Generally we can ring them up if we've got referrals. ...It has been actually really, really good. The only problem is that community groups are overworked too (Rose p34 L11-28).*

> *All these people that you have to liaise with making a huge job [for the midwife] and they are all in with the social deprivation group (Jane p14-15 L33-2).*

> *I tend to not directly address needs like problems with WINZ [Work And Income New Zealand] or problems with housing.*
> ***So who does that then for you?***
> *It would most likely be a community worker or a [social worker] or advocacy services... (Anne p4 L3-10).*

Anne continues with an explanation of who she does liaise with.

> *I do invest a lot more time in trying to liaise with agencies or network and give advice, where people don't have the resources to try and sort that out themselves (Anne p6-7 L33-3).*

Like some of the midwives experiences of dealing with government agencies, dealing with community services was not always successful.

> *I have tried on many occasions to have a successful relationship with [partially government funded community service] and have failed abysmally. I feel that they have got partial government funding to do something [and] that they are not living up to their requirements. I will refer women to [them]. I send them referrals. ...I will ring them and say 'why didn't you follow this woman up?' And I will go and see the woman who is on the phone and they will say they haven't heard a word from them. And then I'll have another woman who will have a fantastic relationship with [them] and [they] will redeem themselves. ...and then I'll think okay then, I'll refer another woman to them and it will be an abysmal failure (Linda p30-31 L30-13).*

Such an experience was very frustrating for the midwife who was doing her best to refer the woman on to an appropriate agency. It was also time consuming.

...I felt like I sent a referral off and it went into this big black hole and never came back again (Linda p33 L30-32).

Working with these women meant the midwives often had to be innovative in searching for alternative solutions to the variety of problems these women faced.

...[we] make huge efforts to arrange things like attending family planning clinics following the birth of the baby...(Lisa p5 L11-12).

Yeah you do manage your postnatal care [differently] because at the time you go in and she [the woman] was shattered so what you do is you start organising the kids and say, 'well come on, you've got to help look after mummy,' and you start giving them little jobs and you get the hoover out and you do it, which I would normally not do, but, what can you do, when the woman is alone? In fact I do not see it as the role of a professional person. I also do not believe it is good business sense, but I do believe it is part of caring (Jane p12 L11-20).

...I often find that I go into these sorts of homes and there's not a lot of cooking skills and they've often been living on takeaways for long periods of time, cause their own parents probably haven't cooked either. So [I talk to them about making] simple things like [soup] (Carmel p3 L2-7).

And I remember back to the deprived women who I visited with a midwife.... Rather than doing an antenatal class she'd cook a pot of soup or something at lunchtime. ...and women would come and have a social chat with the midwife and...the midwife would say 'now this is far better than food from [a takeaway] and cheaper'...and the midwives would be saying [explaining] the nutritional value of giving this food to your baby. And in that way, these women did change their habits...and also the midwives knew that at least –they used to do it twice a week- two days a week that women got some nourishment for themselves (Jane p23 L14-31).

The midwives also had other tasks they had to perform, which, while not directly maternity related, were all part of the care they provided to women.

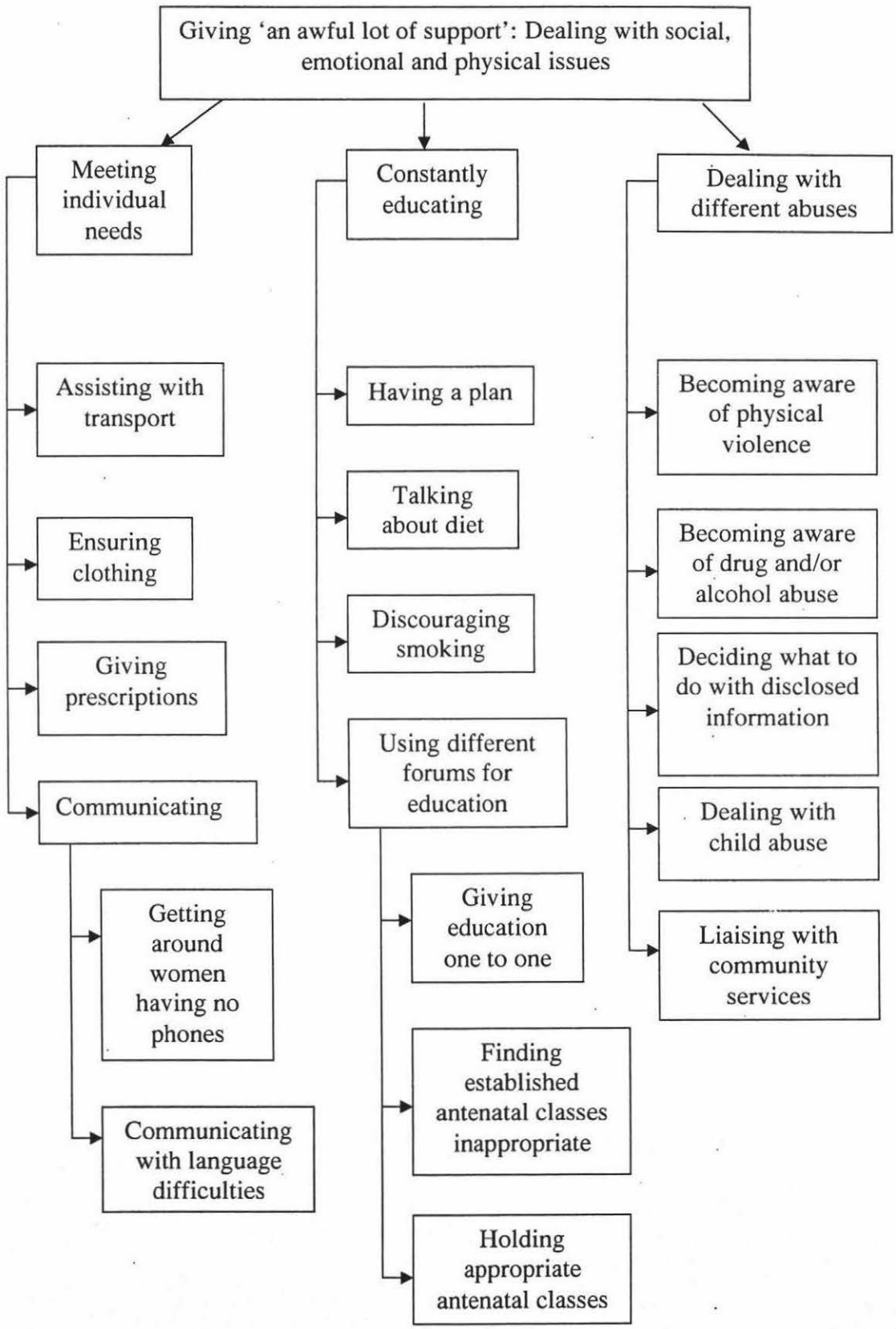
The other thing I have found recently is if someone wants a letter or a note for their PD [Periodic Detention] worker to say when she is actually due, or she can't do any PD work, or somebody else is finishing work at such a such a time...I have to...type these letters and take them to the women.... Those take a bit of time every day. But they are all little things, but when you add it up in the course of the day, it's half a day's work when you've got four of them to do. Plus you've got secondary care letters to do and make sure they're going to go to the lab [laboratory] for the glucose challenge or the GTT [Glucose Tolerance Test]. You know it's a big part of your work those extra bits and pieces (Rose p23-24 L23-4).

Ensuring these things are completed, while time consuming, were considered by the midwives to be essential when working with this group of women if they were to receive optimal care.

5.5 Summary

This chapter has introduced the category of 'Giving 'an awful lot of support': Dealing with social, emotional and physical issues'. The midwives gave women 'an awful lot of support' as they assisted the women in dealing with the social, emotional and physical issues that were frequently encountered during the period of providing midwifery care. The sub categories of 'meeting individual needs', 'constantly educating' and 'dealing with different abuses' were identified from the data as ways in which the midwives attempted to provide the care the women required. Throughout, the midwife stayed involved. Chapter Six introduces the category of 'Remaining Close By' to describe the process of what happens when the midwives oversee labour, birth and the postnatal period.

Figure 5-1 Giving 'an awful lot of support': Dealing with social, emotional and physical issues.



Chapter 6: Remaining Close By: Overseeing labour, birth and the postnatal period

6.1 Introduction

In this chapter, the category of 'Remaining Close By' is introduced to describe the process elicited from data analysis which describes what happens when the midwives oversee labour, birth and the postnatal period. The sub categories of 'planning for labour, birth and the postnatal period', 'attending women in labour' and 'providing postnatal care' and the properties making up these sub categories are described and discussed. The conditions, strategies and consequences by which these sub categories are theoretically linked to the category of 'Remaining Close By' and to the other categories which emerged from analysis of the data are detailed. The properties of 'watching and waiting' and 'being 'like the conductor of an orchestra'' form part of the description of the process by which the midwife participants attend women in labour; one of the sub categories making up the category of 'Remaining Close By'. 'Remaining Close By' identifies how the midwives stand back and intelligently observe the woman, not interfering while all is progressing normally yet being available when required. Figure 6-1 is a diagrammatic representation of the properties and sub categories making up the category of 'Remaining Close By'.

6.2 Planning for labour, birth and the postnatal period

Under Section 51 of the Health and Disability Services Act 1993 (Health Funding Authority (HFA), 1998), midwives are under a professional obligation to assist and encourage each woman to undertake some planning for her forthcoming labour, birth and the postnatal period. This planning involves not only deciding where the most appropriate place to birth will be, but deciding who the woman's supporters will be, what her choices for different procedures are, planning to accommodate any special requirements she has or wishes for while in labour, ensuring childcare is arranged for any other children, accessing any equipment or clothing necessary for the new baby, arranging support for the early postnatal period and identifying the preferred feeding method for the baby and any educational issues surrounding this. According to Section

51 (HFA, 1998), this plan should be written down formally in the woman's clinical notes and the midwife and the woman should each retain a copy for their own records.

6.2.1 Not getting set ideas

Midwives in the study found that in general this group of women did not have set ideas on what they wanted to do during labour, birth and the postnatal period, nor did they want to spend time making plans for how they wished their labour and birth or postnatal period to go.

> *They don't tend to ask a lot about pain relief options and things like that. I think I bring it up, 'are you aware...?' They don't come to an antenatal checkup and say 'I want an epidural for this birth'. I don't tend to get that type of set ideas (Linda p26 L11-16).*

> *They probably still don't have strong ideas about what they want. They're probably still in that model where they want to do what you want them to do (Theresa p9 L9-11).*

> *...I talk to them and say 'now we sort of have to get a bit ready for this baby business that's coming' and we do talk about have they got enough equipment and clothes and things like that. But apart from that they don't make a big thing of it (Lisa p19 L9-13).*

> *And you as a midwife can discuss [pain relief options] with them as we did as part of the care plan. But they're usually quite confident that their family would be there and we were back to the good thing of support (Jane p4 L13-17).*

Instead of wishing to spend time planning for the birth, the women saw birth as a normal part of life and accepted it as something that was going to happen, and with which they would cope at the time.

> *...they accept it as part of life. It's not something that they're going to take out and make a big issue of. ...basically they accept that they're going to have a baby and they're going to birth that baby and they know they'll do it well or as well as they can and there's not a huge fear of the birthing process with these type of women, as there are often with [more affluent women], and that makes a huge difference (Lisa p19 L6-19).*

> *I think they're a little bit more accepting that labour is a part of life and you have to deal with it. Yeah, it's another thing you have to cope with and you just have to get on with it (Linda p26 L20-27).*

Believing this group of women feel that labour and birth is something they 'just have to get on with it' is supported by the results of a study exploring the communication

experiences of 68 working class primiparous women in Scotland (McIntosh, 1988). This study found that this group of women had low expectations of the birth and its management with few of the women regarding it as a potentially positive or rewarding experience or desiring participation in the process (McIntosh, 1988). As a consequence, the women approached the labour and birth with the priority being to get the event over with as quickly as possible (McIntosh, 1988).

Evidence elicited from the data in the current study and the findings of McIntosh's (1988) study are inconsistent with the results of a study undertaken by McCrea and Wright (1999) exploring the extent to which women feel they have been able to control what happened to them during labour with emphasis on satisfaction with pain control. McCrea and Wright (1999) found that contrary to prior evidence working class women look for speedy and pain free labour and are less concerned with personal satisfaction with their birth experiences. Also, none of the demographic variables, including social class, had an impact on women's satisfaction with pain relief. McCrea and Wright (1999) concluded that women should therefore be encouraged to be active and equal partners in the care planning process.

Despite the women not wanting to spend time on making labour, delivery and postnatal plans, the midwives were under an obligation to give the woman some information anyway.

6.2.2 Ensuring women have the information

The midwives did their best to ensure women had the information they required to make informed decisions for events surrounding labour and birth. In general however, the midwives found that this group of women tended not to have strong views on labour and birth planning and did not want to spend time planning for labour and birth antenatally. They preferred instead to see how labour progressed once it commenced and be guided by their midwife. This was not to say that these women had no opinions on what they would prefer, rather that formalizing a plan of care was not always welcomed or desired by the woman.

> *...most of these women, if you've looked after them in the past, say 'well I just want you to do exactly what you did the last time', or you just take it as it comes on the day... (Jane p9 L20-23).*

...it's quite important to guide them to what their choices can be. In their own minds they can be very strong about what they want and what they don't want, but they'll not necessarily write it down (Theresa p9 L12-26).

This was in sharp contrast to the more affluent women who midwives found tended to be much more focussed on the birth plan aspect of preparing for birth.

...they know exactly what they want. They come with it typed out, or if it's not typed out they'll come with their views so you can say 'what do you want? Would you want this, would you want that?' and they can answer you (Jane p9 L11-15).

In an article written on the issues of power and choice during pregnancy and childbirth, Lovell (1996) states how not all women want the same things and there needs to be caution before imposing unwanted choices and decision-making on those women who might prefer letting the professionals involved in their care take charge. This is highlighted in the comments from midwives in the current study as above, when the formalising of a birth plan is under discussion. In Lovell's (1996) view, any effort to force women to make formal plans for their care could be interpreted as substituting one regime of oppression for another. An example of this is that of the medical dominance and control over childbirth which midwives and women have latterly fought so hard to reposition in the discourse on normal pregnancy and childbirth.

If the woman had not formulated a plan antenatally for how she wished her labour to be managed it sometimes became difficult, once the woman was in labour, for the midwife to anticipate the woman's needs or how she was feeling about the care being provided.

...the common things in my practice [such] as a woman sitting on the toilet and pushing, especially [when] having her first baby- some of the families find that time in the toilet difficult to handle. It's very hard because I don't know what people want and if people tell me this I'm really happy to do it. But sometimes I feel like I'm guessing or I'm trying to guess by looking at the family who are looking at the woman. I'm getting the feeling that they feel like something's not right or they're not happy with this situation, but they're not being explicit. ...I think I find it challenging to work with people who are not clear about what they want, or not assertive about what they want, that's the thing. It's really easy when someone says 'don't do that to me. I don't like it'. ...Yeah, it's really hard when you're always getting the feeling that you're not quite getting it right and you're trying to guess (Anne p39 L7-29).

Being left to guess whether the care they are providing is acceptable to the woman and her family, as Anne describes in the situation above, was uncomfortable for everyone involved.

Under Section 51 (HFA, 1998) midwives are under an obligation as LMCs to commence a care plan at their first meeting with the woman, and to keep this care plan updated throughout their ongoing contact. For the midwife, this meant taking some steps to ensure women had some information to enable then to make choices so that informed consent could be gained prior to labour and birth procedures. This was to prove difficult when working with these women.

> *...I think that you can't plan a birth and that you just make informed choices at the time. ... All I do is at each antenatal visit I talk about different topics like what type of third stage management do they want...I then ask them what they think they'd like to do or to tell me [at the] next appointment, and then I will document that we have discussed it. Some decisions are not made until the time of the birth and that's fine. As long as I've explained what an epidural is and what pethidine is, and baths and things like that I don't have to document 'Jane Brown wants to have a bath first, and then a...'. Because I think that's nonsense, because nobody knows what they're going to do when they're in labour...you've just got to go with the flow (Linda p25-26 L18-4).*

The midwives decided that the giving of information to the women in this way met both the information needs of the woman and their obligations to the requirements of Section 51 (HFA, 1998).

6.3 Attending women in labour

Much of the work that midwives did with the women during the antenatal period, was to ensure that when labour commenced the woman was as prepared as possible physically, emotionally and socially for the transition to parenthood. Once labour commenced, the midwife provided the encouragement and support necessary to ensure the most optimal outcome for both the woman and her baby.

6.3.1 Managing latent labour at home

One of the common practices of the midwives in the study was the provision of midwifery support to the woman in latent labour in the woman's home. This enabled the woman to remain at home for as long as possible. It also meant the woman received

either minimal or no intervention and therefore increased the possibility of her having a normal birth. Labour was left to establish unimpeded and the woman only transferred to hospital once well established in labour. Providing this support required commitment from the midwife plus the support of her colleagues for back up, as this meant keeping in touch with and visiting the woman regularly over often several days in the lead up to established labour, to ensure all remained well with the woman and her baby.

> *I'll go and see them at home and...if they've been up for a wee while and I know that the cervix is still uneffaced I may give them a Temazepam [mild sleeping tablet]. If they're reasonably well rested then I may in the daytime say 'have some Panadol and use the bath and go for a wander and keep up the food and fluid intake' (Carmel p25-26 L31-4).*

> *Sometimes I'll just give two Panadol, and two Temazepam, 20mg or 10 mg of Temazepam. And that's just enough to relax them and make them sleep (Linda p11 L28-31).*

> *...we manage them at home....always on the phone and available to talk to.... Yeah keeping in touch and popping in as they need it (Lisa p16 L17-27).*

Sometimes the midwife would meet the woman in the hospital for a check to ensure all was normal and decide on further management following this.

> *...or I may get them in for a check up and send them home again if they really felt they needed that reassurance. ...Often I say if you're having a posterior labour I'd probably get them in for a CTG [cardiotocograph]. I want to make sure they're not having an obstructed labour. Make sure they haven't got prolonged rupture of membranes. With some of those women I have occasionally admitted them overnight and reviewed them in the morning and given them pain relief to help them sleep (Linda p11 L1-24).*

This need for sleep is emphasized by Carmel also.

> *In fact the biggest thing with these latent labours is the rest thing so I do sometimes resort to Temazepam because I think that two or three hours of reasonable sleep is better that none at all, especially you know if they've been up from 10 at night, and I'm seeing them the next day at 8 o'clock or something because if they don't, then the scenario later is not great (Carmel p26 L4-11).*

Part of what was involved in supporting the woman at home was ensuring that family members were coping with the situation and that they knew what they could do to support the woman during this time. They needed to know what the expected signs of progress would be as the woman became established in labour.

...it's preparing the family members and things too so that they're not getting anxious and so that they know what's going on. So it's sort of emphasizing the rest thing and food thing and talking about what to expect with the contractions (Carmel p26 L20-24).

If the plan was for the woman to deliver her baby in the hospital, at some point the midwives and the women together made the decision to travel to the hospital for the remainder of the woman's labour.

6.3.2 Watching and waiting

The midwives had all been granted contracts to access the maternity facilities of the local hospital. Maternity facilities are required to enter into access agreements with non-hospital employed midwives, as access to the maternity facility is fundamental to a woman being able to choose a non-hospital employed midwife to provide her care during a hospital birth (HFA, 2000). This meant the midwives are able to bring women they were working with into the maternity facility in the same way that general practitioners and obstetricians can, and have free access to the resources required to provide women with care. Currently a condition of a midwifery practitioner being granted an access agreement in most maternity facilities in New Zealand is agreeing to abide by the policies, standards and guidelines of the accessed hospital's maternity facilities (HFA, 2000). Being bound by this contract meant that at times the midwife had to alter her practice in order to ensure she complied with the policies, standards and guidelines. Generally the changes required to adjust to these were minimal i.e. performing a 20-minute admission CTG. However issues such as handing over women to secondary care, as previously discussed (Chapter Five), caused significant distress and controversy.

The two main clinical tasks for the midwife when admitting a woman in labour to the maternity unit are to assess the woman's progress and condition and the baby's condition, and to make decisions about the care required (Garforth & Garcia, 1987). Respect for an individual woman's needs, giving the woman information and choice and involving her in decisions about her care, while preserving the woman's dignity and providing reassurance are the crucial personal tasks required of the midwife on the woman's admission to the maternity unit (Garforth & Garcia, 1987).

When the midwife admitted a labouring woman into the delivery suite, the admitting procedure undertaken appeared to be relatively standard between all the midwives in the study.

> *Well, we've all signed access contracts saying that we'll follow the unit protocols, so according to [local hospital] protocol they all have an admission CTG unless declined. I'll do initial obs[ervations]; temp[erature], pulse, BP [blood pressure], urinalysis if they want to go to the toilet. I always palpate their tummy before I put the CTG on to check the presentation and position. ...I might palp[ate] their contractions, just ask them how they're feeling. Go through the history of what's been happening in the labour (Linda p14 L16-26).*

> *If she comes in fully dilated [laughs] it's pretty much 'catch the baby' stuff. But you can just look at things, the CTG and see if it is generally normal – there's nothing to do apart from delivering the baby. If she comes in in early labour and is just niggling around then I do the normal routine stuff of admitting her to delivery suite.... ...then I do the normal things like taking her blood pressure and checking her urine and normal obs[ervations]; temp[erature], pulse and checking the baby; the position of the baby, whether we've got ruptured membranes or got any bleeding, then a 20 minute CTG (Rose p14 L18-32).*

After the initial admission procedures had been undertaken, the midwives waited to see how the labour was progressing and how the woman was coping. The midwives watched and waited, before deciding whether they needed to alter their management.

> *Then I just watch the woman for a while. If she doesn't appear to be in as strong a labour as she'd hoped then I may do an internal with the view of sending her home...to come back in established labour. If she appears to be in established labour, depends on whether or not it's a multip or primip what I would do. Multips I don't tend to VE unless I have a concern... (Linda P14-15 L 23-4).*

> *And then if not much is going on then I would encourage her to mobilize if she wanted to do that. She could go out for a walk. ...If she's tired and stressed then we would look at the [pain relief] options for her...or if she opts not to have that then she may just want to pop in the bath for a wee while and try and settle down if she can. However if...things are progressing relatively quickly, things just may progress on to fully dilated and she may get a nice normal delivery...me not having to do anything if I can help it (Rose p15 L7-23).*

Not doing anything unless necessary seemed to be the one thing the midwife could do to ensure the woman had as much chance as possible to labour and give birth normally. The outcomes for labour and delivery, to be discussed later in this chapter, support the effectiveness of this stance.

Just watching her really. I don't have to do anything, just keeping an eye on her, how she's coping. I think it's a great skill, listening and watching (Rose p15 L28-30).

6.3.3 Calling another midwife in

All the midwives had other midwives in the group they worked in that they could call on for assistance or relief if the labour was long and/or complicated. Some midwives always called in a second midwife to assist at the birth of the baby. For others, this was not done routinely. If the labour was difficult for some reason, for example, the midwife was both midwife and support person for the woman, the midwife may call another midwife in for support.

...the group I work with, always have another midwife for the birth. So I would still call someone in and perhaps I might call them in a little earlier [if the woman had no support]. It also depends on how the woman was managing and what she needed. If it was a really stressful, difficult situation then I probably would call someone in. But it's not usually like that (Anne p22 L1-7).

If I was passing through delivery suite and [midwifery colleague] was having a baby and she felt like she wanted me there, then I would. For some reason I don't feel I need it, so I don't. I feel quite happy if everything's quite normal and I feel that there are [hospital] midwives there if you ring the bell if you have an unexpected outcome that can support you and that the [hospital's] actually funded for that. ...so I don't feel that I need another pair of hands, so I don't tend to call another midwife in (Linda p38-39 L25-2).

A common reason for calling in a second midwife was to provide some relief for a midwife who had been at a long labour and/or had been up all night. This was to enable the midwife some time away from the woman in order to get some rest. Calling in a second midwife was not always an easy decision to make.

...but I'd have to be really quite tired and I'd be reluctant to call the other person if I knew that she'd been up recently. I might keep going for longer than what I should, given what else is going on. ...sometimes I will call the other midwife if I knew that we were heading towards a forceps delivery or something like that because I think it's quite useful to have an extra person there if it has been quite a long labour. But it just depends (Carmel p23 L1-15).

...if I've been up all night and it's about 8 o'clock in the morning I'll ring and say 'look this is what's happening. I might need you in a couple of hours if we don't make progress soon'. And sometimes I've gone home and had four hours sleep and come back for the birth, or sometimes I

haven't and the women want you to go then. It's like you're holding them back from making progress because you're too tired (Linda p39 L18).

Here Linda brings up an interesting point. Does the tiredness of the midwife have an effect on a woman's labour progress? While potentially 'holding them back' is not specific to this group of women, it is an issue which could be the focus of another research study. Linda continues...

...it's like they need someone fresh, and they send you home, and they don't worry about you, it doesn't hold them back and they deliver about an hour and a half later or something, and you think 'oh I could have stayed' but you couldn't because you were holding them back (Linda p39-40 L28-2).

The midwives were not the only people in attendance with the labouring women however. The women were generally well supported by family members. Working with the family to enable the family to support the woman was seen by the midwives to be an important part of the midwife's role in being with these women in labour.

6.3.4 Attending births with family

The midwives noticed a lack of male involvement in this group of women's labours and deliveries and found that it was more common for them to be attending labouring and birthing women with only female support people present. Midwives identified cultural reasons as being one possible explanation for lack of male partner involvement. In many cultures, for example some Pacific Island groups, events surrounding pregnancy and birth are considered women's business, and therefore the men are not involved.

But then it depends on the culture as well and if it's a Samoan woman, there will be other women there. It won't actually be her partner or her husband with her. It will be her aunty or her sister. But there will be two or three others around her. Very big support for them (Rose p16 L10-14).

I think, for me, on my reflection of the women I've looked after who have got challenging personal circumstances, that birth is very much a woman's business. They are supported by a lot of women and not a lot of men necessarily (Linda p26-27 L30-1).

Pacific Island women are often quite well supported and they're often supported by the women in the family. The men will keep away and if they want to be close and around they're actually out in the lounge and not in the delivery room because they want to be out in the lounge. And they feel more comfortable there. And often the women around her are

older women usually, whereas with some of the Maori women you'll find that they've got people of a similar age around them (Carmel p12 L2-11).

...mums are nearly always there and quite often aunties are there (Lisa p20 L3-4).

That cultural reasons may be an explanation for lack of male partner involvement is supported by a study exploring the midwifery care of Samoan women in Porirua; a New Zealand city (Fa'asalele, 1999). Fa'asalele (1999) found that all the women in the study felt comfortable having their family present during labour and birth, especially first time mothers who felt they needed their mothers more than their partners support. Another study exploring what support from midwives Chinese women find most helpful in contributing to a positive labour and childbirth experience found that husbands do not traditionally attend the births of their children, instead female members of the family are present to provide emotional support (Holroyd, Yin-king, Pui-yuk, Kwok-hong & Shuk-lin, 1997). Madi (1998) found that women who had the continuous presence of a female relative to support them during their labour and delivery were more likely to have an intervention-free vaginal delivery, and suggests that the psychological impact of suddenly separating women from their female carers at the crucial time of labour when they are in need of that support, does not appear to be recognised.

The midwives also found that there were usually more support people present during the labours and births of this group of women than that of their more affluent counterparts.

They're either totally on their own or you've got every member of the family there helping you (Jane p10 L27-29).

I find that [in] this socioeconomic group that we're talking about, there certainly is a larger percentage of women who have a larger number of people there (Lisa p19 L25-28).

There would be a...small group who come in just with partners, or one or two people, and there would be quite a large group who come in with, everybody (Anne p21 L9-11).

I find at the first birth [there is] heaps [of family]. And usually they come to the second birth and say 'I don't want so many people next time round'. And you say that's fine. But you do generally find there's another couple/two/three around (Rose p16 L6-10).

I think most of them do have really good family support. It depends on their culture...the Polynesian people often have more family and I feel comfortable with that (Theresa p7 L1-8).

There actually is more family around. Possibly transport reasons as well. They'll all come in the same car together and all stay for the duration 'cause 'if you go we all go' type scenario. But there is probably more family around and children too (Linda p21 L18-22).

Having less family around during labour and delivery appeared to be more common with European women. Asian women and recent refugees/migrants often had no members of their family living close by, so either laboured alone or with only their partner supporting them. This was also apparent with some Maori women living at a distance from their family.

...I think with Pakeha [European] women –they tend to just have their partner a lot of the time. They don't have other family members [there] although I think more of them sometimes will have a sister or a mother present too (Carmel p12 L14-17).

The young ones yep, yeah, certainly, the Pakeha race were very much on their own. Teenagers might have the school kids, the class there, but I mean (laughs), well that's support though, that's support, but you wouldn't actually perhaps have a mother or a mother figure there (Jane p6 L17-22).

And often the Asian immigrants don't have anyone at all and that's quite hard for them as well as the language and all that (Theresa p7 L4-6).

There's a small group of women who come into labour on their own...probably in a year I've had five or six like that perhaps who come in on their own entirely (Anne p21 L4-8).

But then if they are out of the area then you may not have their family there. ...like a Maori [woman] from Whangarei is a long way from home, there may be no one around here to help them and a newly arrived Pacific Islander may have nobody around either (Jane p5 L23-28).

Having family present during the woman's labour and delivery was accepted and welcomed by the midwives as part of what happens when working with this group of women. Midwives felt there were many advantages to both the woman and themselves in having the family being involved at this time.

...I'm much more comfortable when there is extended family. Births go much better, it feels better. It feels like, often the woman is more comfortable. It's what she's been used to all her life anyway. So...it gives her a buffer zone between her and the hospital, sometimes her and me even. I think she feels safer and secure. Sometimes it's the buffer zone for

me as well from the whole system. She doesn't actually have to interact particularly with anyone. She doesn't have to see the hospital wall particularly because there are so many family there.... So I think her feeling safe and secure helps a lot and things are much more likely to go good (Anne p4-25 L11-2).

Midwives found their role in working with a woman during her labour and birth changed somewhat when there were several family members present.

6.3.5 Being 'like the conductor of an orchestra'

When several members of the family were present, the midwives encouraged the family members to actively support the woman and stepped back from this role themselves.

And I see my role when there are a lot of people there and they are doing things, as a co-ordinator and rather like the conductor of an orchestra. You know, you're bringing them in from this side and that side and you're sort of saying 'how about we do this now?' But the focus for me is always going to be the woman and I don't really care whether they all like that or not...I still think it's quite important to have the woman as the main point of interest and not her partner or mother (Lisa p21 L12-23).

I tend to delegate a lot of support type things to family so that they're all involved, like getting ice water, and back rubbing, and hand holding, and encouragement, and you end up taking a bit more of a back seat, in the background type role when there's a lot of family around.
And how do you feel about that?
I don't mind. It's a family experience having the baby. As long as I can do the things I need to for safety and support and observations, I don't have to be the most important person in the room (Linda p21-22 L27-6).

...you tend to step back a little bit and I would get the family quite involved with helping her through her contractions and things (Carmel p11 L10-12).

And I think because I am often used to working with families I feel like my role is not directly doing lots of the cares. My role is often standing at the back and prompting, and kind of monitoring more as a role (Anne p21 L17-21).

In a study undertaken by Vague (2001) the midwives also spoke of times when the woman and her family are working together as a unit and only required the promise of the midwife's presence if needed. The midwives identified these moments as being intimate times in the woman's birth experience when unnecessary intrusion by the midwife is undesirable (Vague, 2001). While stepping back, the midwives continued to

observe and assess the woman's progress. Instead of 'doing', they prompted and guided the families in ways to actively support the labouring woman.

> *...sometimes I actually think genuinely I am doing nothing. I am doing basic monitoring. When a woman comes in I would do a basic assessment on her...I am watching to see that she is doing okay and that she is progressing, and watching her. I'm also watching the family to make sure that they are doing okay, that they're not anxious, that they are doing the right thing. And often, especially as she goes into transition they need prompting. As she becomes distressed often the family will become distressed, and if, rather than talking to her, if I can say to her mum 'try rubbing her back', or...'maybe if you take her out to the bathroom and bring her back again', if I can prompt them that seems to be the more functional thing to do than for me to do things or go in and go 'yep, yep, change all this' (Anne p25-26 L29-14).*

> *And some of them go to the Samoan midwife in the community and they've had massages throughout and so sometimes she will turn up with them as well and she may provide that, but quite often I see her sitting back and just watching as well, and then it might be the aunty or her sister who is doing the backrubs...because they [the women] are more comfortable with that as well (Rose p16-17 L24-1).*

The role of the midwife in prompting and guiding rather than actively doing is supported by a Swedish study which aimed to describe women's experiences of the encounter with the midwife during labour and birth (Berg, Lundgren, Hermansson & Wahlberg, 1996). One of the results of this study was that women wanted to be guided by the midwife but on their own terms; to be left in peace was desired and to be given time in order to have control over giving birth (Berg et al., 1996). The women wished the role of the midwife to be that of a calm presence- if the guidance was too predominant, the women had negative feelings about their childbirth experience (Berg et al., 1996).

Walker, Hall and Thomas (1995) found that women who were experiencing an uncomplicated labour preferred to be left alone with their support person during much of the first stage with the knowledge that the midwife was available and would come immediately if called and give any help that was necessary. Women and their support people appreciated the lack of intrusiveness once the initial contact with the midwife had reassured them that everything was progressing normally and that they knew how to cope (Walker et al., 1995). Discussion with the midwives in the same study (Walker et al., 1995) also found that they were able to recognise when a labouring woman and her

support person preferred to be left alone, especially in the early stages of labour, and respected their wishes. The women and their support person thus had both personal control and assurance of support (Walker et al., 1995).

A study exploring women's experience of pregnancy and childbirth (Lundgren, Dahlberg & Wahlberg, 1999) concluded that midwives should only interfere in a woman's labour if the woman asks or if the natural process is disturbed i.e. complicated in some way. In order to bring this about, midwives need to have presence, that is be familiar with the woman seeing her as an individual, affirm what is happening to her through good communication, and to give her time, supporting and guiding her when necessary (Lundgren et al., 1999).

Kirkham (1995) examined what happens to the flow of information in labour. On very few occasions were midwives in Kirkham's (1995) study observed to be waiting on the actual process of birth. Midwives who were waiting on the birth process gave their whole attention to the labouring woman with their knowledge and skill being a resource to be called upon as appropriate rather than a routine to be imposed. The midwives took their cues from the woman in labour and waited on what they trusted, having gained knowledge and confidence which they conveyed to the women in their care (Kirkham, 1995).

Howell-White (1997) found that women who chose a midwife rather than a doctor to oversee their pregnancy care wanted less control over the birth experience representing a belief that labour should progress naturally rather than on a particular timeframe or being controlled or manipulated, and wanting to relinquish personal control to the naturalness of the event. The positive comments the women gave about having a midwife reflected these beliefs e.g.

> [she] didn't do very much.... ...[She] kept back [and] let things happen. [She] was not intrusive. (Howell-White, 1997, p.933).

These women desired to maintain power and control over the interaction.

A Canadian study was undertaken to examine the amount of support, as opposed to direct care, provided by nurses (who rather than midwives, care for labouring women in Canada) to women during their labour and birth (Gale, Fothergill-Bourbonnais &

Chamberlain, 2001). Supportive care was defined as being the provision of physical comfort measures, emotional support, instructional/information giving and advocacy (Gale et al., 2001). The results of the study were that the nurses spent only 12.4 percent of their time providing supportive care to labouring women and only 27.8 percent of their time in contact with labouring women (Gale et al., 2001). The nurses who were interviewed after the observation periods had taken place, were able to describe well the components of supportive care they considered essential to provide, despite the amount of time they spent in the provision of that care. The researchers concede that a limitation of the study may be that nurses describe ideal care rather than that actually practised in order to appear favourable to the researcher (Gale et al., 2001). Also, no attempt was made to examine if the labouring women considered the care provided to be supportive (Gale et al., 2001). Although strong research evidence already exists showing the effectiveness of support in childbirth and its importance to women (Guilliland, 2001; Homer et al., 2001; Biro et al., 2000; National Health Committee, 1999) Gale et al's (2001) study is one of the few undertaken to examine the amount of supportive care actually provided.

Tarkka and Paunonen (1996) explored the networks of social support available for mothers during pregnancy and birth and found that the mothers reported an average of seven support persons each, most typically their partner, close friends and relatives. This network acts as a major source of emotional support, aid and affirmation for the women (Tarkka & Paunonen, 1996). During labour however, the main source of emotional support for the women was found to come from the midwife and a significant association was found between the emotional support midwives provided and the women's positive experiences of childbirth (Tarkka & Paunonen, 1996). The midwives in the present study actively sought to ensure the woman was well supported by those that accompanied her during labour and delivery.

Sometimes, the woman's family were not particularly supportive of the woman during her labour and delivery. In an effort to try to avoid this situation occurring, the midwives discussed the role of support people with the woman antenatally and often tried to meet with the family at the woman's home during antenatal visits at some time during the pregnancy.

...I talk to them through the pregnancy about support and support for them and not just having people there to watch the baby being born –to actually be helping them through labour. And mostly I find that there's usually one person that they know well enough to feel comfortable with...(Carmel p10-11 L32-4).

...even though I accept that [having family members there] is what they do, I don't actually always think that that's such a brilliant thing. I don't always think that they birth as easily having an audience there, because although they're there as support people they are often distracting and the women sometimes then lose it a little bit and can't get on with the job of birthing. So I don't say they can't come of course. If they want to have 10 people there, that's fine.... But I always make it a point of trying to meet both the people who are going to be at the birth beforehand, which is a bit of a drag, but it does mean that we end up having a better flow, because these [women] are going to be hugely influenced by their mothers and their aunties and their sisters. And that's because they're family and they've known them for a long time and any influence that I have is only for a short time. It's only a year in the whole process (Lisa p19-20 L28-13).

At times the midwives found having the family so involved more difficult than if there had only been the woman's partner present.

Ah well, you get used to it. At first oh it was one of these things I thought 'oh my God' because coming from a nursing background, you are so used to being organised and doing things in routine and this sort of stuff that you think 'oh my God' you know (laughs) 'I want to get this done'. I am shattered at being here all night and the whole lot of them are in there talking and you've got to wait and get them out. But then you just get used to it and you accept it may be the only time that this particular woman is made a fuss of...(Jane p11 L1-11).

If there's a real lot of people there it's actually quite hard to do my job sometimes, because you feel like often you can barely get in to catch the baby really [laughs] which is okay but I feel it would be a problem if anything became complicated but then I'd just shoosh a few of them out if there was something going on or I'll talk to a small group of them to try and explain what's happening, after I've talked to the woman...(Carmel p11 L12-24).

Other women were alone because their partners had left them during the pregnancy.

...quite a lot of them the husbands take off, or their partners take off so they may have someone at the start of the pregnancy but they haven't at the end (Jane i1 p11 L15-18).

An American study focused on men's experiences of first-time fatherhood found that men established an emotional distance from the pregnancy in relation to the amount of

ambivalence they experienced about it (May, 1982). The effect of this was that women usually sensed this distance and attempted to involve their partners more closely which often resulted in the man responding by withdrawing more (May, 1982). Reasons for this include the man's lack of preparation for parenthood and the more unprepared the expectant father feels for the pregnancy the more emotional distance he will require (May, 1982). Another study exploring the social, emotional and sexual experiences of men during their partner's pregnancy found that if both the pregnant woman and her partner were informed early in the pregnancy that ambivalence, anxiety and increased tension were common experiences during pregnancy, then they could concentrate on establishing ways to effectively deal with these changes rather than experience a mismatch in their expectations of the relationship (Donovan, 1995). Men who are opposed to or strongly ambivalent about the pregnancy are unlikely to become willing participants and may be unable to support the woman effectively, the alienation and resentment building until the relationship eventually dissolves (May, 1982).

The absence of a partner may mean that the midwife is the support as well.

6.3.6 Being both midwife and support person

Attending a woman who is unsupported by family throughout her labour and the birth of her baby added an extra dimension to the midwife's role.

> *I find them incredibly hard work...because you have to not only do the midwife thing but you also have to be the support person as well. And I find it such a strange role when everything that's been done is only being done by me, such as backrubs by me, if it's the bath being run, it's by me, if it's blood pressure, it's by me (Anne p21 L8-25).*

> *It's quite hard I know because you're trying to do both [be both midwife and support person]. But it's not impossible...but we do sometimes have women without any support and that's fine (Carmel p10-11 L30-5).*

Anne found women who came in to the hospital to labour on their own to be very self-controlled,

> *Those women who come in on their own tend to be very stoical and, I don't know, endure (Anne p22 L7-9).*

Making plans antenatally for childcare for the woman's other children while the woman labours can be difficult.

And then there is the huge social problems about getting somebody to look after the children while they are in labour and delivery. ...You know beforehand if they're organised they get someone in, especially [for] if it's not the middle of the day and usually they have got a neighbour or someone and they organise it. ...Well you can offer them social support, trying to get Social Welfare in, but they often won't take it (Jane p11-12 L18-30).

I think childcare is a bigger problem.
So what do you do about that?
I just ask them what they're going to do with their kids, and who they're going to ring and where are they going to take them. Most of the people actually find someone to care for the kids or they end up bringing a sister in with them or a relative who cares for the kids while they're in labour with them in the room (Linda p16 L9-20).

Occasionally women who are on their own bring their young children with them when they come into labour with no accompanying adults to care for them. This brings its own challenges for the midwife.

...that's a nightmare...because they have no one else. They may be a young woman who lives at home with her two preschoolers and she goes into labour and she gets a taxi to the hospital, and what can you do? (Anne p23 L18-25).

I think it's quite difficult for the women. ...But for some people that's the most ideal situation and they don't have anyone else they can leave the children with. ... I think that the hospital staff would find it a problem and I think it's problematic for other women there too, there's no place that the kids can go with reasonable safety. If no one's actually supervising them they're likely to get into all sorts of mischief (Carmel p20-21 L16-10).

However midwives preferred that the women bring their children into delivery suite with them than the alternative of leaving them at home alone while they laboured.

...she had her baby and went straight home, which is not unusual and I went in the next morning just to see how she was and she'd left those kids [alone]. Thank God she had a quick labour and it had all been fine. But she'd just left them. She just didn't have another soul (Jane p12 L6-11).

When children did accompany their labouring mothers' into the hospital, ensuring the children were cared for and safe while their mother laboured was a responsibility shared between the midwife and the woman. It was not always easy for the midwife to do this while supporting the woman as well.

Well the women are amazing. They can be 8 cms and still tending to their children's needs, but it does mean that especially for the birth, my hope is always that the children fall asleep if I give them blankets and pillows

and feed them biscuits and Milo (laughs). If they don't, then you have them running around your ankles. You just put up with them, and it's terrible and the hospital staff hate it when these little children are running around ringing all the bells and...(laughs). The hospital staff are nagging me and I'm trying to do the support to this woman at the same time as being her midwife –and I suppose that's difficult (Anne p23-24 L29-11).

...and if the children are seen to be running around, they're berated in front of everybody. It's awful (Rose p18 L22-24).

I usually get the drinks and biscuits and what have you. It is quite tricky I think if the woman is trying to concentrate on what she's doing and they're roaring in and out (Carmel p21 L16-19).

Midwives found it hard knowing the woman needed to return home soon after delivery to care for her children due to a lack of support.

...knowing that this woman is going home and not getting any rest at all because she has got to pick up her home where she left (Jane p11 L21-23).

Being both the midwife and support person was a difficult role for the midwives but one which they accepted as being part of working with these women.

6.3.7 Noticing differences in how these women cope

All the midwives felt these women had a different attitude to their labour and delivery than other more affluent women they had worked with.

These women somehow they haven't lost that natural instinct that...labour is actually painful. ...It's normal, yeah they accept it more. They know it's going to be painful and they try their best to cope with it. ... A bit of gas or something- they know they can have that. The tendency is not to ask for an epidural. What you often find is that people want to give them it (Jane p4-5 L22-3).

I think they probably labour often better. ...Just because they haven't got those high expectations I think they probably generally need less pain relief and are quicker. ...It's hard to generalise; I mean not all of them and not all are quicker. But I think overall they probably do (Theresa p10 L1-14).

We certainly have a low epidural rate and I don't know whether that comes from the kind of women we have or our preferences in education. Yeah, I don't know. ...I think often they are more accepting that life does things to them and they have to live with it. Yeah, I mean there is a group of them who don't, who have no tolerance (Anne p22 L20-30).

They just sort of get on with it a lot of the time, whereas I think that certainly some of the very affluent women that I've cared for –it's like they've got all right in their head but they haven't got it right down here [pointing to the pelvic region] (Carmel p12 L22-26).

I think they're one extreme or the other. Some of those women will come in in really well established labour and have the baby really quickly (Linda p15 L15-17).

Well again the whole business of them having less expectation, means that they actually labour better as far as I'm concerned, and they often birth, from a midwifery perspective, better than a woman who comes from an upper class home.... ...in fact the women who birth with me from the lower socioeconomic groups are not nearly as difficult to birth with. Not nearly as demanding. ...they don't make the demands for interventions that the people on the other end of the social scale do. They don't ask for epidurals and caesarians and things like that, because they just say 'having a baby is part of life'. ...I see that over and over again. Far less. And it's because they don't have an expectation that they should have, you know, pain free births. I mean they just say 'life is full of things and one of the things it's full of is having babies, and having babies does cause some pain, and I accept that and that's the way it is'. And to me it's fantastic (Lisa p10-11 L11-8).

An American study by Nelson (1983, also cited in Green, Coupland & Kitzinger, 1990a) compared the attitudes and experiences of women with different socioeconomic or educational status. The study found that working class woman had different attitudes towards childbirth during pregnancy, different experiences during labour and delivery and different postpartum evaluations of their experiences when compared with more affluent women (Nelson, 1983). While middle class women generally wanted active, involved births free from medical intervention, working-class women wanted more passive birth experiences with more medical intervention (Nelson, 1983). This is in contrast to the results of the present study. McIntosh, (1995) reporting on a study of the expectations, experiences and reactions to childbirth of 80 working-class women having their first babies found that the women's expectations of childbirth were largely negative with the majority regarding it as an ordeal and a means to an end. The women's priorities were to get the birth over with as quickly as possible, to keep pain and discomfort to a minimum and to maintain self-control during what they anticipated would be a frightening and unpredictable experience (McIntosh, 1995). The labour and birth were assessed in terms of how long it lasted, the amount of pain experienced and the extent to which the woman felt able to control her reactions, with most saying it had been better than they had anticipated (McIntosh, 1995). The women placed little value

on the experience of childbirth itself; their main focus was the baby, with the labour and delivery being considered as something merely to be endured (McIntosh, 1995).

The midwives in the current study had several other explanations for why these women seemed to have a different attitude to labour and delivery compared to more affluent women.

> *Most of them...have...a far better pain tolerance and just trusting their bodies (Jane p9 L27-30).*

> *I think the women...often...'do their babies', i.e. their birthing and their child raising from what they have inherently known themselves. I think it is more instinctive. So that it becomes a 'mother-daughter' hand on or a family/whanau thing. (Lisa p4 L2-8).*

> *I think certainly the Pacific Island women because of their support don't often expect to have pain relief because they've seen their sisters or their mothers birth babies reasonably recently without pain relief. So I would see that a lot. Slightly different again for some of the Maori women that I see. They're often maybe aware of things like Entonox. It really depends on what their friends have done a lot, but I think that there is really a difference in how these women labour. I mean I don't use the epidurals very often at all (Carmel p13-14 L32-9).*

> *...in general we have low use of epidurals particularly, and I presume a lot of that is from the women. ...Yeah they know they're available. Certainly our education promotes low use of them so I'm not sure which is the most influential at that point (Anne p23 L1-9).*

An Irish study examined the influence of midwives' approaches on the care given to women for pain relief in labour and found midwives' approaches to pain relief differed (McCrea, Wright & Murphy-Black, 1998). In the middle of the two extremes of the midwife acting as the 'cold professional' and 'a disorganised carer' was the 'warm professional', whose approach had a positive influence on women's experiences of labour pain (McCrea et al., 1998). The warm professional stayed close to the woman and her support people offering words of encouragement and support to them, even if the support people were active in the woman's care. This continued support was valued by the women in the study, one of whom commented 'I couldn't have gone through the pain without the midwife being there for me' (McCrea et al., 1998, p.178). McCrea et al. (1998) identified continued support as being the essence of being a midwife. In the current study, the continued support of a known midwife throughout each woman's labour may contribute to the low use of analgesia amongst this group of women.

A study undertaken to determine the expectations of childbirth of 825 women (Green et al., 1990) found that most women expected birth to be a fulfilling experience, with women in low socioeconomic groups being most sure of this. While this was not an overt outcome of the current study, it could be deemed implicit in the comments from the data such as that from Lisa, Jane and Carmel as above. This issue requires further investigation.

The midwives in the present study noticed that this group of women required less intervention in labour than more affluent women. There is much evidence to support the stance that total midwifery care is associated with a reduction in a range of adverse psychosocial outcomes in pregnancy, and with reductions in the use of labour augmentation, regional analgesia/anaesthesia, operative vaginal delivery and episiotomy (Enkin et al., 1995). One example of this is a study comparing caseload midwifery care to traditional 'shared care' which found that caseload midwifery care resulted in 95 percent of women having a midwife known to them care for them during labour and birth and that this appeared to be associated with a reduction in the amount of syntocinon augmentation and epidural anaesthesia used during labour (The North Staffordshire Changing Childbirth Research Team, 2000).

The National Health Committee (1999) found significant differences in the use of epidural pain relief among different ethnic and socioeconomic groups in New Zealand, with Maori and Pacific Island women have almost half the epidural use on both counts. The age-adjusted caesarian section rates also show a correlation with socioeconomic status, with the lowest rates occurring amongst the least advantaged, as measured by the NZDep96 index score (National Health Committee, 1999).

Haire and Elsberry (1991) report the maternal and infant outcomes of a maternity service in the Bronx, New York catering for an unselected population of disadvantaged women of whom 70 percent were considered to be at risk or high risk. In the service, midwives were the primary care providers for all low risk women, carrying their own caseload of women and caring for all women who gave birth spontaneously and the care of women considered to be high risk (up to 70 percent of the women in the service) was co-managed between the midwives and attending obstetricians (Haire & Elsberry,

1991). Of the 3287 women in the year studied, 86.1 percent gave birth spontaneously. The caesarian section rate was 11.8 percent and the instrumental delivery rate was 0.3 percent (Haire & Elsberry, 1991). Minimal use of pain relieving drugs ensured that only a small number of the women required augmentation of their labour (6.4 percent) and shoulder dystocia was rare (Haire & Elsberry, 1991). Haire and Elsberry (1991) conclude that these results suggest the maternity care of both high and low risk women could be improved by minimising obstetric intervention whenever possible.

Another reason the midwives gave for the women requiring less intervention was the woman's other children in that being concerned about their other children's welfare meant that often women just wanted to get the labour and delivery over to enable them to return to the other children as soon as possible.

> *Or in the case of women who were on their own, their mind was often 'I must get back to the kids'.... They were preoccupied and they knew that labour was going to be painful (Jane p4 L17-21).*

That women in lower socioeconomic groups have less labour and birth intervention is supported by the data derived from midwives in the current study.

6.3.8 Having a variety of birth outcomes

According to current literature, in New Zealand, Maori and Pacific Island women, and European women living in similar areas to those in which this study took place, are far more likely to have a normal birth with less labour intervention than more affluent women (Guilliland, 2001; Langdon, 1999; National Health Committee, 1999). Having more women give birth normally is the experience of the midwives in the current study

> *We have a high normal birth rate, a very high normal birth rate, and a low caesarian section rate. I don't know if that's anything to do with our care particularly. I think nationally that's what the statistics say for low-income women, so I'm not sure what the impact is (Anne p26 L25-29).*

Carmel believes that the women she works with have more realistic expectations of labour and delivery due to the education they have received from her during their pregnancy.

> *I talk to women about [labour pain]. I never make out they're going to have a painless labour...I just say it's not possible and [that] I've never actually seen it. We do talk to them lots about what happens in labour and what happens in the couple of weeks before labour, so I try to*

prepare [them] for pain well before labour starts. And I just try and sort of explain what their bodies are trying to do (Carmel p14 L14-24).

Jane thinks some of the reason for women trusting their bodies and therefore having better birth outcomes is because they haven't received the antenatal education that other women have.

...I think part of the reason is they tend not to, and again I'm generalizing here, they tend not to read the latest books, sit in the antenatal education [classes]...(Jane p4 L8-10).

Lisa feels the women she works with have better outcomes due to being well supported to stay at home during labour and therefore not arriving in delivery suite until well established in labour and not requesting an epidural.

...I never have people in hospital for ages. Four hours is the ideal thank you very much. ...I mean people do have epidurals of course, there's going to be the odd one that has an epidural but they're not there having an epidural because they've gone to hospital too soon...(Lisa p16 L1-10).

One issue that arose from the data was Anne's belief that there are more infant deaths amongst this group of women.

I guess the other thing about working with those women is that there are a lot of deaths around of children, deaths which are not particularly necessarily birth related, but cot deaths and babies with meningitis...infant deaths around the family. And people – the women and families – seem to be very accepting of them at times, but they are still very distressing for them, for us. I find cot deaths just incredibly distressing (Anne p26-27 L33-10).

Anne believed that more affluent women didn't have these types of outcomes.

I also think that other women don't have the same kind of outcomes in their family to the same degree. ... Yeah, amongst our population...I feel like every month we hear of another baby that's died (Anne p28 L19-28).

When the midwife heard about the death of a baby, having already built up a relationship with the woman often meant becoming involved with the woman again to offer support.

Yes, yes, I would and do hear of them usually...so usually a group of people would be involved with the woman afterwards. Often the midwife is the person with the strongest relationship, so it's often attending the funeral and keeping contact afterwards. ...and usually it's beyond that [the six week check] actually (Anne p27 L21-30).

While Anne's concern about the apparent high number of infant deaths amongst this group of women was not mentioned by any of the other midwife participants, it was felt by the researcher to be an issue warranting further investigation. In a study of the most current Ministry of Health data related to NZ birth outcomes, Guilliland (2001) found perinatal mortality rates have dropped overall and that the 1998 and provisional 1999 figures are the lowest ever recorded. Maori women more than any other ethnic group, were more likely to have a live born baby and Pacific Island women the least (Guilliland, 2001). While Guilliland (2001) appears to attribute the improvement in Maori perinatal mortality to Maori women being more likely to have a midwife LMC, further analysis of reasons for the Pacific Island perinatal mortality rate is required to see if they validate Anne's claims, especially given that Maori and Pacific Island women also have the lowest rates of instrumental and caesarian births.

6.4 Providing postnatal care

A NZ study exploring the formal and informal support made available to first-time mothers found that support services perceived as being the most helpful were those that offered women social and emotional support, practical help and information and advice (Hendricks, 1999). Partners, grandmothers and midwives were those singled out by the women as providing this all-encompassing support (Hendricks, 1999) although the support of the woman's mother has been found to decline generally over the first year following birth (Oakley, Hickey & Rigby, 1994). Midwives assumed a significant role, having a big impact on the women's lives as they helped the women during the transition to their new role as mothers, and with their influence extending beyond the period during which they had personal contact with the women they assisted (Hendricks, 1999). Midwives emphasized to women that they were just a phonecall away being available day or night (Hendricks, 1999). Women in Hendricks' (1999) study reported how there was often a feeling of sadness when the midwife's visits stopped especially if the woman and the midwife had developed a good relationship.

All the midwives in the current study provided postnatal visits to the woman and her newborn baby up until four to six weeks postnatally. The midwives provided the woman and her baby with what they considered to be standard postnatal care followed

by referral of the baby on to a well child provider at the completion of the visiting period.

6.4.1 Providing 'standard' unique postnatal care

While the midwives spoke of the postnatal care they provided as being standard care, it became apparent from analysis of the data that the postnatal care they provided was unique to this group of women.

The midwives visited the woman and her baby regularly during the postnatal period. This included visiting women and their babies if they remained in hospital for a period postnatally, and home visiting once they returned home. The midwives assessed how the woman was physically, as well as how she and others within the household were coping with the new baby. Ensuring the baby's needs were being met was essential.

> *...postnatally...if they've decided to stay in hospital, we would see them for the first two days in there and we would see how they're actually doing physically and how baby is doing and would follow up what needs to be done from there. Then she'll go home and we will generally visit them every day and do a PKU [Guthrie Test] on day four and make sure the baby's had a hip check. Making sure that the other children are coping with this new baby as well, and that she's eating well. I'm checking the fundus and checking her lochia, checking the breast feeding, if she's not breast feeding, [checking] that she's got money for formula, that she's got clothes for that baby and probably weighing the baby on day six or day seven, and then I would see them maybe once or twice in the second week and then weekly until they get to four weeks, then everything going well we would hand them over [to a child health provider] (Rose p30 L11-28).*

> *Well usually I see most women every day during the first week. Really to help with breast feeding and obviously just keeping an eye on her and the baby and making sure that the baby is physically well and just encouraging family members to get to know the baby. Again I just go over things that people want to know....Very early on I talk about the positioning of the baby, and talk about layers of clothes that you can take on or off. Antenatally often if there's someone in the house that's smoking we'll talk quite extensively probably about [that]. So I would reinforce that postnatally. So yes it's really just supporting the woman with her breast feeding and asking her about her lochia, and pain if she had stitches, talking about hygiene and things (Carmel p16-17 L24-6).*

Section 51 (HFA, 1998) stipulates that it is expected that women will receive between five and ten midwifery home visits within the first six postnatal weeks, and more if

clinically indicated. The recent review of maternity services in New Zealand (National Health Committee, 1999) reported that 59 percent of women received between six and ten home midwife visits in the first six postnatal weeks, seven percent received over ten and 34 percent received five or less visits. Overall, 29 percent of the women surveyed would have liked more postnatal visits and of these women, 75 percent had received less than five visits (National Health Committee, 1999). These figures show a considerable variation between midwives. The results of a postnatal home visiting postal survey carried out in England (Garcia, Renfrew & Marchant, 1994) showed that most National Health Service districts had changed from a traditional policy of daily home visits up to the tenth postnatal day, to one of selective home visits by midwives. The researchers point out however, that questions remain as to how midwives decide whether to make a home visit to a particular mother and baby could be beneficial or not (Garcia et al., 1994).

One Scottish study which aimed to determine what factors affect the time that midwives working in the community spent on each individual postnatal visit, found the average length of a postnatal visit to be 24.2 minutes with a range of between four to ninety minutes (Marsh & Sargent, 1991). Data analysis also determined that visits undertaken where the midwife and woman are familiar with one another are shorter (Marsh & Sargent, 1991). Factors found to be significantly associated with the length of visits included time consuming procedures such as physical examination of the mother or baby and PKU testing; administration related factors e.g. the number of other visits the midwife had to make that day, the need to liase with other people or agencies, whether the mother was unknown to the midwife and the time kept waiting at the woman's house; feeding related factors such as the existence of feeding problems and whether the mother had breastfed before; and delivery related factors e.g. complications during the birth of the baby (Marsh & Sargent, 1991). Marsh and Sargent (1991) found that the lack of support or the presence of health, social or emotional problems were not associated with visits of longer duration.

Laryea (1995) examined the similarities and differences in the views of motherhood of midwives and new mothers. Data from the study suggested that midwives and new mothers use fundamentally different perspectives in defining the meaning of motherhood, with midwives emphasizing the biological and medical aspects of

motherhood as reflected by ensuring the woman was in good physical condition postnatally to care for her new baby, whereas for the woman, the main emphasis was on the emotional impact of childbirth and acquisition of a new social role (Laryea). The midwives' perspectives were missing the social perspective of motherhood, yet the women were stressing the social aspect (Laryea, 1995). Feelings of conflict, frustration and tension arose therefore because the women's expectations were not achieved and their needs not fully met by the midwives. Laryea (1995) concluded from the study that for assessment and evaluation of maternal needs to be of benefit, both the woman and the midwife need to be involved in the process taking into account how the woman sees her own needs.

Ball (1995) explored what effect, if any, current patterns of postnatal care given by midwives have upon women's adjustment to motherhood. One of the main findings from Ball's (1995) study was that the way midwives give care has an effect upon woman's emotional reactions to the changes that follow childbirth, and the best thing midwives can do to help new mothers gain confidence in themselves and their ability to care for their baby is to provide encouragement and praise. For example, women in Ball's (1995) study who were younger and socioeconomically deprived fed their babies in the delivery suite much less frequently than those in other socioeconomic groups because they were generally less articulate and demanding of their wish to feed their baby as soon as possible after the birth. The need for midwives to review current patterns of postnatal care in favour of becoming more flexible is an overriding theme of Ball's (1995) article.

For the midwives in the current study, the postnatal period did not always go smoothly however.

> *Occasionally things turn to custard postnatally and then it takes time (Anne p5 L15-16).*

If the midwife had concerns about either the mother or the baby, she may seek another midwifery opinion prior to deciding a course of action.

> *Sometimes if we're not happy with the baby's progress we'd get another midwife to come in and check it over, get a second opinion, if we had concerns about the baby (Rose p30 L28-31).*

Jane was the only midwife in the study to mention women having a low birth weight baby. Having a growth retarded baby meant that both the woman and baby required extra postnatal care from the midwife.

> *...and obviously a lot of them do have these problems. They're not all in neonates [the neonatal unit] but they still have their problems and you know that is a different kind of midwifery input that you put in there. It's longer, more intensive, and sometimes to the mother who doesn't realise the importance- she's used to having skinny babies. She doesn't realise the importance of keeping the baby not only fed but warm and sometimes this is very difficult if they can't afford heating. And those are the things you come across as well. The baby may be readmitted to hospital through no fault of yours, through not fault of the mother's, but you take it personally. It's a social issue (Jane p20-21 L31-14).*

A low birth weight baby is defined in the literature as a baby weighing less than 2500g, or five and a half pounds at birth (Spencer, 1996; Mutale, Creed, Maresh & Hunt, 1991; Willis & Fullerton, 1991; Rajan & Oakley, 1989; Williams, Dickson, Forbes, McIlwaine & Rosenberg, 1988). Low birth weight babies are more common for women living in areas of high deprivation. That the most socially deprived mothers have the smallest babies is well documented (Wilcox, Smith, Johnson, Maynard & Chilvers, 1995; Kogan, 1995; Read & Stanley, 1993; Willis & Fullerton, 1991). Maternal smoking, low maternal birth weight, lack of education and having a first infant as a teenager are associated with recurrent low birth weight babies (Kogan, 1995; Chadwick, 1994; Read & Stanley, 1993), as are poor diet, drinking alcohol, drug taking (Chadwick, 1994; Willis & Fullerton, 1991; Rajan & Oakley, 1990), low social support (Roberts, 1997; Chadwick, 1994; Mutale et al., 1991) and maternal weight gain (Ahluwalia, Merritt, Beck & Rogers, 2001; Kogan, 1995). Short interpregnancy intervals also increased the possibility of delivering a low birth weight baby (Klerman, Cliver & Goldenberg, 1998; Willis & Fullerton, 1991).

Being of low birth weight is significant because as children low birth weight infants are more likely to have disabilities, hospitalisations, brain damage, poorer language development, be placed in special education classes and display more intellectual impairments (Kogan, 1995; Chadwick, 1994; Willis & Fullerton, 1991). Low birth weight is the most powerful determinant of survival (Spencer, 1996). In the United Kingdom two thirds of low birth weight babies are born to women from working-class homes (Oakley, 1992). Being a low birth weight baby puts the adult at increased risk of

health problems such as adult chronic conditions, ischaemic heart disease and being in the lower socioeconomic classes (Kogan, 1995; Willis & Fullerton, 1991).

The midwives had noticed that this group of women (women living in areas of high deprivation) appeared to breastfeed with minimal difficulty.

> *I do find that these women tend to breastfeed better and longer and more easily than that other [more affluent] women who has much more access to going out and socialising, who needs to have that free time- is much more 'me' orientated (Lisa p11 L29-33).*

This is in contrast to a current study by Barton (2001) who examined infant feeding practices in a rural American population of infants at risk for failure to thrive and found that although at birth 41.2 percent of mothers chose to breastfeed and a further eight percent chose to both breast and formula feed, by one month of age only 29 percent of babies were still breastfeeding.

Why the breastfeeding went so well had been considered by Lisa;

> *I think again it's come down from mother to daughter. I think that there's much less of an expectation that she's going to be going back to work, because she didn't go to work to start with, so that's one of the things. And the other thing is they're much more inclined to breastfeed- unless there's a big difficulty, and then they'll just stick them on a bottle (Lisa p12 L3-10).*

Libbus, Bush and Hockman (1997) researched American primigravid women of low income on their beliefs about breastfeeding. Results showed that immediate family including parents, were the most commonly cited people referred to as approving of the woman's choice to breastfeed (Libbus et al., 1997). The researchers concluded that accurate and positive information and education about breastfeeding must be provided to both women and the key people who influence the women's feeding decisions (Libbus et al., 1997).

From their study of breastfeeding intention among socioeconomically disadvantaged pregnant women Humphreys, Thompson and Miner (1998) recommend the use of lactation consultants and peer counseling as beneficial in improving breastfeeding rates, rather than education conducted by health professionals alone. Kistin, Abramson and Dublin (1994) studied the effect of support from trained peer counselors on breastfeeding initiation, duration and exclusivity among low-income women and found

that women receiving peer counseling had significantly higher rates of these three factors than women who were not in the counseling group. Although a limitation of the study was that the breastfeeding practices of women who received peer counseling were compared with the breastfeeding practices of women who intended to breastfeed and had requested a counselor but were unable to have one due to resource issues, so were therefore a selected group of women, the results of the study have relevance when planning breastfeeding education for women (Kistin et al., 1994). Including the woman's family members in breastfeeding education sessions, ongoing support from trained peer counselors and providing an environment which is consistently supportive of breastfeeding are ways in which health professionals can improve the effectiveness of breastfeeding education (Humphreys et al., 1998; Kistin et al., 1994).

A study of teenage American mothers found that mothers with low socioeconomic status relied on their own mothers for knowledge about infant feeding and that it is normal for babies to be fed cereal in the bottle and other semi-solid foods within the first month of life (Bently, Gavin, Black & Teti, 1999). In nearly all households, grandmothers were found to play the dominant role in deciding when and what the infant should eat (Bently et. al., 1999). While nurses (read midwives) were important to the mother's decision to breastfeed, after the first month their influence dropped off to be replaced by the increased influence of grandmothers (Barton, 2001). Barton (2001) concluded that breastfeeding mothers need additional support to continue breastfeeding beyond one month and that both mothers and grandmothers need education on how to select appropriate solid food for infants and the timing of their introduction for the good health of the infants.

An American study found that provider encouragement significantly increased breastfeeding initiation in populations traditionally less likely to breastfeed (Lu, Lange, Slusser, Hamilton & Halfon, 2001). Also, while 75 percent of women who were encouraged to, initiated breastfeeding, less than 50 percent of women did so without encouragement (Lu et. al., 2001).

Whelan and Lupton (1998) investigated factors which promote or discourage successful breastfeeding in a sample of women with low income. Several implications for improving midwifery practice to promote improved breastfeeding rates among this

group of women arose from the study findings. These were; creating realistic expectations and increasing women's confidence and desire to succeed in breastfeeding, the provision of quality professional advice and support to new mothers and improving the social support networks available to breastfeeding mothers by identifying their key family support person and involving them in late pregnancy discussions on breastfeeding, early postnatal education in latching the baby to the breast and subsequent support sessions in the woman's home (Whelan & Lupton, 1998).

An earlier study of 459 predominantly socially disadvantaged women who participated in a randomised controlled trial of social support in pregnancy (Rajan & Oakley, 1989) found that 38 percent of women randomised to receive social support intervention in addition to standard antenatal care breastfed initially compared to 33 percent of the control group, suggesting that improved social support from health professionals and others in the postnatal period can increase breastfeeding success rates (Rajan & Oakley, 1989).

From the literature it would appear that breastfeeding education and support provided by the midwife and those close to the new mother has a positive effect on the initiation and sustainability of breastfeeding in socioeconomically deprived women. This has implications for the ongoing health of the baby. The importance of involving those closest to the woman in the ongoing care of the new mother and baby, recognised by the midwives in the current study, is further reinforced by the results of an Australian qualitative study which explored the experiences of 55 first-time mothers (Rogan, Shmied, Barclay, Everitt & Wyllie, 1997). A framework emerged from the data enabling predictions of the way individual women are likely to react to early motherhood and therefore provides midwives with indicators of distress in women and families where intervention may be required (Rogan et al., 1997). Rogan et al. (1997) caution against midwives becoming preoccupied with the individual woman at the expense of not acknowledging the woman's social context, as this has the potential to prevent full understanding of the woman's problems and therefore limits the assistance provided by the midwife to the woman in adjusting to new motherhood.

Ensuring women had access to the contraception of their choice was part of the midwife's role and an important aspect of the care the midwives provided postnatally.

For midwives working with this group of women, this sometimes meant transporting women to the medical centre or the local Family Planning clinic to ensure this occurred. Some of the midwives also undertook cervical smear taking, knowing that if they did not do this opportunistically, the woman may not have this screening done for an extended period.

> *...we look after our women in our practice till the end of six weeks. So they get on an average 12 postnatal visits, which means they get for the first week between five and seven, and from there on they get whatever is needed, but usually about one a week. And then you know things like smears...are always done for them because they won't go to the doctor. ...arranging for follow up with Family Planning for intrauterine contraceptive devices...is all quite important and really significant for women who have got six children.... ...so it's getting them off to those sort of appointments. It's quite tricky (Lisa p14 L12-30).*

The significance of ensuring appropriate contraception is commenced by women during the postnatal period is born out in an American based study undertaken by Radecki (1991) who surveyed low-income women on their pregnancy history, attitudes to fertility and contraceptive use. Analysis of the data showed that there is an increase in nonuse of contraception due to perceived health dangers between first and subsequent pregnancies, highlighting the need to reinforce contraceptive information long after the initial use of a particular contraceptive method (Radecki, 1991). Killion (1998) emphasises the need for health professionals going beyond just providing information to women about how to use the various contraceptive methods available, to ensuring there is some fit between the method used and the life circumstances of the woman. If the method chosen is to be effective it must be free of side effects, easy to use and acceptable to a cooperative partner (Killion, 1998). A recent Danish study found that short interpregnancy intervals were associated with women of low socioeconomic status and they suggest that the short interpregnancy interval is a marker of poor reproductive outcome (Kaharuza, Sabroe & Basso, 2001).

Midwives in the current study considered the postnatal care they provided to be standard postnatal care.

> *...I guess it's just the standard sort of care. ...often they're getting really good support from their family- the ones that have got good family around. So in some ways they actually get better support from their family than middle class women.... But just being careful with the*

explanations. That they really understand what you're doing and why you're doing it (Theresa p7 L18-26).

While the midwives considered the care they provided to these women to be standard postnatal care, it was apparent from the data obtained from the midwives, as illustrated in the midwives' words above, that many features of the postnatal care they provided to women and their families were in fact unique. Another example from Lisa gives further weight to this.

With these women, I visit frequently in the first weeks. If there's not much whanau [family] support or family support I will take in meals. That's part of the thing that I do, and especially in the winter when it's really cold and miserable and there's not quite enough heating...then I will nearly always take them in soup. ...I do feel it's important that the mother is nourished (Lisa p11 L17-27).

Although making and taking meals to women is not normally considered to be part of the midwife's role, this was something Lisa did if she identified a need for this in the women with whom she worked.

...I suppose it's a bit old fashioned but if they eat well, and they rest well, then they do breast feed well (Lisa p11 L27-29).

Lisa considers providing the family with meals to be a normal part of the postnatal care provided to this particular group of women. Leap, (1991) one of a group of five midwives practising in an area of South East London, describes how one way of responding to the needs of the local community may mean the midwives expanding their role to include bringing in food, taking home washing, doing the housework and childcare for the women they attend in the early postnatal days if support for the woman is limited.

Jane, one of the midwives in the current study, also mentions helping with the housework when a woman is unsupported.

...and you get the hoover out and you do it, which I would normally not do, but what can you do when the woman is alone? In fact I do not see it as the role of a professional person. I also do not believe it is good business sense, but I do believe it is part of caring (Jane p12 L16-20).

Women who had been transferred to the hospital secondary care clinic during the pregnancy were often transferred back to these midwives for their postnatal care.

6.4.2 Picking up women again postnatally

The midwives usually took the woman's care back from the hospital secondary care team postnatally, becoming her LMC again. This was to provide some form of continuity and to ensure the woman received quality care.

> *Normally we would pick them up again postnatally because the hospital has no interest in them at that point. It's not lucrative enough (Anne p47 L23-25).*

> *I still feel that they need some degree of continuity. So sometimes I will [pick them up postnatally] actually (Linda p20 L4-5).*

> *...I find they've monitored her in the pregnancy, and they've done labour, then they come back to us, but she's still needing so much care. ...I don't find that fits properly with secondary care. ... So if you look at that properly they should be looking after the whole process (Rose p28-29 L21-6).*

By providing good postnatal care the midwives hoped to somehow compensate the women for the lack of continuity of care they had received from the secondary care team. Being forced to hand over the midwifery care of these women to the secondary clinic team hospital midwives, and therefore forgo their official professional midwifery involvement with these women, was difficult for the midwives in this study to resolve both professionally and personally.

6.4.3 Referring to a well child provider

The midwives referred the baby on to a well child provider, usually the Plunket Nurse or to Whanau Hauora, an alternative service which specifically targets Maori, towards the end of their period of regular postnatal visits. The well child provider will assess the child regularly during the first five years of its life to ensure physical and developmental milestones are being reached and to give support and information to the child's mother regarding child health issues. The woman usually returns to her general practitioner for any medical requirements she and/or her child may require.

> *I tend to see them more intensively up till four weeks. At about [the] three to four week mark I'll send a Plunket referral off, saying that my last visit is at six weeks. ...I'll go to their six week check and they've seen the Plunket nurse three days before or she's coming that week. So I like to know that when I go for that six-week check that they've had contact with the Plunket nurse, so I feel that there's been more seamless care (Linda p22 L14-25).*

Sometimes however, the midwives continued to see women once the six-week postnatal period had ended.

6.4.4 Having long term contact with her

All the midwives in the study endeavored to see the woman and her baby regularly for up to six weeks postnatally. Occasionally however, the midwife would find it difficult to end the relationship at six weeks postnatally for a variety of reasons. Usually these women and/or babies had complicated maternity or social circumstances in some way and the midwife worried about how they would get on once her involvement had ceased.

> *...there is certainly one or two women who I found extremely hard to discharge. Like I had one woman who I looked after for...months postnatally, because I couldn't, because her situation was so terrible that I couldn't stop looking after her. And I tried very hard to link her into other services and was unable to, just because she refused to. And I couldn't, I just couldn't not see her, but I carried on seeing her every week or two for...months, because, because there was no where else for her to go (Anne p16-17 L19-5).*

> *...afterwards with the babies – IUGR [intra uterine growth retardation] or anything like this, they [the women] miss all that support that you are carrying on with too [once the midwife stops visiting postnatally] (Jane p20 L29-31).*

> *...I had one woman who had a really bad haemorrhage and she nearly lost her uterus. We talked about contraception but her and her partner wouldn't acknowledge it even though I said how serious it was, they were still reluctant to use contraception.... And you think 'golly, if she gets pregnant again...' (Theresa p12 L8-18).*

The ongoing needs of her midwifery practice and current caseload of women soon ensured that the midwife was unable to continue with the intensity of her concern for those she had previously discharged from her care. This did not stop the midwife from thinking about these women from time to time. Occasionally they did see them.

> *And I think probably the thing that stopped it wasn't my good sense or good management, it's to do with I got very busy and then I went on holiday and it lapsed. And I still do see her occasionally socially, but yes I have stopped doing regular postnatal visits (Anne p17 L16-21).*

> *...it's really a time and workload thing that doesn't allow me to go and see them. From time to time, I'll occasionally see people but I don't go out of my way because I'm busy enough without that. I mean I'd like to.*

In the ideal situation I'd like to do that, but it's just not feasible (Carmel p26-27 L32-4).

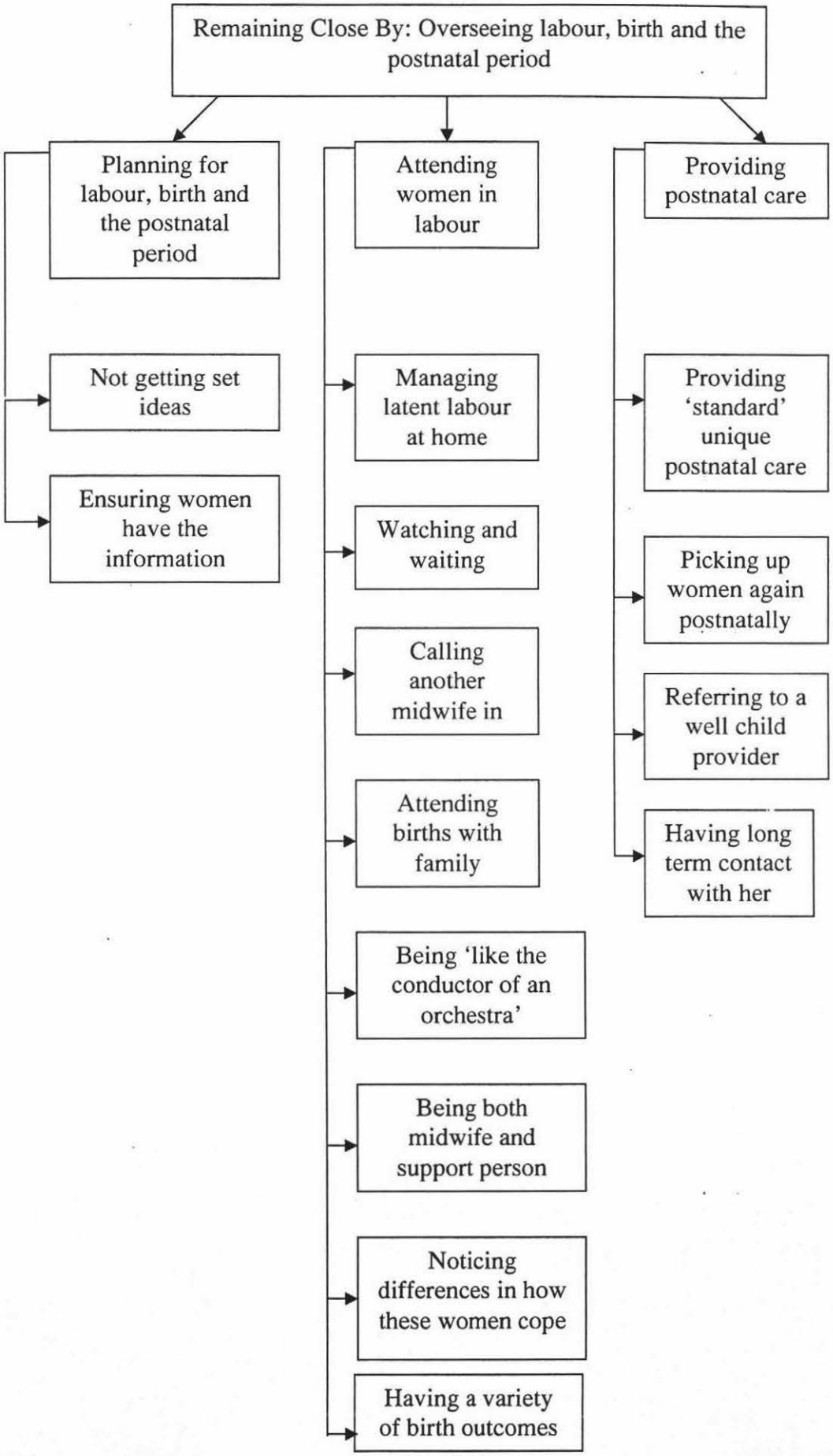
I really push the coffee morning at their six-week check. I'm like 'oh don't forget to come to our coffee morning' and I always remind them of the date and 'mark it on your calendar' because I like that. I like seeing women at six months down the track and knowing that maybe they're still breastfeeding and seeing how they're getting on with motherhood. And on occasion I've driven past and popped in and said 'hello' and seen their baby. Curiosity's got the better of me (Linda p23 L4-13).

The relationship formed between the woman and the midwife, by the necessity of it being a professional relationship and the midwife's ongoing workload of women, did have a finishing point. While the midwives at times found this difficult, this was recognised as being part of working as a midwife choosing midwifery as a profession.

6.5 Summary

This chapter has introduced the category of 'Remaining Close By' to describe the process by which midwives oversee labour, birth and the postnatal period. Throughout the preparation for the woman's labour, birth and postnatal period, during the process of the labour and birth itself and for the first four to six weeks postnatally, the midwives remain close by the woman, being either physically near her or readily available by telephone during this time. Working with the woman's family to enable them to actively support the woman and stepping back from this role themselves, was seen by the midwives as crucial. Remaining close by allows the midwife to keep a watchful eye on the woman and her unborn/newborn baby while letting the woman utilise her family support network, stepping in if this is not visible, not interfering while all is progressing normally, giving suggestions if required. In order to be effective in remaining close by women, the midwives need to ensure they are coping personally with the various aspects of working with this group of women. How midwives cope personally is the focus of the next chapter.

Figure 6-1 Remaining Close By: Overseeing labour, birth and the postnatal period.



Chapter 7: Ensuring Personal Coping

7.1 Introduction

In this chapter, how midwives cope personally with working with women living in areas of high deprivation is introduced. The category of 'Ensuring Personal Coping' emerged from the data collected and is concerned with how the midwives ensured they coped personally with working with this group of women. It was necessary for the midwife to ensure she was caring for herself if she was to be effectively caring for the unique needs of this group of women. 'Ensuring Personal Coping' is made up of the sub categories 'evaluating effectiveness of the midwifery care', 'coping personally day to day', 'ensuring personal physical safety' and 'working with the frustrations'. Each of these sub categories are defined and discussed in view of their properties, conditions, strategies and consequences, for example; as a consequence of the property 'finding the women have different expectations' of midwifery care compared to other more affluent women, the midwives are able to evaluate the effectiveness of their midwifery care- a sub category which together with the other sub categories form the category of 'Ensuring Personal Coping'. The theoretical linkages by which the category of 'Ensuring Personal Coping' is linked with the other categories developed from the study's data analysis are detailed. Figure 7-1 provides a diagrammatic representation of the properties and sub categories which together make up the category of 'Ensuring Personal Coping'.

7.2 Evaluating effectiveness of the midwifery care

For most of the midwives involved in the study, the majority of their midwifery caseload was made up of women living in areas of high deprivation. Choosing to work specifically with these women had been a conscious decision on the midwives' part.

> *I didn't end up working in the area by accident. It was an active choice for me to work where I work and to work with these women (Anne p9 L22-25).*

Establishing whether the care the midwives provided to this group of women was effective or not was important to the midwives as they attempted to establish if their

care made any difference to the women. Trying to articulate the effectiveness of the midwifery care provided was not easy.

7.2.1 Finding the women have different expectations

Describing what it was really like to work with these women was hard for the midwives to put into words. Sometimes the midwives compared working with these women to working with their more affluent counterparts in an attempt to decide.

> *It's different, it's different and in many ways it's easier. ...I think their demands, their needs, are different, but their [this group of women] demand isn't as great, so probably it balances itself out (Jane p13-14 L23-5).*

> *They're easier in some ways and they can be really easy if you wanted to be lazy. You could just breeze in and out because that's all they expect. But if you go deeper they can be harder (Theresa p16 L5-11).*

> *Sometimes they're easier in the sense that they don't have the middle class expectations of you. They don't expect you to be their best friend. I think there's that. I think there's clearer role division. You're there to do something for them. You're there for a professional relationship and they may thank you and enjoy seeing you, but they don't say 'come back in a month and have a coffee' or those types of things that a more upper middle class woman may expect from the relationship with you (Linda p40 L14-23).*

> *...and I like the women and I think it's really easy to make it sound like they're really really really hard, and in a way they're not, cause often they're really straight talking, and they often have really good priorities. To me they have their life so much more. They're not nearly as precious as a lot of all the more educated women...and the difficulties all make sense to me. You know, there are very clear and concrete difficulties. So there's things that are easier and things that are harder. But I like them (Anne p37-38 L20-2).*

The midwives spoke about how they found looking after women living in areas of high deprivation to be different from looking after other, more affluent women. Some aspects of providing the midwifery care the midwives looked upon as being more difficult, while other aspects were seen as being easier. As summed up by Lisa

> *And you know what the differences here are that one has plenty and wants more and the other one is accepting of her status quo and gets on with it, and does her best. ...There's a different type of looking after. I don't think that they're easier, unless you took the easy options out and didn't do anything for them. But I mean they're less...whingey. ...affluent women often look for a problem about which they can be important,*

whereas...people in that...lower socioeconomic group tend to just sort of say 'oh, well that's the way it is' don't they (Lisa p9 L3-31).

The midwives consistently expressed enjoyment in working with these women.

I like looking after them and that made it [working with the women] easier (Jane p14 L2-3).

...I really enjoy the care, I do enjoy the women (Theresa p17 L4).

Yes it's lovely. I love it (Lisa p23 L14).

I would like to think well it's part of the care. Caring I think should be a central focus and that's why I look after these women –the concept of caring, to care for women (Jane p7 L22-26).

The enjoyment the midwives found working with these women helped to offset the more difficult elements of providing the women with care which were discussed in Chapters Four, Five and Six.

7.2.2 Giving 'care that the women like'

The effectiveness of the care was judged by the midwives in a number of ways. All the midwives believed that the women were generally happy with the midwifery care they had received.

...I go with what women are telling me and the fact is that we do have a high number of women that return to us, so that's my way of determining whether the care is effective or not, because if it's not then they're not going to come back (Carmel p28 L13-17).

I think it is care that the women like and that's shown in that, they come back to us again and again. And I think the kind of women we look after often do vote with their feet, so if they don't like the care they don't tell you but they just, they're not around next time or they don't turn up for appointments (Anne p29 L11-16).

I survey all my women afterwards and some of the most wonderful appreciative survey feedback that I've had has been from [these] women...and it's been lovely (Linda p46 L4-8).

This group of women's expectations of midwifery care were seen by the midwives as being minimal. The women expected very little from their involvement with the midwives so therefore anything that was provided was considered a bonus.

...they're very appreciative of anything you do and if you do something extra, they don't expect it and...so compared to the other group of [more

affluent] women who are expecting more and more and more from you, these women are not expecting a lot from you and so everything you do is appreciated. So that's nice (Theresa p17 L20-26).

Having women return to the midwife for midwifery care during subsequent pregnancies and feeling the care they provided was appreciated by the women, were the main indicators midwives used to determine the effectiveness of their care.

I think they certainly spread the word. If you've done a good job with them then they certainly [say] 'oh you know she's good, she looked after me' (Theresa p19 L30-32).

In trying to ascertain the effectiveness of the care provided, the midwives also spent time reflecting on how worthwhile they considered their involvement with the women to be.

7.2.3 Making sense

The midwives indicated that in order to cope personally with working with these women they had to decide whether their involvement with the women had in any way made a difference to how the woman's pregnancy and childbirth experience had been-whether they felt the women would consider the midwives' involvement to be in any way of value and/or worthwhile to the women.

...what I have perhaps made them do is think that they perhaps shouldn't smoke quite as much, that they do need to feed their kids a bit more fruit and veges, and that they know that they can actually access somebody if they need somebody because I'm there and if I can't answer the questions or do something then we can get it to somebody else. And that they've made a relationship with me that's comfortable, so in that respect it's good. But in the wholeness of the whole thing I as one individual can't make a huge difference (Lisa p23-24 L24-1).

So you learn to know that you are there for just a short period of their life. You do what you can and that is all you can do (Jane p7 L2-5).

I don't think there's anything exceptional, because I think that, it's hard to think about what you actually do half the time, because you just do it. ...But I know what I do and I know what we're doing and generally we know our limit (Rose p33 L1-8).

It was important for the midwives to come to some personal justification that their involvement in these women's lives was worthwhile, otherwise they risked being

overwhelmed with the enormity of the issues they came across during their day to day interactions with the women.

> *...the time you spend worrying about those women is non productive time because you don't actually achieve anything in it, but the feeling of helplessness and how futile it is because you go away from those situations of...a woman who has a totally bare house with a bed in it, and she's just had a child and...we've got things for the baby through the local community house, and she goes there and gets food parcels but she's totally isolated. She's crying a lot when you go there and every time I leave her it's like a weight that I'm leaving something behind that I shouldn't (Anne p7 L4-17).*

> *...really why should they be deprived you know, so you sort of want better things for them. I don't know that that helps you to cope but that's the way you work your way around it (Jane p15 L18-21).*

The midwives were aware that other midwives sometimes refused to provide care for this group of women, or otherwise, initially took them on as part of their caseload, found them too difficult because of the time these women required, and so then found a reason to refer them on to an obstetrician.

> *You see this with midwives who either won't look after these women or who just see them, get angry with them and get rid of them off their books just as quick as they can because they're in to take the blood pressure, feel the palp [palpate the woman's abdomen], tell them the baby's too small, send them off to the doctor and out the door. [They] don't really want to be there. ... They just wouldn't [want to look after these women]..... ...A lot of the work that I did was with these women because somebody had to do it. ...They [the other midwives] are not about to go out and look for things, to help them through (Jane p21-22 L25-18).*

> *Well I guess they [the other midwives] just feel uncomfortable with that [looking after this group of women]. It's out of their comfort zone. And I guess that's fine because if they're not comfortable then they're not going to be providing the right care. It's not a bad thing. It would be uncomfortable for both parties (Theresa p19 L8-12).*

> *And I think that you have to have an acceptance that you're not going to change the world, but that you may be able to make a little bit of a shift and a dent in it. ...And I think that as a midwife you bring to these people's lives something that's a little bit different from what they've had before, and it's something that's probably warmer and fuzzier and nicer and more comfortable, and more accepting of them and their role as women, and mothers (Lisa p24 L17-30).*

The midwives found it was crucial to make sense in some way of the time and effort they put into their work if they were to continue practicing as they did.

7.3 Coping personally day to day

While enjoying working with the women and believing they gave care these women liked, all the midwives found working with these women demanding at times.

> *It can be frustrating can't it because you're not going to be able to change their life circumstances really. You can't change where they are. You can't improve their financial things or whatever... (Theresa p15 L26-29).*

> *Sometimes I find it's all quite demanding you know I mean at this stage in my practice I'm actually a bit tired... (Lisa p28 L14-16).*

> *But no you can't worry about them because, God, if you worried for all of them you'd go mad (Jane p7 L9-11).*

And again from Jane

> *...I suppose the more I think about it, they are difficult to look after in a time consuming sense, definitely in time, definitely in time (Jane p23 L6-8).*

> *...it's quite wearying on you, like you're looking after yourself, but these are such needy, needy women (Rose p7 L26-28).*

> *But it is difficult especially if I have things that I want to do and there's a woman...who wants me to do something for her. If I weigh up her needs against my needs, her needs are always going to be more. So, I want to go home and go to the gym, is trivial compared to the fact that there is a woman with a three-week-old baby who is totally desperate and in tears. So they always are more important, so I think it's very very easy to give more and more and more of yourself and have less and less left over, because the need seems so huge (Anne p7-8 L31-6).*

In order to be able to continue to function effectively and to continue giving optimal care to the women, the midwives needed to find ways of personally coping with the demands of the job. Midwives varied in what they did for themselves specifically to enable them to cope with working with these women on a regular basis. Working in a team was one strategy the midwives indicated they used to cope personally day to day. This strategy and others that midwives use are the subject of the two sections that follow.

7.3.1 Working in a team

None of the midwives worked alone. Each midwife was a member of a midwifery group consisting of two to four midwives. The midwifery group members all worked in the area in which the research study was undertaken. While being a member of a group, each midwife was responsible for providing midwifery care to her own caseload of women. Being a group member enabled the midwives to have midwifery cover/back up for amongst other things, long or complicated labours, time off call, holidays, days off, sick leave and study leave. While having named midwifery back up was one of the conditions of being granted a contract to access the local maternity facilities, the midwives cited many other reasons for working as part of a group. The group relationships enabled the midwife to be supported in her practice, and indeed, to survive working the long hours with the 24-hour call, which was part of providing total midwifery care to women.

Having the support of midwifery colleagues in the team was essential for discussing ideas with, for planning and managing care of the women and for off-loading stressful or upsetting events.

> *I work in a really supportive team of...the midwives that I work with.... ... But actually just being able to share it and go back to my colleagues and kind of talk about it can put some perspective on it for me. That's probably one thing working in this sort of team (Anne p8 L11-29).*

> *I think talking about it with other midwives. I think you have to do that, have some support... (Jane p15 L16-17).*

> *I have a colleague that I see...most days of the week who I run decisions by. ... Just through things like clearing out mail together and chatting together about births and decisions (Linda p35 L23-30).*

> *...you just talk to your midwifery partners for support (Theresa p15 L30).*

Sometimes however, group midwifery colleagues were not available to talk to. When this happened, midwives had to look at other ways of coping.

> *I think mainly just talking to colleagues especially when you've had a difficult birth and just talking really. ...But yeah it is quite hard, especially because I live on my own. So you take the stuff home. It is always there. You can't always talk about it to people so you take it home (Carmel p21 L25-32).*

> *I get a bit tired (laughs). ...I grizzle (laughs) (Lisa p12 L24-28).*

...having a good relationship with the hospital staff helps. It's just someone else to unload to as the day goes on (Anne p8 L31-33).

If I've been at a long birth, I usually like lots of sleep! I don't like being tired so usually I can generally hand my calls over until I feel I've had enough sleep (Rose p31 L22-25).

One feature which was essential to enable the midwife to sustain her practice and prevent burnout, was to have regular time off call.

Well we have a roster between the midwives I work with. So like today for instance, is my rostered day off, but if one of my women goes into labour, unless I said that I was actually physically going away...then I would be called. ...we've always tried to take probably two months a year [holiday], sometimes three months depending really, though we'd only ever take a month at a time. I think if you take less than that it's not that worthwhile, although sometimes in between those two month periods we might take a short week, or we might take a long weekend or something like that (Carmel p22-23 L4-28).

I have alternate weekends off, with a colleague and I wouldn't do this job if I couldn't have that (Linda p36 L19-21).

[Holidays are] very very important! I find my holidays are when I catch up with family and friends, because I don't generally do that until I go on holiday. Then I feel that I can actually think about doing things like that. ...We have about eight weeks a year. ...Plus just regularly having a few hours break (Rose p32 L1-13).

Working as part of a midwifery group and having regular time off call, were positive strategies midwives used to maintain their health and prevent burnout. A study drawing on data from a survey of a 5 percent random sample of midwives in England found that reported burnout and distress was higher for midwives working in teams providing midwife led care (Sandall, 1999). This was because midwives who worked in teams had less control over their decision making and work pattern and worked longer hours than midwives who work shifts in hospitals (Sandall, 1999). Midwives who work on call and flexible hours are therefore more likely to suffer from burnout (Sandall, 1999). These results are supported by an earlier UK study which evaluated the satisfaction of team midwives compared with their hospital based colleagues and their views about working practices and care provided (Todd, Farquhar & Camilleri-Ferrante, 1998). Todd et al. (1998) found that community midwives disliked the long on-call, working unsociable hours and the disruption to family and social life. Another study based on Dutch community midwives (Bakker, Groenewegen, Jabaaij, Meijer, Sixma & de Veer, 1996)

disputes these findings, instead reporting that personal resources such as social support and coping style, seemed to play an important role in whether the midwife developed symptoms of burnout, showing that burnout depends not only on workload, but also on the individual midwife's ability to handle stressful situations. Bakker et al. (1996) recommend that the importance of developing social support networks and an active coping style be a more explicit part of the midwife's education to enable midwives to become better able to cope with the stressful situations in their job.

Rolston (1999), a New Zealand midwife, explored burnout and the steps taken by five independent midwives to cope with this syndrome. Each of the midwives identified the need to have good strategies in place for coping and stress management, including offering continuity of care rather than carer, working in teams with some case loading to allow the flexibility to work safely with some continuity of care, the use of telepaging and rostered routines. Rolston (1999) summarizes that independent midwives who use the continuity of care model are at risk of burnout unless they put strategies in place to reduce the stressors placed on them by the nature of working in the community and within the economic and legal constraints of the midwifery profession. Page, Cooke and Percival (2000) have found peer support at work and emotional and social support at home to be significant factors in reducing stress and preventing burnout. This includes peer review, meeting regularly with colleagues both professionally and socially, regular time off and managerial support (Page, Cooke & Percival, 2000). The midwives in Engel's (2000) study exploring midwives experience of working in a continuity of carer model of midwifery practice, recommended setting boundaries with the women and making sure the women met the back up midwife during the antenatal period to ensure a known midwife at the birth. Practising in this way diminishes the possibility of the woman becoming overdependent on the named midwife (Engel, 2000).

While working as part of a midwifery group and having regular time off call were commonly cited methods for coping personally with working with these women, other strategies were also employed.

7.3.2 Other coping strategies

Some midwives undertook regular exercise. They felt that if they felt fitter, they were more able to cope physically, emotionally and psychologically with the demands of the job.

> *I joined the gym and that's good so the fitter I am the better I deal with my stress and the more energy I have when I look after women, so I've noticed a difference since I've gone back to the gym because I wasn't as energetic (Linda p36 L12-16).*

> *I usually go to the gym, and that's my big thing. I think physical exercise for me is really important and sometimes I just want to walk and walk and walk. I find I can think a lot then (Rose p31 L11-15).*

There were other things the midwives did which, while not applicable to every midwife, are relevant as alternative ways to ensure the midwives' well being and to prevent burnout.

> *I have professional supervision once a month, ...which is very very good. Other than that it's just things you do to try and forget about work when you come home (Anne p8-9 L33-4).*

> *I think spiritually, because of being a Christian, that's a huge factor. I find that a lot of my strength comes from that faith I have to focus on... (Rose p31 L15-18).*

> *We have paid someone to do locums. ...and it worked out well for her because she was earning extra money and it meant that the midwife that was left while I was on holiday only had to look after her own caseload and any urgent labours or any urgent antenatals. ...So it didn't increase her caseload significantly at all, whereas in the past I've been in a team where it was terribly stressful when someone went on holiday (Linda p37-38 L 24-13).*

While the midwives used a variety of strategies to assist them in coping with the demands working with these women brought, what was common to all the midwives was their recognition of how important it was that they take active steps towards safeguarding their own wellbeing. If the midwives wished to ensure their ability to cope with the job on a long-term basis, this was essential. Part of safeguarding their own wellbeing was protecting their own physical safety.

7.4 Protecting personal physical safety

Visiting people in their own homes, whether as a midwife or as personnel from any other agency does have associated physical safety issues. These have long been debated in the literature (Hunt & Martin, 2001; Footner, 1999; Lamplugh 1999). The midwives in this study mostly saw women in the women's homes. This, combined with the factors common to high deprivation areas such as unemployment, gang related issues, violence, alcohol and drug abuse, meant the physical safety risk was relatively high, both for the midwife and for the woman she was visiting.

7.4.1 Trying to keep yourself safe

The midwives were aware of the possibility they may unsuspectingly be putting themselves at risk by visiting women in their own homes, but appeared to accept this as part of the job rather than dwelling on the potential risks involved.

> *But I don't know what else you can do –you try to keep yourself safe but you never know at times when you're going to be in a situation that's going to be unsafe for you or the woman. You can protect yourself to a point (Rose p35 L24-28).*

> *Once or twice [I've felt unsafe] but it's not very often really. ...I don't know why but generally it is all okay (Carmel p25 L7-10).*

> *And also the thing that I did not get used to, was the gang problems that you sometimes came across. I mean you coped with them but it was a bit risky.*
> ***What sort of things?***
> *Sometimes you'd have to go past them all sitting smoking [marijuana] to get to the woman who is in the back room (Jane p16 L25-33).*

There is a lot of literature (Hunt & Martin, 2001; Footner, 1999; Lamplugh 1999) pertaining to the risks to personal safety that health professionals are potentially exposing themselves to, when visiting homes in the community alone.

Footner (1999) writes of the conflict that ensues for the midwife when confronted with abusive behaviour. Writing as a midwife used to home visiting in an area of high deprivation where drug abuse is problematic, Footner (1999) writes of the effect being subjected to verbal abuse from one of the women she was working with had on her professionally, and the conflict between wanting to ensure the woman and her baby received the kind of care they needed, and the loss of motivation and accompanying

strong desire to withdraw totally from providing the woman with care. Footner (1999) stresses the importance of midwives being aware of their own limitations and being able to ask for advice or assistance knowing that they will be supported.

7.4.2 Being at risk

There were times when midwives were very aware that they could be putting their personal safety at risk.

> *I sort of felt I could be unsafe [before] but [there was] one particular house where I did actually feel I wished I didn't have to go and...the police were involved. In actual fact I pulled out of that case. The woman vanished and you know, you went to her house and she wasn't there. You went back and you went back and then the woman actually called [me] and then when I went visiting the police were there and she'd vanished two days postpartum. She had been beaten up and the little toddler had been sexually abused as well. And I just thought 'I never felt safe in that house' (Jane p17 L20-30).*

> *There was a time when I went to visit somebody and she'd just gotten beaten up by her partner. You could feel [it]. I had no idea what had gone on before, so it was like I'd walked straight into it with a student. It was all of a sudden. So therefore he [the woman's partner] told me to go. He didn't want me there. And so I had a talk with the woman, just to see if she was safe and she was scared to stay there. She ended up walking out and I ended up taking her. And I took her to [her] GP to get checked out cause she was pretty knocked about with bruising. I could have said I felt unsafe, but I felt more for her –that it didn't really matter for me. [What mattered was] getting her seen to and making sure that she wasn't going to go back there, that she had somewhere that she could go back to (Rose p35 L3-18).*

These were serious situations and the chance of physical risk to the midwife was potentially high. In both situations however, the midwife's desire to ensure the safety of the woman involved, overrode the concerns she had about her own safety. Although each situation needs to be assessed individually by the midwife involved, who has developed some relationship with the woman and therefore knows something about her living circumstances, one has to wonder how long it will be before a midwife gets seriously hurt through visiting women in their homes. While most, if not all midwives now carry cellphones, these are of little help if the midwife is caught by surprise walking into an unexpectedly dangerous situation in a woman's home.

The potential dangers involved in visiting women at night is also an issue. While this did not come up in the data collected, the reality of many of these women not having transport or home phones, meant that midwives were often called out to assess women in their homes for a variety of reasons at night. Due to the woman's lack of transport, midwives would visit the woman at home in the first instance to save her from maybe inconveniencing others in searching for transport and childcare at night and/or an unnecessary and perhaps expensive taxi trip to the hospital. Lack of a phone meant that the contact about a woman who required assessing would perhaps be from a relative using a neighbour's phone and the only message given was 'she wants you to come and see her at home'. The lack of detail conveyed would mean the midwife was compelled to go and do a home visit – she could not assess the situation with any accuracy based on the amount of information she had been given.

Anecdotally there are many stories midwives tell of what they consider to be more of an everyday hazard to their safety: unleashed and wandering dogs. Only one of the midwife participants mentioned this however. This was somewhat surprising considering the narrative on this subject that abounds once the subject is introduced to a group of midwives gathered together.

> *And another time I felt unsafe is going in and unlocking the gate and knowing there is a dog there but the dog is not there. And then it comes bounding at you, and it's usually a rottweiler, and it's like getting that gate between you and the dog (Rose p35 L18-22).*

Being presented with this situation was a constant possible hazard. Midwives had thought about and taken active measures to try and ensure their personal safety.

7.4.3 Taking precautions

Trying to ensure their safety when going into a situation which was potentially volatile meant taking precautions. This the midwives did in various ways.

> *We have been given a card with a security guard number, so we've got that option if we do feel unsafe. I haven't used it yet but I'm sure there will be a time. ... You either make sure someone knows where you're going or else you take somebody with you (Rose p35-36 L29-7).*

> *Oh if I felt really unsafe, no I would probably not continue to see the woman. ...I've never felt that threatened that I've had to do that (Carmel p25 L16-23).*

...there was one particular house I went to. When the Police found out I was going they were absolutely appalled and said 'don't you go in there on your own, I wouldn't'– and yet I felt perfectly safe in that house. ...It wasn't the woman they were concerned about of course, but no, I was always absolutely fine, but once the Police told me that I always made sure that someone sat outside in the car (Jane p18 L15-25).

In a book written specifically about personal safety for health care workers, Bibby (1995) details simple precautionary measures which health care workers can incorporate into their working life as a matter of routine. Bibby (1995) includes several options that are available to the individual who encounters a threat to their personal safety and also guidelines for providing after care to staff who have encountered violence in some form. An important aspect of Bibby's (1995) work is to encourage acknowledgement of the risks faced by health care workers in both the primary and secondary health care settings and that by giving attention to risk, the incidence of aggression and its development into violent acts may be reduced.

Lamplugh (1999) gives some recommendations to follow when planning ahead for home visits, especially those considered risky. She emphasizes the importance of looking confident as people who seem confident are less likely to be attacked. Five golden rules Lamplugh (1999) recommends are; to be aware and trust your intuition, to be alert and aware of your surroundings, to avoid risk by assessing potential risk, to take action when in danger by defending yourself only if really necessary and with the aim of getting yourself away fast, and to always report an incident no matter how trivial to avoid putting others at risk also. To date, the precautions the midwives who participated in the current study have taken have worked.

The midwives working with this particular group of women were faced with other challenges which took up much of their time and energy.

7.5 Working with the frustrations

Some of the frustrations midwives had to cope with when working with these women were just part of the reality of becoming involved in these women's lives.

...and you think 'Oh God. Why do I do this job?' In that way it is extremely frustrating (Jane p16 L1-2).

The events which caused the frustration for the midwife were often a consequence of the woman's life that may not have happened had the woman been living in more affluent circumstances. These frustrations included visiting women at their homes for antenatal checkups only to find they were not there so having to decide what to do next, dealing with dilemmas and feeling unprepared to work with these women.

7.5.1 Searching for women

At regular intervals, the midwives would find women were not home when they visited them. The amount of times this happened did vary for the midwives in the study.

> *I go and see them and if they're not there I'll try again. The area I work in is quite a circular sort of area anyway so you're always passing them. ...I think most of them if you make an appointment they're nearly always there.... I know there's some women can be a bit of a problem, but it's generally not a problem. The ones I've looked after have usually been home (Theresa p18 L5-19).*

> *...it's a consistent problem. I think people not being home is for a number of reasons. One is that we change appointment times...and if someone is not on the phone then you can't let them know, so then you have to just try and find them, and that is an issue. ... And...I used to think that perhaps we only did half the antenatal visits that other people did in the end, because of being non compliant, or not being home, or being transient, but in fact when I've looked at my figures, I do a lot of antenatal visits with people.... That actually the times I see them is as high. ...and I would think that I spent twice that many visits looking for people as well. And often to look for somebody, it's really hard to find them. ...it can take several hits to get somebody at home. It's very hard to estimate the percentage of time it would take extra (Anne p4-6 L23-4).*

Anne summarizes the rationale she gives for women not being home when she calls in on them for their regular, prearranged antenatal checkups;

> *...another part of it is to do with their attitude to their antenatal care, and I think quite often our appointments have been low priority in their lives. And I can kind of understand that when you see the housing problems and relationship problems, that a visit from the midwife is kind of trivial (Anne p4 L28-33).*

For all the midwifery rhetoric around birth being a normal life event (Guilliland and Pairman, 1995; Donley, 1998; 1986) it would appear that for many of the women living in areas of high deprivation, birth is in fact such a normal life event that they do not stop the rhythm of their everyday lives to focus on the forthcoming pregnancy. Women not being home for their antenatal appointments could be seen as an extension of this as in

Anne's comments above where appointments with the midwife are seen as low priority in the woman's life. Alternatively not being home for planned appointments could be seen as a form of resistance. The woman may have few events happening in her life that she feels able to control, so missing a planned appointment with the midwife is one way in which the woman seeks to regain some of the control she feels she has lost from her life.

Midwives found that their decisions surrounding what to do when a woman was not home as arranged, often altered as their experience of working with these women grew.

> *I use to race around after them when I first started but [now] I actually don't. I'll just leave a note and I'll say that I've been and that I'll come on such and such a day and I'll say if that's not convenient can they give me a call. Mostly they're there after they've got the note.... So I mean I just keep going back but I won't go back three times in a day, which is maybe what I did, well twice in a day, when I first started, but no I won't do that now (Carmel p19-20 L26-2).*

> *And I had to visit them so yes, I did go backwards and forwards to the house but I found on the whole that we kind of worked out a system with individual women that I would come every fortnight or whatever. ... But that to me was a huge problem in a time factor, waste of time when they just decided they were going to up and go out (Jane p5 L7-16).*

> *...I think that, there comes a time...like you can search and search for them and there are women that you know that are at risk, so yes you do go out to them. But if a woman has chosen to not keep that contact with you, then I find I have to let that go because I can't carry any extra...stress. But if a woman that I know or a baby is at risk then yes I would go out to visit them. ... It depends on what stage in the pregnancy it is and it depends on the woman. If you know that she's okay and you know that at some stage she will [get in contact], which they generally do, or if she's decided to move and they haven't let you know, at some stage [they will] and I think that working in this particular environment you do actually hear about it, either from one of her friends, or a relative...and if she comes back that's fine as well. It's just the flexibility of it (Rose p12-13 L30-9).*

> *...I just document thoroughly in my notes. I leave my card. I keep ringing. Sometimes I'll get a relative at the house. Because they won't volunteer that they've shifted they'll often say something like 'she's not here' and what they mean is she's shifted. And I'm like 'well this is her midwife. Where is she?' (Linda p44 L12-18)*

> *...they would just suddenly vanish, nobody would tell you that they had gone (laughs). You wouldn't know (Jane P6 L5-7).*

However, as Jane states

> *...but looking at the other side of the coin of course you can ring the person who's got a nice posh house and tell her you've been up all night but she doesn't give a damn- she just wants you there and you get angry with them too you know (Jane p16 L2-7).*

The midwives did what they considered to be best when faced with a woman who was not home.

7.5.2 Dealing with emotional conflict

At times the midwives were faced with dilemmas regarding the women when they had great difficulty deciding what the correct course of action should be. Finding ways to deal with emotional dilemmas was essential if the midwife was to ensure her personal coping. Although the situations which caused the dilemmas may seem clear cut to others and it may seem obvious what the midwife's response should be, knowing the individual woman and the context of her life made the decisions to be made far from clear. The midwife had to find a solution that she could live with. One example from the data is Jane finding out that a woman had left her children alone in the house while she went into the hospital to have her baby.

> *...it is a conflict in a sense that if you wanted to abide by the law I suppose I should have rang the Police and reported her but morally I couldn't do that. She was doing the best for her family. The kids were well looked after. She was doing the best with what they had...(Jane p13 L8-12).*

Another dilemma involves working with a pregnant woman and needing to contact CYFS about her forthcoming baby for some reason. The dilemma here is whether and how to tell the woman, given that the midwife wants to continue to provide her with care and the risk the midwife takes in ruining the relationship by being honest.

> *...when it happens those...events carry on for several months so it's not just a one day stressor, and it's always a lead up to the decision about whether you're going to, tell, whether it's something that needs reporting, how you are going to talk to the woman about that, if you are going to talk to her, how you deal with the situation afterwards, and the danger that gives to compromising her maternity care.... ...It's very hard when you're in the situation, from my observation looking at myself and the other midwives, mostly the midwife who's in the situation is quite emotionally linked to the woman and is less likely to want to report her to CYPS [now CYFS]. ...it's complex and the woman really wants the child and loves the child and it will devastate her to have the child taken*

off her, but perhaps it's the relationship or the partner that's the problem (Anne p14-15 L8-4).

In this situation it is helpful to be part of a midwifery group to ensure the decision is shared so the midwife doesn't feel she is carrying the decision by herself, and also to ensure the decision is the best decision.

Deciding to break trust after building up a relationship between the woman and the midwife was not an easy decision to make. Anne speaks of the sense of betrayal the women can feel.

> *...I've had two women who have been really cross with me, understandably really, because they were women who I had looked after for a long time and they did see it as a betrayal (Anne p15 L19-22).*

Wanting to be honest with the woman is weighed up against the midwife's desire to not do anything which may lead to a breakdown of the relationship which has been formed between the woman and herself. Maintaining an ongoing relationship with the woman following the above scenario takes ongoing commitment from both the midwife and the woman involved.

Another source of emotional conflict has been brought on midwives in the study by the local hospital staff not allowing a woman's partner or family member to stay overnight in the postnatal ward with her and her new baby. Many women, particularly those of Pacific culture, have never during their lives spent a night in a room by themselves separated from family members. To expect the women to do this in an alien hospital environment, when they are tired, sore and have a new baby to care for, seems to be not particularly sensitive towards meeting woman's individual needs. This causes anguish for the woman's midwife who is not in a position to change the rules.

> *...and what are we doing to their bonding by throwing their partners out? First time mums you know! This is a new family unit and what are we doing to encourage it; tossing people out. And it sounds like there are some people who really back [the manager] and that's the hard thing you know (Rose p20 L1-6).*

This is one of the dilemmas inherent when providing continuity of care. As a consequence of spending time with the woman and getting to know her and her family as individuals, the midwife providing total midwifery care sees the woman within the context of her life situation when attempting to meet her needs. In contrast, many of the

hospital staff see the woman as just one of many women on the ward whose needs they are attempting to meet within an often short staffed and under resourced unit. To ensure the smooth running of the busy maternity ward, it is imperative therefore that the woman fits into the hospital ward's needs, rather than the hospital attempting to meet the needs of the woman. It would seem it would be so much easier for both the woman and the hospital staff if the woman could have one of her support people stay overnight to assist her in the care of herself and her new baby. While having a support person stay is available in some other maternity units within New Zealand, it was not routinely available at the maternity unit which the midwives in the study accessed.

7.5.3 Learning on the job

None of the midwifery programs the midwives had initially undertaken had had any educational component specifically related to the unique needs of this group of women. This meant the midwives often felt unprepared to adequately meet the needs of this group of women when they first went into independent practice.

> *No, everyone's needs were the same.... There's never been any education about what their extra needs might be, yeah and so you just learn as you go along. ...How to access things and that sort of thing (Theresa p10-11 L31-6).*

> *I don't think we are prepared at all (Rose p8 L6).*

> *No, I think you learnt about it on the job really. Midwifery training doesn't teach you how to deal with these things (Carmel p27 L10-13).*

> *I don't think the average midwife is actually prepared to cope with them (Jane p2 L4-6).*

> *I was probably fairly naïve when I first went out [into independent practice]. Although I've worked with people in the lower socioeconomics for years. When I worked in [overseas country] I worked with a lot of [ethnic group] women who were the same in many ways and although I didn't do the same type of midwifery it was very much a giving role...and I didn't find it particularly strange, I really like these people (Lisa p22 L24-33).*

Some of the midwives felt they had had some preparation however. This was either through their previous work experience, the student midwife placements they had had with midwives who worked with these women, or through general life experience.

> *I don't find looking after low socioeconomic women abnormal because that's what I've always done. I don't think the [midwifery education]*

prepares you well for those types of women, but I was prepared for those types of women through the midwives I worked with...(Linda p40 L12-16).

In some ways I did [feel well prepared], and some ways not well prepared but I felt very comfortable with them. ...I grew up in a state housing area, which is very similar to the kind of areas I work in, so when I went into houses they didn't feel foreign or uncomfortable, [they] felt very normal. So in that way, it was fine...(Anne p9 L13-18).

Well I think because I had worked in a drug and alcohol addiction centre then I was probably more prepared than some...and I have worked in a poor socioeconomic area...so I did have this experience that I took with me to midwifery. But I certainly know it's a huge eye opener to some people and certainly to some of the students who have never been exposed to it (Jane p8 L23-30).

I mean [I had] probably only my previous nursing experiences I suppose, because I did work with HIV and stuff like that so there is drugs and things involved from time to time. So that was probably more helpful than anything I would have learned as a midwife (Carmel p27 L19-23).

Some midwives felt they had only learned how to effectively work with these women from the experience they had gained while on the job. Midwives saw this lack of preparation as a major deficiency in their midwifery education. Given that an estimated 17-20% of New Zealand's population lives in relative poverty (National Health Committee, 1999; Waldegrave et al., 1999), this does represent a significant proportion of women not having their needs represented/addressed in a formal way within the midwifery education program.

Midwives had ideas about what information would have been helpful to assist them in meeting the needs of these women.

Oh I think it would be good to have more education about it and how to access things and how to access it appropriately (Theresa p11 L27-29).

I think that new grads...need to be in a group that will support them and help them through. Because when you first start working with deprived people it is hard. ...resources for them to go and gain better experience...there isn't anything is there? I mean you've got to give them a list of things and say if you need this or need that then this is where you send them, but really for them to go and learn how to deal with these people, it just comes from experience you know (Jane p20 L4-18).

Needing to gain some skills in how to deal with some of the specific problems that came up with this group of women saw one midwife arrange to attend a relevant course.

> *The thing I found the hardest was the counseling issues. ...people stated to confide in me a lot, and I would go into houses and I would be taking someone's blood pressure and they would say 'oh, by the way' and come up with some story which was really heavy like a story of being abused as a child or of abusing their own children or, of something their partner was doing to them which was really nasty (Anne p9-10 L25-7).*

So

> *I went to a counseling course. I decided the answer was to learn how to counsel because I was obviously counseling wrongly. I was certainly counseling badly I think (Anne p11 L3-6).*

However, this proved to be unhelpful so Anne began having professional supervision.

> *Fortunately I started having supervision.... And that was helpful. And I think I did learn to manage those situations better (Anne p11 L23-29).*

Professional supervision enabled Anne to learn skills that assisted her in setting boundaries around the relationship with the woman to ensure both her professional and personal survival in the job.

It would appear that in the past, midwifery education programmes both within New Zealand and overseas have not adequately prepared midwives to meet the unique needs of this particular group of women. Whether the current midwifery education programmes do contain specific information to aid midwives when working with women such as those the midwives worked with in the study is not known. This issue needs urgent attention.

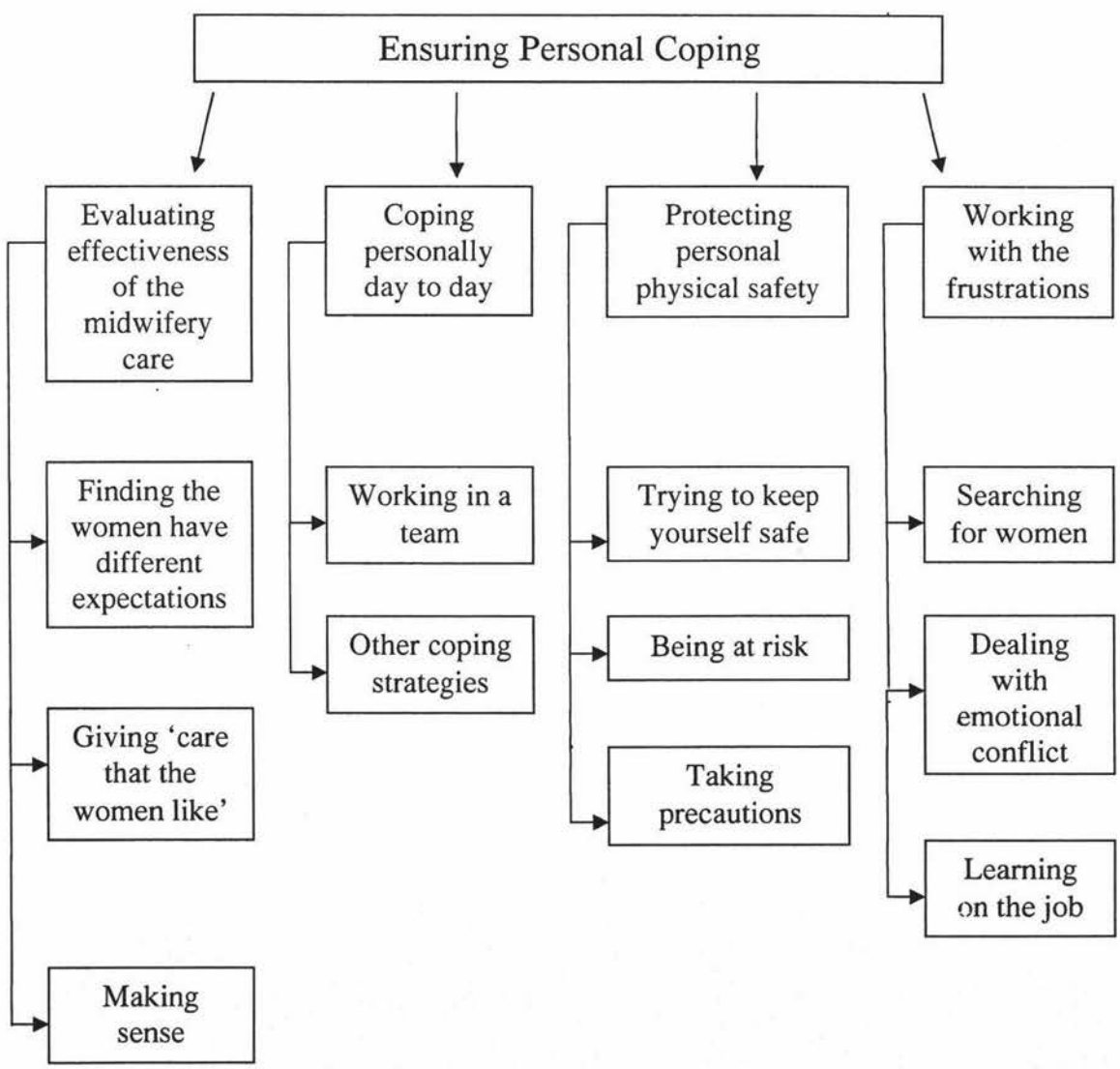
7.6 Summary

This chapter has introduced the category of 'Ensuring Personal Coping' to describe steps the midwives took to ensure they coped personally with working with this group of women. The data identified that the midwives employed several strategies to help them to cope. These strategies included evaluating the effectiveness of the midwifery care they provided, working as part of a team of midwives, having time off call and taking exercise. The midwives endeavored to ensure their personal physical safety when visiting women in their own homes and had developed tactics to help them decide what to do when women could not be found and for dealing with any emotional conflict

which may arise for them during the course of working with these women. Overall the midwives felt their basic midwifery education had not prepared them for meeting the unique demands of this group of women. Instead they found that mostly they learnt how to meet these demands on the job.

Chapter Eight presents the core category/basic social process of the conceptual framework developed from analysis of the data. Discussion of the developed conceptual framework and the implications of the research findings for midwifery practice, education, future research and policy development follow.

Figure 7-1 Ensuring Personal Coping



Chapter 8: The Conceptual Framework: Discussion, Limitations and Implications

8.1 Introduction

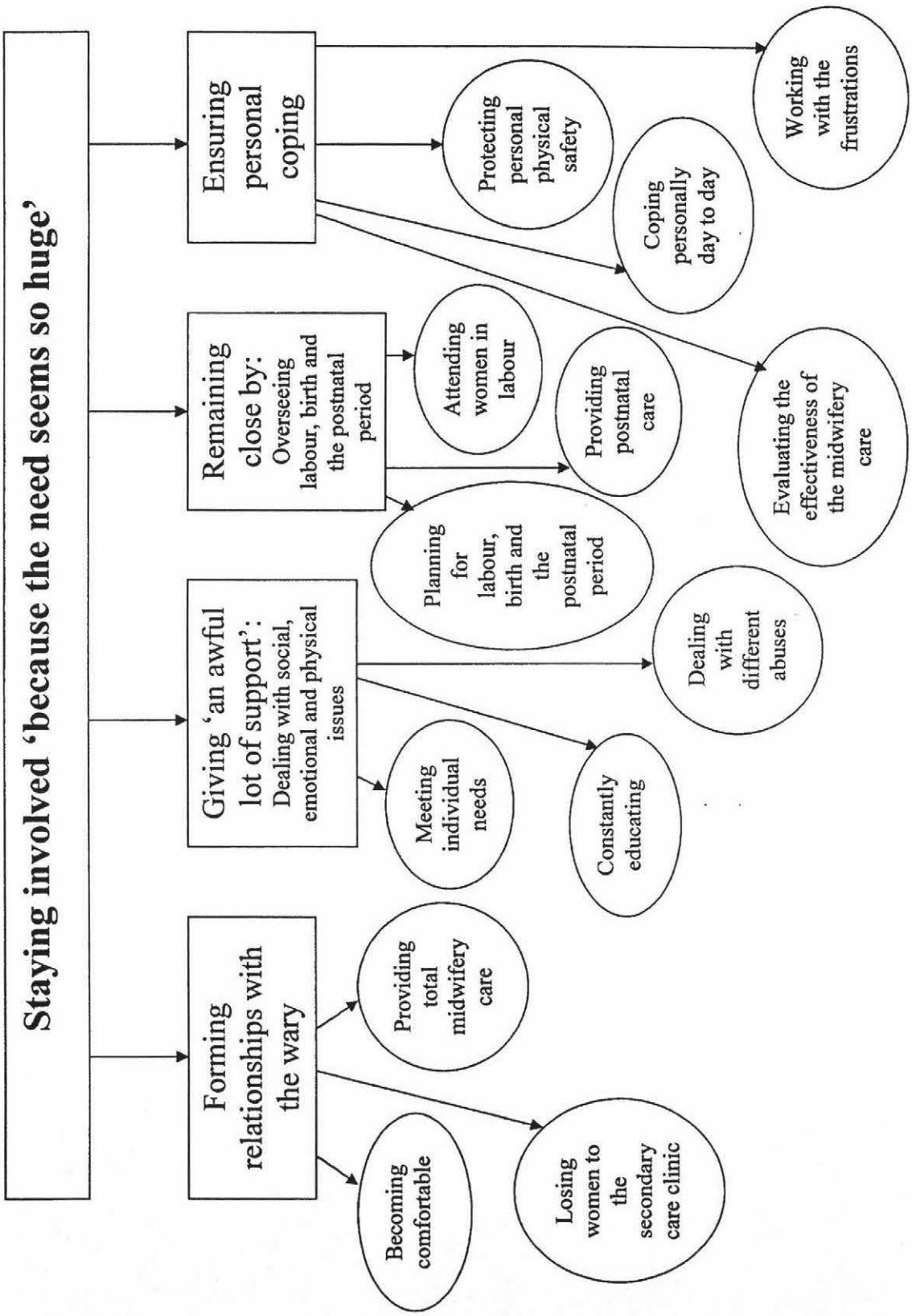
This grounded theory study set out to explore the research question; 'what is the care provided by midwives to women living in areas of high deprivation?' From analysis of the data obtained from the midwife participants, categories and properties were elicited which reflect the care processes used by the midwives. As the number of study participants was small it cannot be stated that theoretical saturation of categories was reached, so a substantive theory could not be developed. A conceptual framework was instead developed, based on a grounded theory analysis of the collected data. The conceptual framework is discussed. Figure 8-1 gives a diagrammatic representation of the sub categories and categories of the conceptual framework from which the core category/basic social process emerged. Limitations of the study and implications for midwifery practice, education, future research and policy development are detailed.

8.2 Staying involved 'because the need seems so huge': Discussion

Staying involved 'because the need seems so huge' was identified from the data as being both the core category and the basic social process. Throughout the identified categories of 'Forming relationships with the wary', 'Giving 'an awful lot of support'' to women as social, emotional and physical issues were addressed, 'Remaining close by' the woman while overseeing labour, birth and the postnatal period, and while 'Ensuring personal coping', the midwives continue to stay involved with the woman. This involvement is not confined to a strictly midwifery focus, rather, the midwife stays involved and gives assistance with many other issues that present in the woman's life. The midwife stays involved like this 'because the need seems so huge'.

Having two stages; 'staying involved' and 'because the need seems so huge', identifies the core category as also being the basic social process by Glaser's (1978) definition.

Figure 8-1 The Conceptual Framework



The importance of 'staying involved' is supported by Kennedy (1995) who found that knowing the midwife would be a 'continuing presence', whether that presence was at the end of the phone, being nearby if needed while affording families the privacy and space to spend time together as a new family with the newborn baby, or being present in the birthing room, to be a special part of the childbearing experience.

The first of the four categories which emerged from the data analysis has been identified as 'Forming relationships with the wary'. The midwives in the study spent time forming relationships with the pregnant woman and her family. It took time for the women to become comfortable enough with the midwife for a trusting relationship to develop. The women were often wary of the midwife initially due to previous bad experiences with other health care providers. The midwives were careful to ensure that the relationship with the woman encouraged self-responsibility rather than dependence. Midwives felt they were accepted in a special way into a woman's life and into the life of her family. As all the midwives in the study provided total midwifery care, analysis of the data revealed that such care meant more than the provision of pregnancy, labour, birth and postnatal care. The midwives identified that these women had additional requirements. The midwives took on women considered to be problematic by other providers because they wanted them to have care during their pregnancy. The midwives assessed and booked in women antenatally, provided all the woman's midwifery care while the pregnancy was progressing normally and referring the woman to specialist care when necessary. When a woman's care was transferred to the local secondary care clinic, the midwife continued to stay involved with the woman, despite being unable to continue to provide midwifery care, to ensure the many complex needs the woman had would be met.

The second category which emerged from data analysis was 'Giving 'an awful lot of support': Dealing with social, emotional and physical issues'. The midwives gave 'an awful lot of support' as they assisted the women in dealing with the social, emotional and physical issues that were frequently encountered during the period of providing midwifery care. The sub categories of 'meeting individual needs', 'constantly educating' and 'dealing with abuses' were identified from the data as ways in which the midwives attempted to provide the care the women required. While assisting women in dealing with social, emotional and physical issues, the midwives stayed involved.

The third category of 'Remaining close by' describes the process by which midwives oversee labour, birth and the postnatal period. Throughout the preparation for the woman's labour, birth and the postnatal period, during the process of the labour and birth itself and for the first four to six weeks postnatally, the midwives remain close by the woman, being either physically near her or readily available by telephone during this time. Remaining close by allows the midwife to keep a watchful eye on the woman and her unborn/newborn baby while letting the woman utilise her family support network and encouraging family involvement, giving suggestions or taking action if required.

The fourth category of 'Ensuring personal coping' describes the steps the midwives took to ensure they coped personally when working with this group of women. Staying involved meant the midwives had to ensure they coped personally. It was necessary for the midwife to first care for herself if she was to effectively care for this group of women. The data identified that the midwives employed several strategies to help them to cope. These strategies included evaluating the effectiveness of the midwifery care they provided, working as part of a team of midwives, having time off call and taking exercise. The midwives endeavoured to ensure their personal physical safety when visiting women in their own homes and had developed tactics to try to help them decide what to do when women could not be found, and to try and help them deal with any emotional conflict which may arise during the course of working with these women. Overall the midwives felt their midwifery education had not prepared them for meeting the unique demands of this group of women. Instead they found that mostly they learnt on the job.

Much of the overseas literature supports midwives providing social support to woman living in areas of high deprivation because of the improvement in pregnancy and childbirth outcomes that result (Davies, 2000; 1997; 1993; 1988; Oakley, Hickey & Rigby, 1994; Davies & Evans, 1991; 1990; Hughes, 1992; Rajan & Oakley, 1990; Oakley et al., 1990). Support during pregnancy has clinically measurable effects (Rothberg & Lits, 1991) including the new mother's adaption to motherhood and the quality of care given to her newborn baby (Lapierre et al., 1995). Oakley et al. (1994) found women who were offered support were 60 percent more likely to report good psychological and physical health at six weeks and one year post birth, than those

women who had no access to this help, concluding that social support seemed to have an influence on the health of woman and children independent of the effects of material deprivation, stress and previous health status.

A study undertaken by Simkin (1991) explored the long-term impact of the birth experience on a group of 20 women from the natural childbirth movement of the late 1960s and early 1970s. Simkin (1991) found that 15 to 20 years following childbirth, the women in the study believed they had achieved something highly significant in giving birth. Simkin (1991) determined that the way a woman is treated by the professionals on whom she depends during her labour and birth may largely determine how she feels about the experience for the rest of her life. In concluding, she encourages caregivers to be aware of the potential for psychological benefit or damage at every birth and to let the aim for a goal of good memory as well as a safe outcome guide the care provided.

It would appear that much of the social intervention promoted by previous researchers as above, is already considered part of the day to day practice for the midwives taking part in the current study and is integrated into the care they provide to this group of women. Staying involved enables the midwife to provide the comprehensive care this group of women require, meeting the huge needs the women have on a daily basis, to ensure an optimal pregnancy outcome for both the woman and newborn baby.

8.2.1 Credibility

Holloway and Wheeler (1996) state that to be credible the developed theory must have explanatory power, linkages between categories and specificity. This means that the categories must be shown to be grounded in the data. Also, demonstration of links between the categories is important as these links provide the developed theory with 'explanatory power' (Holloway & Wheeler, 1996). This means that the theory should explain variations in the data and identify changes in the process under study. The theoretical ideas that emerge from the theory should be significant if they are to help in understanding the phenomenon under study (Holloway & Wheeler, 1996). Glaser and Strauss (1967) espouse the view that to be credible the theory or conceptual framework should have fit, understanding, generality and control as defined previously in Chapter

Three. The three midwives to whom the emerging categories were taken back to several times during their development all indicated the categories were representative of the care processes involved when working with this group of women. From this feedback it would appear the developed conceptual framework meets the criteria for credibility as set by both Holloway and Wheeler (1996), and Glaser and Strauss (1967) and can therefore be considered a relevant outcome of this grounded theory study.

8.3 Limitations of the study

This qualitative research study was of a small group of midwives who practised in a city in the North Island of New Zealand. No claim can be made that the same study undertaken in another area of New Zealand would yield the same results; it is therefore not generalisable. Given that some issues within the area studied are peculiar to that particular area alone, for example, the mandatory hand over of midwifery care when a woman is transferred to the secondary care clinic, it is likely that some different data would be collected if the same study was to take place in another area.

The focus of this study was on the care processes used by midwives in their work with women living in areas of high deprivation. The focus was not on the care processes used by midwives in their work with more affluent women, although all the midwives in the study did work with more affluent women as well- from five to eighty percent of their yearly caseload, so did mention some aspects of the care provided to these women occasionally. It cannot be determined whether the data obtained was influenced in any way by the care the midwives gave to more affluent women. While it is possible there may be some overlap in the care processes used by midwives with these two groups of women, establishing whether this is or is not so was not an aim of the current study and has therefore not been addressed.

Although the midwives in the study all worked with women living in areas of high deprivation and every effort was made to explore the various aspects of the care they provided to this group of women, the data obtained may have benefited from a larger study sample of participants. Although no new ideas emerged from the data of the sixth and seventh participant interviews, given the sample size in this study, it cannot be said that data saturation of categories occurred and the researcher did not set out to verify

saturation had occurred. Instead, after the seventh participant's interview, the decision was made between the research supervisor and the researcher to focus on data analysis due to time constraints for the completion of a Masters thesis.

8.4 Implications of the study

While this research is based on a small group of New Zealand midwives, the conceptual framework developed has implications for midwifery practice, education, research and policy development.

8.4.1 Implications for midwifery practice

It would be easy for midwives to say that they cannot do anything about poverty or do anything about the effects of poverty on women's health, but that would be wrong. Care that is planned and targeted at those in greatest need, delivered with compassion, sensitivity and without patronising or stigmatising women, is likely to make a significant impact on women's lives. Poverty is an issue of social justice, midwives need to know and to understand exactly what they can do to make a real difference to the lives of childbearing women and their children (Hunt, 1999, p. 36).

Taking on the midwifery care of this group of women usually means taking on the involvement of the woman's family also. The family will have an influence on all aspects of the woman's care. The care required when working with the woman will not only be midwifery care, but will include becoming involved in all the complex issues affecting the woman's daily life. To work effectively with this group of women, midwives must take the time required to build a relationship of trust with each woman, taking into consideration the past experiences with health professionals the woman may have had. Research has shown that interventions that are successful with high-risk populations all seem to have health professionals involved who have the time and the skill to establish relationships based on mutual respect and trust (Schorr, 1988). Providing total midwifery care is an attempt to make sure that women receive the continuity of care required if they are to have the best possible pregnancy outcome for themselves and their newborn baby.

Working towards meeting the individual needs of pregnant women is a basic tenet of providing midwifery care. To assist in meeting the individual needs of this particular group of women, data analysis identified the importance of seeing each woman not only as a pregnant woman requiring care, but also seeing her within the context of her everyday life. The very real problems that the women have which were identified by the midwives, mean providing assistance with things normally considered to be out of the realm of midwifery practice, such as providing assistance with transport, clothing, and prescriptions, while at the same time providing education and information in an appropriate format; one which is acceptable to women. By having an awareness of the woman's personal home circumstances midwives can impart knowledge in an individualised manner (Salmon & Tyler, 1998).

Midwives found that providing care to this group of women means having to deal with a wide variety of community groups and government agencies. The midwife must ensure time is spent developing close links with these groups and agencies to ensure effective liaison when the services are utilised.

Midwives must have a philosophy of midwifery care which enables them to remain close by women rather than taking over their care. The importance of the family in the ongoing support and nurturing of the pregnant woman and her newborn baby, especially once the midwife's involvement has ceased, must be acknowledged, promoted and enhanced by the type of midwifery care provided.

While midwives may feel unable to effect fundamental change, it is possible to take account of the social needs of this group of women and make changes to practice to accommodate these (Salmon & Powell, 1998). The midwifery care provided must be flexible and encompass an understanding of the reality of the woman's daily life. While working with this group of women, midwives must take care to not replace the dictatorial disempowering medical model with a similar model of midwifery.

To continue to work effectively with this group of women it is vital midwives put processes in place to ensure they are able to sustain the demands of midwifery practice. Working in supportive midwifery groups which meet regularly, having planned time off

call and maintaining a life away from work are all essential if midwives are to deal with stressful work related situations without developing symptoms of burnout.

8.4.2 Implications for midwifery education

It is apparent from the data collected that the midwives initial midwifery education left them feeling unprepared for the many varied aspects of working with this group of women. Some examples of this include working with women who were poor, socially isolated, unsupported, abusing drugs and/or alcohol and living in domestically violent situations. It is imperative that midwifery education acknowledges the resources required by this group of women and provides students with the education required to assist in the provision of those resources. It is questionable how an effective curriculum for educating student midwives can be written when the influence of high deprivation on women's health is not comprehensively addressed.

Most of the midwives in this study had a student midwife working with them for several weeks of the academic year. The students were at varying stages of their midwifery education and therefore had varying levels of prior knowledge and practice experience. Midwives found that some of the student midwives were unprepared for the realities of working with these women. However, the midwives felt the experience was worthwhile for the students and added positively to their midwifery education.

> *...just economic deprivation –they seem to handle that. They find it difficult, but they seem to handle that much easier than they do with the abuse and drugs and...going to prisons. They know what happens. They just don't think as midwives they are going to come across this sort of thing. And you do spend a lot of time with them talking to them of course. Again each individual student is different and we don't know their backgrounds and some of them fit into it very well (Jane i1 p19 L19-28).*

> *I think that sometimes they find it quite hard because it's not the ideal. I think they come out with a very ideal set way of doing things and they're wanting to talk about everything there is to know, and that's not necessarily what the woman wants to know about. But it's what they think she should know, sort of thing. So sometimes I think that they find it's not always what they're expecting (Carmel i1 p24-25 L27-2).*

> *It's eye opening for the students. It's great for them because they just get to see so many different types of people (Theresa i1 p11 L16-18).*

If the student was to gain from the experience of being out with her independent midwife in practice, it was crucial that she too formed a relationship with the woman, so that the woman would allow her to observe and take part in her childbearing experience under the guidance of the midwife involved. This was seldom a problem.

> *I think that most of them [the women] are fine because they know me. What I try and do beforehand is, when I'm booking them in, I tell them that we may have students from time to time. Like at the moment I've got a student with me, and anyone I haven't remembered to talk to, I always make the student wait in the car and say 'look, I just have to double check with the woman'. And mostly they're fine. If I've had a few visits with them and they're fairly relaxed with me then they're usually okay for the student. They're actually quite open (Carmel, i1 p24 L1-11).*

The midwives and the women appeared to enjoy having students working with them and contributing to their education.

> *It has been okay, but it depends on what year they are. ...First year was just a breeze.*
> ***And why do you think that is?***
> *Because she listened a lot. She did question a lot too which was good because it made me think. But she was good. It was a lot of watching and she was just so excited to be at the birth (Rose i1 p33 L12-26).*

Continuing to ensure student midwives spend adequate time with independent midwives in a variety of practice settings is considered very worthwhile from the excerpts quoted above. If the practice experience midwifery students were receiving while working with independent midwives tallied with institutional educational sessions surrounding the issues that arise, the education of midwifery students would be greatly enhanced.

Lamplugh's (1999) recommendations to enhance physical safety when planning home visits should be core education for all midwifery students and registered midwives.

The current emphasis on 'The Midwifery Partnership' (Guilliland & Pairman, 1995) being promoted as the only true way to practice midwifery and as being the model to which all midwives, both students and otherwise should aspire, needs further reflection. The importance to the pregnant woman of family and her interconnectedness with them is not acknowledged within Guilliland and Pairman's (1995) model.

Post graduate courses pertinent to the midwifery needs of this particular group of women would be of benefit and could be enhanced by presentations from midwives

working in areas of high deprivation perhaps presenting case studies on relevant situations. While professional organisations such as the NZCOM are in the midst of organising a national series of educational sessions surrounding child abuse, educational sessions surrounding issues such as alcohol abuse warrant equal priority. By having an awareness of the restrictions poverty inflicts on pregnancy and childbirth, midwives can adapt their skills and provide appropriate care to this group of women (Salmon & Powell, 1998).

8.4.3 Implications for midwifery research

The conceptual framework developed from analysis of the data needs to be tested in other areas to enable it to be extended and for theoretical propositions/hypothesis to be formulated to aid the development of a theory on the care provided to this group of women.

Research exploring the care processes used by midwives in their work with more affluent women could be undertaken and then an analysis performed comparing the results with the current conceptual framework. This may answer the question of whether care provided to these groups of women is different in any way.

Research on the experience of New Zealand women living in areas of high deprivation as well as on the experience of their more affluent counterparts regarding having midwifery care provided by an independent midwife, may provide further valuable insights with which to direct midwifery care appropriate to the New Zealand context.

Research on interventions which midwives initiate to improve the health and wellbeing of childbearing women living in areas of high deprivation requires attention.

Exploring what happens when midwives and/or women end the midwifery-woman relationship warrants further research. It is not known whether the women find other caregivers whom they form a satisfactory relationship with for the remainder of the pregnancy, or whether these women instead receive no pregnancy care and either arrive in the local delivery suite when in strong labour or opt to have a homebirth without midwifery or medical supervision. What happens to these women at the end of the

postpartum period also warrants investigation. Do their babies receive any followup from well child providers? Do the women self refer to GPs for any ongoing medical needs?

Although the midwives took great care to ensure the relationship they were developing with each woman was one which encouraged some self-responsibility rather than being one of dependence, this requires further research. Was this true in all situations or is it possible that some form of co-dependency was sometimes fostered instead?

Establishing whether overall this group of women expected birth to be a more fulfilling experience compared to women in other socioeconomic groups, as was suggested by three of the midwives in the study and supported by the results of a study undertaken by Green et al. (1990) would be interesting to know.

A study of the most current Ministry of Health data related to NZ birth outcomes has found that despite a fall in perinatal mortality rates, they remain the highest amongst Pacific Island women (Guilliland, 2001). If this situation is to be addressed further analysis of the reasons Pacific Island women, as a group of deprived women, have the highest perinatal mortality rates is required.

8.4.4 Implications for policy development

The 17-20 percent of New Zealand's population that is estimated to live in relative poverty (National Health Committee, 1999; Waldegrave et al., 1999) represents many childbearing women and their babies. Poverty and health are inextricably linked. Health care workers are aware that social issues such as deprivation, poor housing, loneliness and unemployment have an overriding influence on people's health (Lazenbatt, Orr, Bradley, McWhirter & Chambers, 2000). The role of the midwife in addressing the challenges for women living in high deprivation at an economic, social and political level must be made visible (Morris, 1992).

The behaviour of pregnant women, like the general population, is often determined by social and economic conditions over which they as individuals have little control (Chalmers, Oakley & MacFarlane, 1980). Rajan and Oakley (1990) caution health

professionals to ensure that when giving advice on such things as poor diet, smoking, drug taking and drinking alcohol, that care is taken to separate guilt for not being able to change the unchangeable from women's responsibility for their own and the health of their children. Women on low incomes may not be able to afford good quality food and therefore cannot be blamed for having a poor diet (Kent, 2000). 'Working class women smoke more than middle class women because they live in poor housing, manage on low incomes, and have more stressful lives generally' (Ragan & Oakley, 1990, p. 82). Problems such as those mentioned above are structural problems, not individual and have to be changed through fundamental changes in society, not by imposing an additional burden of guilt on the victims of poor social policies (Rajan & Oakley, 1990).

There are no simple solutions to the problems associated with impoverished social circumstances. Tyler (1994) states that if, as a society, we are really serious about making improvements in health outcomes and on using resources more effectively, it is the group of women living in areas of high deprivation who should be the priority for receiving the enhanced midwifery care that caseloading midwifery teams can provide. Research studies that focus on women's views and experiences of maternity care consistently show that women respond positively to care they perceive as supportive, and when offered social support show greater confidence in their carers and in their ability to cope with birth and parenting (McCourt & Percival, 2000). These are the women who benefit most from the expertise and skills of a midwife offering continuity of care (Tyler, 1994).

The hidden financial costs for midwives when working with this group of women need to be acknowledged and reflected in the money they may claim for the provision of midwifery care. Hidden costs such as buying prescriptions, transporting women and paying interpreters do not currently form part of the payment schedule for midwives in Section 51 (HFA, 1998), nor does the current payment schedule address an alternative of who could instead pay for these services. What the long term costs to the health service would be of midwives not paying for these services for this group of women needs to be addressed. That midwives are expected to pick up these costs themselves is abhorrent.

On a more practical level, if lobbying maternity units resulted in the availability of labour, birth and postnatal rooms which catered for family size and a policy which stated that a support person staying overnight is welcomed and well accommodated, these would be helpful additions to the care midwives provide to this group of women.

8.5 Conclusion

The conceptual framework developed from analysis of the data obtained from the midwife participants in this research study has shown "Staying involved 'because the need seems so huge'" to be the core category and the basic social process which provides an explanation of the care processes used by midwives in their work with women living in areas of high deprivation. The four categories which emerged from data analysis provide links to each other as well as to the core category. The midwives stay involved throughout the woman's pregnancy and childbirth because the woman's need is so huge, to ensure an optimal pregnancy outcome for both the woman and her new baby.

These midwives are attempting to make a difference.

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APPENDIX A

Massey University
COLLEGE OF HUMANITIES & SOCIAL SCIENCES

School of Health Sciences
Private Bag 11 222,
Palmerston North,
New Zealand
Telephone: 64 6 356 9099
Facsimile: 64 6 350 5668

14 June 2000

TO WHOM IT MAY CONCERN

Scientific review of Christine Griffiths research proposal for a 100-point project for a Master of Arts in Nursing.

A research review committee has been set up within the School of Health Sciences at Massey University. The committee is constituted as proposals are submitted for review. Academics from within the School who have research experience and have not been involved in the development of the particular research proposal which is being reviewed are invited to participate in the work of the committee. The proposals are reviewed to ensure that the proposed research is ethical, methodologically sound, and of sufficient scope to meet the academic requirements for which the research is being undertaken.

Christine Griffiths proposal was reviewed on 30 May 2000. Issues that required clarification and suggestions to ensure the project was methodologically clear and appropriate were discussed with Cheryl Benn (Associate Professor in the School), Christine's supervisor. Recommended changes were made to the proposal.

Woods.

Martin Woods, MA.
Lecturer.

APPENDIX B

Wellington Ethics Committee

Room 425, Fourth Floor
Community & Support Services
Wellington Hospital
Private Bag 7902
Wellington South
Phone (04) 385 5999 ext. 5185
Fax (04) 385 5840
Email: sharonmc@wec.org.nz

18 July 2000

Our Ref 00/07/086
Please include the reference number and study title in all correspondence.

Christine Griffiths
[redacted]

Dear Christine

00/07/086 – An exploration of the care processes used by midwives in their work with women living in areas of high deprivation: A grounded theory study.

The above study was considered by the Wellington Ethics Committee at its meeting of 11 July.

The Committee considered the study to be a very worthwhile aim and commends you for your very careful consideration of the participants' rights with respect to the interview, the confidentiality and the feeding back of both transcripts and tapes. The only point we would make is that there is also likely to be a high rate of Pacific Island clients amongst the women in the areas where these midwives primarily work and that you may wish to seek guidance from appropriate representatives of the Pacific Island communities as well as Kuini Puketapu, the Maori health advisor.

However the Committee does acknowledge that you have considered the cultural issues carefully as well.

Ethical approval for the above study is granted by the Wellington Ethics Committee. It is a condition of Ethics Committee approval that you provide a brief progress report no later than July 2001 and at the completion of the study a copy of any report/publication for the Committee's records. Please notify the Committee if the study is abandoned or changed in any way.

We wish you well with your research.

Yours sincerely

Jan Ostres

for
Sharron Cole
CHAIRPERSON

C:\Documents\0007086griffiths.doc

Massey University Human Ethics Committee
Room 2.02, Main Building, Turitea
http://www.massey.ac.nz/~muhec

Telephone: 64 6 350 5249
Fax: 64 6 350 5622
Email: S.V.Rumball@massey.ac.nz

Massey University

Private Bag 11 222,
Palmerston North,
New Zealand
Telephone: 64 6 356 9099

26 July 2000

Ms Christine Griffiths
[redacted]

Dear Christine

Re: Human Ethics PN Protocol – 00/84
An exploration of the care processes used by midwives in their work with women living in areas of high deprivation: A grounded theory study

Thank you for the above protocol that was received and considered by the Massey University Human Ethics Committee: Palmerston North at their meeting held on Friday 14 July 2000.

The protocol was unconditionally approved with the following suggestion:

Information Sheet

- paragraph four, remove sentence two "Once you have returned this .... with this study" as it may turn out to be very restrictive.

Any departure from the approved protocol will require the researcher to return this project to the Massey University Human Ethics Committee for further consideration and approval.

Please note that the approval letter from the Wellington Ethics Committee has been received and placed on file.

Yours sincerely

Professor Sylvia V Rumball, Chair
Massey University Human Ethics Committee: Palmerston North

cc Associate Professor Cheryl A Benn
Health Sciences
TURITEA

APPENDIX C

HUTT VALLEY HEALTH

Christine Griffiths
[redacted]

1st March 2000

Tena Koe,

Thank you for the opportunity to meet with you this afternoon regarding your proposed research into Independent Midwives experiences of providing total midwifery care to women living in poverty.

I would like to thank you for your consideration to consult with me in this process and would like to formally re-iterate my continued support to you throughout the duration of your research.
For any queries or concerns, please feel free to contact me direct on telephone 570-9056.

Good luck on your studies

Heio ano

K Puketapu

Kuini Puketapu
Maori Health Advisor
Maori Health Development Unit
Hutt Valley Health

Hutt Valley Health Corporation Ltd
High Street Private Bag 31907
Lower Hutt New Zealand
Telephone 0-4-566 6999
Fax Hospital 0-4-570 4401
Fax Administration 0-4-570 4424

APPENDIX D

Massey University
COLLEGE OF HUMANITIES & SOCIAL SCIENCES

School of Health Sciences
Private Bag 11 222,
Palmerston North,
New Zealand
Telephone: 64 6 356 9099
Facsimile: 64 6 350 5668

Research Study

Research study: Care processes used by midwives in their work with women living in areas of high deprivation.

Dear Colleague,

I am a practising midwife and a student currently enrolled in the Master of Arts (Midwifery) degree at Massey University. As part of my degree I am undertaking a research study. The research study will explore the **care processes used by midwives in their work with women living in areas of high deprivation.**

I would like to invite you to consider being a participant in my study if you are an independent midwife who

- is a Lead Maternity Carer
- provides total midwifery care to women
- works with women who are living in one or more of the meshblocks on the attached maps
- works in the greater Wellington area.

For further information about the study or to receive an information sheet, please contact me.

Christine Griffiths.
[redacted]

APPENDIX E

Massey University
COLLEGE OF HUMANITIES & SOCIAL SCIENCES

School of Health Sciences
Private Bag 11 222,
Palmerston North,
New Zealand
Telephone: 64 6 356 9099
Facsimile: 64 6 350 5668

Information sheet

Research study; Care processes used by midwives in their work with women living in areas of high deprivation.

Dear Colleague,

I am a practising midwife and a student currently enrolled in the Master of Arts (Midwifery) degree at Massey University. As part of my degree I am undertaking a research study. The research study will explore the **care processes used by midwives in their work with women living in areas of high deprivation.**

If you are an independent midwife who is a Lead Maternity Carer providing total midwifery care to women who are living in one or more of the meshblocks on the maps attached, and you work in the greater Wellington area, I would like to invite you to consider being a participant in my study.

If you consent to participate I would like to interview you. Participation in this study will involve at least two interviews with you. These will each last up to an hour in length and will be held at a time and place convenient to both of us. During the first interview you will be asked to talk about the care you provide to women living in the selected meshblocks of high deprivation. The interview will be audiotaped if you agree. My research supervisor, the transcribing typist, possibly my examiners, and I, will be the only people to have access to the taped interview. The transcriber has signed a non-disclosure of information form. During the interview I may make notes about key points or non-verbal gestures. Your participation in this study will be kept confidential and the tapes and transcripts will not be identifiable as you will be given, or may select, a pseudonym.

I will send you the typed transcript from the first interview and then arrange to meet with you for a second interview to explore points or issues raised at the first interview (if required), to ensure the transcript reflects the initial interview, to clarify any points which may still be unclear and to enable you to make any changes you may wish. Once you have returned this transcript to me, I will assume that you give me your permission to use the data for my thesis and for any publication or presentation that may arise in association with this study. The transcripts from the tapes and any quotes in the final report will use your pseudonym. The tapes and transcripts will be stored securely throughout the study. When the study is completed you have the options of having the tapes and transcripts returned to you, archived, or alternatively I will destroy the tapes and transcripts after five years (requirement for auditing purposes).

Information sheet
(Research study: Care processes used by midwives in their work with women living in areas of high deprivation)

You have the right to

- refuse to participate
- withdraw from the study at any time before you return the transcript to the researcher for analysis
- refuse to answer questions at any time
- ask questions about the study at any time and expect answers from the researcher
- refuse to have all or parts of the interviews taped
- have the tape recorder turned off at any stage during the interview
- confidentiality
- provide information on the understanding that your name will not be used
- hear the tapes and see the transcriptions and notes made by the researcher
- change the text or remove quotations

The information given during this study will be used to develop a thesis for examination. From this thesis, articles for publication may be written and parts of the study may be presented at midwifery conferences. A summary of the research findings will be made available to you at the completion of the study. A copy of the completed thesis will be available at Massey University Library.

I will ring you within the next few days to ask if you wish to participate in this research study.

Christine Griffiths
[redacted]

You may wish to contact my research supervisor if you have any questions about the study:
Dr. Cheryl Benn
School of Health Studies
Massey University
Private Bag 11 222
Palmerston North
Phone; (06) 3505799 ext. 2543

If you have any concerns about this study you may contact:
The Chairperson
Wellington Ethics Committee
Wellington Hospital
Private Bag 7902
Wellington
Phone; (04) 3855999 ext.5185.

Thank you for taking the time to read this information sheet.
Christine Griffiths.

APPENDIX F

Interview format

Participant number;
Interview number;

Thanks for your interest in being a participant in my research

Purpose of the study

Explanation of what participating in the study will involve (from information sheet, including that you will be sent copy of the typed transcript...)

Written notes during the interview

Participant rights (from consent form)

Sign consent forms –each keeps a copy

Turn on tape recorder

Select or be allocated a pseudonym

Demographic data

- Where did you undertake your initial midwifery education?
- Have you gained any other midwifery qualifications since then?
- How long have you practised as a midwife?
- How long have you practised as an independent midwife?
- How many women would you provide total midwifery care for in one year?
- How many of these women would you consider live in areas of high deprivation?

Could you please tell me what care you provide to women living in areas of high deprivation?

Possible other questions
How do you feel about the care you provide to these women?
How well prepared do you feel to provide care to these women?
On reflection, how effective do you feel the care you provide to these women is?
Are there any ways that the care you provide to these women differs from the care you provide to other, more affluent women?

APPENDIX G

Massey University
COLLEGE OF HUMANITIES & SOCIAL SCIENCES

School of Health Sciences
Private Bag 11 222,
Palmerston North,
New Zealand
Telephone: 64 6 356 9099
Facsimile: 64 6 350 5668

Consent form

Research study: Care processes used by midwives in their work with women living in areas of high deprivation.

Researcher: Christine Griffiths, midwife. Phone [redacted]

Supervisor: Dr. Cheryl Benn, School of Health Sciences, Massey University.
Phone (06) 3505799 ext. 2543

Aim of the research study: An exploration of the care processes used by midwives in their work with women living in areas of high deprivation.

Statement to be signed in the presence of the researcher.

I have read the information sheet about this study and any questions I have asked have been answered to my satisfaction.

I understand that I have the right to

- refuse to participate
- withdraw from the study at any time before I return the transcript to Christine for analysis
- refuse to answer questions at any time
- ask questions about the study at any time and expect answers from the researcher
- refuse to have all or parts of the interviews taped
- have the tape recorder turned off at any stage during the interview
- confidentiality
- provide information on the understanding that my name will not be used
- hear the tapes and see the transcriptions and notes made by the researcher
- change the text or remove quotations

From the thesis for which this study is being undertaken, articles for publication in refereed midwifery journals may be written and parts of the study may be presented at midwifery conferences. I understand that a summary of the research findings will be made available to me on completion of the study.

I understand that the Massey University Human Ethics Committee and the Wellington Ethics Committee have approved this study. If I have any concerns about the study I may contact the Wellington Ethics Committee, Wellington Hospital. Phone (04) 3855999 ext. 5158.

I agree to take part in this study.

I agree/do not agree to having the interviews audio taped.

Signed ..... (participant) / / (date)

Statement by researcher: I have discussed the aims and procedures involved in this study with .....

Signed ..... (researcher) / / (date)

Two copies required -one retained by the researcher and one retained by the midwife.

APPENDIX H

Massey University
COLLEGE OF HUMANITIES & SOCIAL SCIENCES

School of Health Sciences
Private Bag 11 222,
Palmerston North,
New Zealand
Telephone: 64 6 356 9099
Facsimile: 64 6 350 5668

Care processes used by midwives in their work with women living in areas of high deprivation

Non disclosure of information- transcribing typist

I, _____ agree not to disclose the names or any other information which could lead to the identification of the participants in the research study being undertaken by Christine Griffiths. The audiotapes, transcripts and computer discs will be stored securely while in my possession and not be made available to anyone but the researcher or her research supervisor. I will not retain any copies of the audiotapes, transcripts or computer discs, or any data on the hard drive of my computer.

Signed: _____

Name: _____

Date: _____