A Daunting Journey: Accessing a Lead Maternity Care Midwife

The experiences of multiparous women who live in socioeconomically deprived communities of Counties Manukau who have received midwifery care located at their General Practitioner's clinic.

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Abstract

One outcome measure of quality maternity care is the rate of stillbirth and neonatal death. To enhance health outcomes for women and babies in New Zealand, the Ministry of Health and the Perinatal and Maternal Mortality Review Committee (PMMRC) recommend early engagement with maternity services. However, Counties Manukau Health region has a high rate of women accessing and engaging with maternity care after the first trimester of pregnancy and one of the highest rates of stillbirth and neonatal death in New Zealand. To improve engagement with maternity care, in 2012 Counties Manukau Health initiated a recommendation from a maternity service review to co-locate midwives alongside general practitioners' clinics (GP clinic) in high socioeconomic deprivation communities. The initiative was intended to support women to access and engage with midwifery care before 10 weeks gestation.

The aim of this interpretive descriptive study was to explore the experience of eight women accessing the services of midwives using this model of care, co-located with their GP clinic. In keeping with the interpretive descriptive methodology, one-to-one semi-structured interviews were undertaken and data was examined using thematic analysis.

Two themes were identified from this study. **'It's a daunting journey accessing midwifery care' and**: **'Circumventing the maternity health service maze'**; These findings highlight the experience the women had accessing a Lead Maternity Care (LMC) midwife, the socio-cultural influences, the resource and service challenges. The findings revealed that a midwife recommendation combined with support from their GP or nurse assisted the women to access LMC care with confidence and ease. The findings may inform health policy makers, clinicians and others - including the people accessing maternity services.

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Attestation of Authorship

I hereby declare that this submission is my own work and that, to the best of my knowledge and belief, it contains no material previously published or written by another person, nor material which to a substantial extent has been accepted for the qualification of any other degree or diploma of a university or other institution of higher learning, except where due acknowledgement is made in the acknowledgements.

Signed

Date 30/10/2018

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Chapter One: Positioning of the Thesis

Introduction

A significant number of women, residing within high socioeconomic deprivation communities across Auckland's Counties Manukau Health area[1], access midwifery care late in their pregnancies (Counties Manukau Health, 2014). In 2013, Counties Manukau Health implemented an intervention recommendation by Paterson et al. (2012) to co-locate midwifery clinics within General Practitioner (GP) clinics[2], in the high deprivation communities of this region. This intervention sought to improve women's ability to access and engage early with midwifery care, particularly to enable early comprehensive first assessments. To date there has been no research regarding this co-location intervention. Hence, the aim of this qualitative interpretive description study was to review the intervention by better understanding the woman's experience of utilising the co-located midwifery clinics based at the GP clinic. The participants were all multiparous women who had experienced a variety of maternity care models over their pregnancies, including at least one pregnancy with a midwife co-located at their GP clinic. The findings will inform future service planning, as well as midwifery services, primary health care providers, Counties Manukau Health and the Ministry of Health regarding how this co-located model can better assist women to seek early midwifery care, ongoing care and future maternity care services.

Research Question

"What are the experiences of multiparous women who live in socioeconomically deprived communities of Counties Manukau who have received midwifery care located at their General Practitioner (GP) clinic"?

Study Aims

- To explore women's experiences of accessing and engaging with midwifery care when midwifery care was provided at their GP clinic.
- To determine if the co-located clinics actually serve the women's needs.

[1] **Counties Manukau** is the southern geographical region of the greater Auckland metropolis. Counties Manukau District Health Board, now known as Counties Manukau Health, is responsible for providing or funding the provision of health services in its geographical region.

[2] **General Practitioner clinic** or GP clinic also known as GP practice, Health Centre, Family Health practice, Medical Centre, Integrated Health Clinic or The Doctors. Clinics may include general practitioners (GPs), nurses, pharmacists and other health professionals (such as physiotherapists, midwives, dietitian, psychologists, counsellors and occupational therapists) working together and/or side by side to enable people to have direct access to a range of primary health care providers and are usually situated within community settings.

- Offer recommendations for improved service delivery based on the experiential themes that evolved from the data.

Background and Significance of the Study

Women living in areas of high socioeconomic deprivation are at increased risk of experiencing stillbirth or neonatal death of their babies and, in the Counties Manukau Health region, have been identified as having higher perinatal mortality rates (Counties Manukau Health, 2014; Jackson, 2011a; Perinatal and Maternal Mortality Review Committee, 2013). The Perinatal and Maternal Mortality Review Committee (PMMRC)[3] reports recommended that women be encouraged to register before 10 weeks' gestation with a Lead Maternity Carer (LMC)[4] and for further investigation into all factors surrounding women's access and engagement with maternity care to improve the health status of the pregnant women and their babies (PMMRC, 2011, 2012). This research responds to both the PMMRC (2012) and Counties Manukau Health's maternity review recommendations (Paterson et al., 2012).

Evidence demonstrates that better maternity outcomes for women and babies are achieved when antenatal care is commenced early in the pregnancy (PMMRC, 2011); preferably before 10 weeks' gestation, as recommended by the National Institute for Health and Clinical Excellence (2010), the Ministry of Health and maternity related professional bodies. The National Maternity Monitoring Group (NMMG)[5], a Ministry of Health maternity working group, also prioritise timely registration with a LMC (Ministry of Health, 2018a). One of the NMMG's priorities was to strengthen women's timely access to community based maternity care. This is an important priority as it has the potential to bridge and connect all maternity health workers for the benefit of women and their families who use the nationally defined maternity services (Ministry of Health, 2017a). Counties Manukau Health *Maternity Quality and Safety Program* continues to work to improve women's access and engagement with LMC care by 10 weeks gestation (Counties Manukau Health, 2017).

[3] **Perinatal and Maternal Mortality Review Committee (PMMRC),** appointed by the New Zealand Health Quality & Safety Commission and reflects the following expertise: Quality improvement and risk management, in particular quality assurance in the health sector, data and information gathering systems and analysis, clinical epidemiology, District Health Boards' service provision and management, Maori health, Pacific Island health all-inclusive of consumer participation and representation (Health Quality & Safety Commission, n.d.).

[4] **Lead Maternity Carer (LMC),** Primary maternity care is provided by LMCs who work under Section 88 of the New Zealand Public Health and Disability Act 2000. LMCs are selected by women to provide their lead maternity care and can be either midwives, GPs with a diploma in obstetrics or an obstetrician. LMCs take legal, professional and practical responsibility for the care provided to women throughout pregnancy and up to six weeks following, including the management of labour and birth (Ministry of Health, 2007).

[5] **National Maternity Monitoring Group (NMMG**) provides oversight and review of national maternity standards, analysis and reporting and provides advice to the Ministry of Health and District Health Boards on priorities for improvement in maternity service (Ministry of Health, 2018).

There appears to be a global commitment that spans local community health services to support pregnant women to access and engage with antenatal care early in their first trimester. The World Health Organization (WHO) has established a specific 'Sustainable Development Goal' that prioritises resources towards equitable and universal access to quality health care specifically for pregnancy care. The aim is to ensure antenatal care is available, accessible and acceptable – therefore community specific – during the first trimester of pregnancy for all women regardless of where they may live (WHO, 2017).

Early registration with midwifery care better enables opportunities for improved antenatal screening for congenital abnormalities, sexually transmitted infections, mental health, education, assessment of social risk factors, family violence, recognition of underlying medical conditions, referrals to social, medical or obstetric specialists and better identification of vulnerable women (Counties Manukau Health, 2014; PMMRC, 2011, 2012, 2013; Priday & McAra-Couper, 2011). From my experience, as a LMC and that of my colleagues, it is known that many women in Counties Manukau Health are not aware of the date of their last menstrual period and often find they are unexpectedly pregnant. Thus, a first trimester dating scan is ideal. This early scan is a closer predictor of the estimated birth date which is crucial for foetal anomaly screening and foetal growth surveillance. It is also useful for calculating postdate inductions and for preterm labour and birth management (Bamfo & Odibo, 2011; Bennett et al., 2004; Neiger, 2014; WHO, 2017); all reasons for encouraging early comprehensive antenatal care.

The beginnings of this thesis unfolded in October 2012 when Counties Manukau District Health Board (as it was known then) commissioned an external review of maternity services in response to the PMMRC Fifth Annual Report 2011, reporting mortality for 2009. This report stated Counties Manukau region had higher perinatal mortality rates than the rest of New Zealand, particularly amongst Māori and Pacifica women and women under the age of 20 years (Paterson et al., 2012). The high rate of perinatal loss in Counties Manukau region was associated with the high rate of women engaging with LMC care after their first trimester of pregnancy. The commissioned review, led by independent investigator Professor Ron Paterson, resulted in 9 recommendations for change to the maternity services in the region (Paterson et al., 2012). One of these recommendations was co-locating midwifery clinics in GP clinics in the high deprivation communities (Paterson et al., 2012). The co-location of midwives' clinics in GP clinics was part of the 'intervention project' I was contracted to implement over the three years 2013 to 2015.

This 'intervention project' aimed to improve women's ability to access and engage early with midwifery care, reinforce and assist women with choices for LMC care and begin a

personalised assessment of their specific needs with an associated care plan. The intervention of midwifery care integrated and co-ordinated within GP clinics aimed to provide quality seamless maternity care in conjunction with primary health care (Paterson et al., 2012). Additionally, it sought to address the maternity care service gap between pregnancy confirmation at a GP clinic and women finding a midwife to provide ongoing maternity care. Prior to this intervention Priday and McAra-Couper (2011) reported that pregnant women are more readily able to access and engage with midwifery care, in their first trimester of pregnancy, when the midwife is co-located with their GP clinic. The intervention project also addressed another recommendation by Paterson et al. (2012); the mentor midwife would attract and support new LMC midwives to work in the high deprivation communities in the region providing co-located midwifery care at GP clinics, simultaneously addressing the LMC midwife workforce shortages. Outside of the *External Review of Maternity Care in the Counties Manukau District* report, commissioned by the Counties Manukau DHB in October 2012, there are no other recent independent reports that have reviewed Counties Manukau Health maternity services in its entirety.

Co-located midwifery clinics at GP clinics in the high deprivation communities of Counties Manukau Health region

Following Paterson et al.'s (2012) recommendations, between 2013 and 2015, 10 midwifery clinics were established within GP clinics in the Counties Manukau suburbs of Mangere, Otahuhu, Otara, Manukau and Manurewa. These are some of the most socioeconomically deprived areas in the Counties Manukau Health region and have an ethnically diverse population (White, Gunston, Salmond, Atkinson, & Crampton, 2008). The Counties Manukau District Health Board data demonstrated that only 48% of the women residing in the region were registered with a self-employed LMC midwife as their maternity provider in 2012 (Counties Manukau Health 2016). More concerning, only 16.8% of pregnant women in Counties Manukau region accessed maternity care by 10 weeks gestation, with a third of pregnant women booked after 18 weeks gestation or did not book at all (Counties Manukau Health, 2014; Jackson, 2011a). Furthermore, this cohort of women was more likely to present with significant midwifery, medical and social challenges (PMMRC, 2012). To date no research has been undertaken to explore the implications of the co-location intervention for service users, midwives and other health professionals.

Further research in New Zealand, undertaken by Griffiths, McAra-Couper and Nayar (2013) and Priday and McAra-Couper (2011) highlighted the importance of understanding how midwifery care services can be effective and achieve optimal pregnancy and birth outcomes. The co-

located model of care represents one example of an effective enabler for women to access and engage early with midwifery care, providing a seamless maternity service integrated with primary health and social care services in one physical location (Priday & McAra-Couper, 2011). The GP clinic could be called 'health-hubs' or a 'one stop health shop' which are close, convenient and accessible for women seeking primary health care simultaneously with midwifery care. Reciprocity of referrals and collaborative care between midwives, medical, allied health and social support professionals is conveniently possible when midwifery care is physically situated at the GP clinic (Priday & McAra-Couper, 2011).

In New Zealand the majority of midwives tend to have their midwifery clinics as stand-alone services. However, the arrangement of midwifery clinics situated within GP clinics has been operational for over 20 years in the Countries Manukau region and with many of the Union Health Centres in the greater Wellington region (Connor, 2012). Opposition to midwifery co-location at the GP clinic, include a concern there may be reduced autonomy of the midwifery role and midwives may be seen as less knowledgeable than the GPs where the medical model dominates. It could also be argued that midwives may provide fewer services when co-located by diverting some of their role to the GPs, such as treating urinary tract infections and providing family planning options which are within the midwifery scope of practice. Anecdotally, midwives providing co-located clinics have commented that issues for which they refer women to the GP, after women have had their midwifery assessment, include fungal skin infections, scabies, chest infections, mental health, thyroid and maternal vaccinations; all of which are outside the midwifery scope in New Zealand. Connor (2012) reinforced the understanding that many women who are pregnant and living with the effects of poverty often have additional health needs that fall outside the scope of midwifery practice. Thus, when financial, physical and emotional resources are limited, having conveniently located and easily accessible medical input at the same time they see the midwife empowers the woman's health status.

A digest of the maternity and midwifery services in New Zealand related to this research

In the following section, I provide a synopsis of the evolution of the midwifery profession since 1990 as an autonomous maternity health provider in New Zealand, maternity caregiver options and the choice of LMC. I also describe the legislation that informs maternity services and how it frames what options and care information women should receive, from whom and how this links to recommending early access and engagement with LMC care. This section concludes with a brief overview of Counties Manukau Health population and the maternity

services. In providing this background I aim to identify the obligations and contexts that influence the interface with women and health care providers featured in this study.

1. An historical synopsis of the New Zealand midwifery profession, regulation and the genesis of the LMC and non-LMC carer.

With the 1990 amendment to the Nurse's Act 1977 (Ministry of Health, 1990) midwives regained autonomy and were no longer required to have a doctor oversee their care (Guilliland & Pairman, 2010). Subsequently, in 1996, the 'lead maternity care model' was introduced. A LMC is contracted to the Ministry of Health via the Primary Maternity Services Notice: Section 88, 2007 (Ministry of Health, 2007) [hereafter known as The Maternity Notice Section 88]. In the case of this study and in Counties Manukau region, a LMC is generally a self-employed midwife, to distinguish from the hospital employed midwifery workforce.

The Maternity Notice Section 88 (Ministry of Health, 2007) sets out the terms and conditions on which the Crown will pay the maternity carer when he or she has provided a specific set of maternity services. These payments are modular. There are three separate modules for the antenatal period, a module for birth and a postpartum module that covers for up to six weeks postpartum. The Maternity Notice Section 88 covers service requirements and payments for both the LMC and the non-LMC provider of services. The LMC provides antenatal, labour, birth and postpartum care and is available to the woman 24 hours a day throughout the duration of the childbirth time frame. Whereas non-LMC carers, whom are often GPs, do not provide any other antenatal, birthing or postpartum care, except first trimester care or urgent assessments (if the LMC cannot be contacted) and do not have a 24 hour on call expectation, all in accordance with The Maternity Notice Section 88 (Ministry of Health, 2007). In Counties Manukau Health region, a large proportion of women confirm their pregnancies at their GP clinic (Corbett, Chelimo, & Okesene-Gafa, 2013; Jackson, 2011a) and, if they do this in their first trimester of pregnancy, then their GP is bound to provide the service specifications that are required to claim from the non-LMC payment schedule. This is where GPs and LMC midwifery intersect and women cross from the GP non-LMC carer to LMC midwifery care. Both GPs and midwives can provide first trimester care and both can be paid concomitantly if women access both providers in this timeframe (Ministry of Health, 2007).

2. The LMC structure - Options for maternity care and choice of LMC.

Under the LMC system, pregnant women need to choose a LMC midwife or GP (who has a LMC contract with the Ministry of Health), at no personal cost (for eligible women), to facilitate their pregnancy, birthing and postpartum care - that is from the period when they register with the LMC until six weeks postpartum. There is the choice for a woman to engage a private obstetrician but for whom she may pay fees; although, women can still access at no cost a

hospital obstetrician through the state funded maternity system when referred by the LMC due to risk factors or arising complications.

3. Legislation relevant to maternity providers.

There are numerous laws and policies that determine maternity care in New Zealand. Consideration of these policies and legal requirements assists in having some understanding of the New Zealand maternity system and the interface between GPs and midwifery. The GP/midwifery interface is where women transfer their pregnancy care from their GP (if they are not a LMC carer, which is the majority in New Zealand) to a LMC carer; and, in the case of this study, a self-employed midwife for their childbirth journey. The regulations that govern the care each of these health carers must provide are laid out in the Ministry of Health's 'Primary Maternity Services Notice: Section 88 2007' (Ministry of Health, 2007). This sets out for both non-LMC and LMCs provider service specifications and the payments schedule to be claimed once the services are delivered. The main objectives of The Maternity Notice Section 88 (Ministry of Health, 2007) are shown in Figure 1 (p. 10).

All midwives providing LMC care are legally bound by the overall objectives of The Maternity Notice Section 88 (Ministry of Health, 2007). The extensive service specifications that stipulate the care to be provided across the childbirth journey include the same first trimester services specification as the non-LMC care provider, with an added explanation of the LMC role and the LMC on call contact details. With the non-LMC and LMC providers offering virtually the same first trimester cares, a woman could access either provider to confirm her pregnancy and first trimester care. In the case of the woman choosing the non-LMC GP for first trimester care, there is a need for the woman to then transfer to a LMC for ongoing pregnancy / childbirth care. In this study, it must be noted women mostly accessed their GP for pregnancy confirmation. The women's experience of traversing this timeframe and accessing a LMC carer is documented and discussed within this study.

Additionally, the following excerpts from the professional and regulatory requirements also guide a midwife's practice, whether a LMC or not. These professional guidelines and regulations specifically ensure informed choice is honoured:

- New Zealand College of Midwives (NZCOM) Standards of Practice for Midwives (2015) the framework of partnership is embedded in all aspects of care and professionalism and the NZCOM Code of Ethics. Both infer informed choice and consent are available to women and, within this study context, to freely choose options of carer and care related to her childbirth experience (NZCOM, 2015).

- Midwifery Council of New Zealand Competencies for Entry to the Register of Midwives (2007) – Competence one: includes prompting informed choices. The midwife acts as a professional companion to promote each woman's right to empowerment to make informed choices about her pregnancy, birth experience and early parenthood (Midwifery Council of New Zealand, 2007).
- Midwifery Council of New Zealand Code of Conduct - Professional relationships states: Through their conduct midwives ensure that their personal beliefs should not affect the advice or options that are provided to women. (Midwifery Council of New Zealand, 2010).
- Code of Health and Disability Services Consumer's Rights -–Right 4: *to services of an appropriate standard:* Every consumer has the right to co-operation among providers to ensure quality and continuity of services. *Right 6, to be fully informed:* an explanation of the options available, including an assessment of the expected risks, side effects, benefits and costs of each option *(Health and Disability Commissioner, 1996).*

The concept that consumers have the right to all information dominates the above regulatory and legislative frameworks. Specifically, for this study, the requirement to facilitate informed choice and consent originates with the Cartwright (1988) report. The notion of informed consent essentially dictates that care is '**with'** the consumer not '**to**' the consumer and has overtly influenced much around women's health services in New Zealand; specifically the 'partnership model' of midwifery care and professionalism of midwifery practice.

4. An overview of the people Counties Manukau Health region.

Counties Manukau Health region covers near to 55,200 hectares, urban and rural, providing health and disability services to approximately 524,500 people (Counties Manukau Health, 2015; Paterson et al., 2012). The Counties Manukau region is made up of the following localities Mangere/Otara, Eastern, Manukau and Franklin, with an ethnically diverse population: 39% New Zealand European, 24% Asian, 21% Pacific Island and 16% Māori. Twelve percent of all New Zealand's Māori population, 38% of New Zealand's Pacific population and 21% of New Zealand's Asian population reside in Counties Manukau region. Compared with other DHBs in New Zealand, Counties Manukau has the second highest number of Māori (after Waikato), the second highest Asian populations (after Auckland DHB) and the highest number of Pacifica peoples residing in the region (Counties Manukau Health, 2017).

At the time of the last published Census 2013, 36% of the Counties Manukau population lived in areas classified as being the most socio-economically deprived in New Zealand; with 58% Māori and 76% Pacifica identifying as residing in the most deprived areas (Atkinson, Salmond,

& Crampton, 2014; Counties Manukau Health, 2015). Based on the NZDep 2013 Census measure Otara, Mangere and Manurewa are the most socio-economically deprived communities (NZDep 9 or 10) in the Counties Manukau region which is where the co-located midwifery clinics in this study are predominantly situated. Most women (83%) living in Counties Manukau choose to birth at Counties Manukau Health facilities. Of the women who live in Counties Manukau and birthed in 2014, 30.7% were Pacifica, 26.8% New Zealand European/European, 20.7% Māori, 8.8% Indian, 5.1% other Asian and 7.8% were Chinese women (Counties Manukau Health, 2015).

5. An overview of the maternity services Counties Manukau Health region.

Only 48% of women in Counties Manukau registered with self-employed LMC midwives in 2012. This percentage has increased over the last five years due to a rise in the number of self-employed midwives in the region. In 2016 the majority (73%) of Counties Manukau Health women chose a self-employed LMC midwife (Counties Manukau Health, 2017). Historically, compared with other DHBs around the country, because of a shortage of self-employed LMC midwives in the region, Counties Manukau Health has by default employed midwives to provide primary maternity services to a high percentage of women. These services include antenatal/postnatal midwifery care, with the rostered shift midwives on the birthing units providing the labour and birth care (Counties Manukau Health, 2015).

Compared to the rest of New Zealand, a higher percentage of women living in Counties Manukau Health booked after the first trimester, with only 48% of women registered for LMC care (self-employed and hospital employed LMCs) during the first trimester (up to 13+6 weeks gestation) (Counties Manukau Health, 2017). This does represent a rise from the 2011 statistics cited by Jackson (2011a) when this rate was 16.8%, although Counties Manukau Health state this was up to 31% in 2012 (Counties Manukau Health, 2015). For Māori and Pacific women this is at 40% or less with a decreasing trend between 2014 and 2015. European and Indian women have been registering earlier with LMC care (Counties Manukau Health, 2017).

a. Primary Maternity Services Notice 2007: Section 88

Regulatory requirements; Objectives of primary maternity services for **all providers of care** who are claiming under the notice.

The objectives of primary maternity services are to—

(a) give each woman, her partner and her whanau or family, every opportunity to have a fulfilling outcome to the woman's pregnancy and childbirth by facilitating the provision of primary maternity services that are safe, informed by evidence and that are based on partnership, information and choice; and

(b) recognise that pregnancy and childbirth are a normal life-stage for most women; and

(c) provide the woman with continuity of care through her LMC who is responsible for assessment of her needs, planning of her care with her and the care of her baby; and

(d) facilitate the provision of appropriate additional care for those women and babies who need it (Ministry of Health, 2007, p. 1033).

b. The key elements of the first trimester non LMC Carer services and specifications:

The aim of maternity non-LMC services is to support the provision of lead maternity care…. For a woman in the first trimester of pregnancy a GP or midwife who works for the Primary Health Organisation practice (GP clinic), with whom the woman is enrolled for primary health services, must provide the following services as required:

(i) inform women of their options for choosing a LMC;

(ii) provide information and education about screening and offer referrals for screening tests, provide results and relevant health information to the woman and her LMC;

(iii) provide pregnancy care and advice, including confirmation of pregnancy, review of current and past health status, nutrition, smoking, alcohol and drugs information and education, consumer information on the primary maternity services and lastly appropriate maternity assessments such as blood pressure and uterine size.

(iv) miscarriage and termination care and associated referrals (Ministry of Health, 2007, p. 1075)**.**

c. LMC and first trimester LMC midwifery carer service specifications:

For a woman in the first trimester of pregnancy, the LMC must provide the following services as required**:**

(a) informing the woman regarding—
(i) the role of the LMC, which includes confirming that the LMC will meet the requirements in clauses DA5 (LMC carer), DA6 (General responsibilities of LMCs), DA7 (Continuity of care); and
(ii) the contact details of the LMC and back-up LMC; and
(iii) the standards of care to be expected

(b) providing appropriate information and education about screening and offering referral for the appropriate screening tests that the Ministry of Health may, from time to time, notify maternity providers about

(c) pregnancy care and advice, including—
(i) confirmation of pregnancy; and
(ii) ensuring that the woman has a copy of the Ministry of Health's consumer information on primary maternity services; and
(iii) all appropriate assessment and care of a woman

(d) care and advice if there is a real and imminent risk of miscarriage, the woman is experiencing a miscarriage or a miscarriage has occurred, including—
(i) all appropriate assessment and care of a woman; and
(ii) referral for diagnostic tests and treatment, if necessary

(e) assessment, care and advice provided in relation to a termination of pregnancy, including—
(i) referral for diagnostic tests, if necessary; and
(ii) referral for a termination of pregnancy (Ministry of Health, 2007, p. 1064)

Figure 1: Excerpts from Primary Maternity Services Notice 2007: Section 88 (Ministry of Health, 2007)

However, it needs to be appreciated that Counties Manukau Health has a long history of GPs providing maternity care, mostly antenatal and delivery care in conjunction with the Counties Manukau Health employed midwives who also undertook the postnatal care. This GP maternity service provision continued well past the 1990s when the law reinstated midwives' autonomy. Self-employed midwives slowly, but steadily, started offering continuity of midwifery care in the region although the region has always struggled to attract the numbers of self-employed midwives needed for the high number of birthing women. The shortage of self-employed midwives continued and to some extent is still a factor that restricts women accessing midwifery care today (Counties Manukau Health, 2017). By the 2000s most GPs in Counties Manukau region had stopped providing intrapartum services to women. To address the self-employed midwifery shortages in the region, Counties Manukau Health devised and supported a 'shared care' arrangement whereby women saw their GP for antenatal care. In-conjunction, approximately three midwifery visits were provided by midwives employed by Counties Manukau Health. The women presented at the birthing units for the employed on-shift midwives to provide their birthing care. This shared care system was dominant in the high deprivation communities of the Counties Manukau region where self-employed midwives were scarce and remain fewer in number than other communities in Counties Manukau Health (Counties Manukau District Health, 2013; Paterson et al., 2012).

With the maternity review in 2012 another of the recommendations was to halt the 'shared care' maternity model. Emphasis was placed on attracting and supporting more self-employed midwives to these high deprivation communities, along with the early engagement project co-locating these new midwives at GP clinics where women predominantly went for their pregnancy confirmation (Jackson, 2011a). The shared care system stopped all together in 2015-2016 (Counties Manukau Health, 2017). A legacy of the shared care system is that women often expect their GP to still provide their antenatal care and as the GP can provide first trimester non-LMC care this sometimes continues to happen. Hence, women were often unfamiliar with midwifery care at this early stage; a situation not helped by the shortage of self-employed midwives. The region also has numerous immigrant women who have had maternity care in their home lands which is provided by a hospital doctor and midwife service at their local hospital. Consequently, the new immigrant women can be unaware of the New Zealand midwifery system and by default arrive at their GP or local hospital expecting to be provided with care (Counties Manukau Health, 2015; Jackson, 2011a).

Today, GPs are less involved in the direct management of pregnancy and birth; nonetheless, women have continued reporting and confirming their pregnancies with their GP, although according to the Counties Manukau Health this information is not captured locally (Counties Manukau Health, 2017). When women confirm their pregnancy with their GP, the GP is required by legislation, Maternity Notice Section 88 (Ministry of Health, 2007), to provide the women with non-LMC first trimester care as previously defined. Anecdotally, this is not done well and many women and midwives report that options of care, assistance to connect with LMC care and a full physical assessment are not always undertaken. This has been recognised as a concern in the Counties Manukau Health External Review report, where another of the recommendations was aimed at reinforcing and educating GPs of the requirements for first trimester care and having more GPs with a Diploma in Obstetrics providing this care (Paterson et al., 2012).

These same concerns are common elsewhere in other New Zealand health regions and recognised also by the Ministry of Health's Maternity Quality and Safety programme. This Ministry of Health Maternity Quality and Safety programme has specific goals such as: to address the connectivity between GP's and midwives in their communities; increase information in public places about the importance of early pregnancy care and accessing a LMC as soon as the pregnancy is confirmed. Each of the District Health Boards have developed specific activities to target these concerns with the hope of increasing the likelihood of women connecting with a LMC before 10 weeks gestation (Ministry of Health, 2017a). These concerns are underpinned by the need for women to independently find a LMC carer.

Women are expected to independently find a LMC carer, stepping from the non-LMC GP care to LMC care for the remainder of the pregnancy, birth and postpartum care. This is where the maternity service system appears to be unfamiliar and/or challenging for some women in these communities of the Counties Manukau Health region, resulting in a high rate of women not registered with a LMC prior to 10 weeks gestation (Counties Manukau District Health, 2013; Paterson et al., 2012).

Methodological Approach to Thesis

A qualitative research methodology was selected for this study to answer the research question from the woman's perspective. There is a paucity of qualitative literature that captures the views of women residing in high deprivation communities in Counties Manukau who have experienced receiving their midwifery care co-located at their GP clinic. Receiving midwifery care co-located at their GP clinic has been available to many women in this

community for over 20 years and for some as a new service for the last five years; but nowhere has their voice been heard about how they view this health care service. A qualitative methodology is appropriately suited to the study's aims to contribute to a deeper understanding of this interdisciplinary integrated primary health service from the perspective of those for whom the service is designed.

The study used a qualitative interpretive descriptive methodology developed by Thorne, Kirkham and MacDonald-Emes (1997). This approach focuses on discovering themes and patterns of action to inform clinical practice. It is specifically designed for health disciplines, within clinical practice settings and allows for interpretation of data to inform knowledge and practice within the selected health arena. This methodology has enabled the collection of the women's experiences of receiving their midwifery care co-located at their GP clinic and helps to explain and consider the influential interactivity of the social and health service environments when women are ready and wanting to enlist with LMC midwifery care.

A Personal Reflection

My first experience with providing health care for families on their childbirth journey was as a public health nurse in South Auckland in the mid-1980s. During this time, I recognised that people's lives were adversely affected by poverty, limiting their access to health care. Furthermore, the health services did not meet their needs and certainly the health services were not designed with them or for them.

I then followed a career path that included teaching maternal and infant health in an undergraduate nursing programme where I found I carried my public health 'inverse care law' (Hart, 1971) thinking. I encouraged students to look at the effects of poverty on accessing health care and to ask who designed this health service and for whose purpose? Today, this thinking remains a major motivator of my work in this arena.

When I worked as a student midwife at Middlemore Hospital antenatal clinic in 1994, I heard staff members label women who did not arrive for their scheduled antenatal appointment as "DNA'ers" meaning they did not attend and by implication that some of these women were irresponsible and were ungrateful of a good antenatal service. Quietly I felt anger at the blinkered attitude I was hearing and seeing. I kept coming back to my public health views of who designed this service, and for whom. To me it was not serving the needs of the women for whom it was intended.

In 1995, after briefly working as an employed new graduate midwife, I was offered clinic space in two GP clinics to start midwifery clinics. Both GPs were ceasing to offer birthing options to the women at their practices. Both GPs discussed the context of the families for whom they provide primary health care and the possible advantage to early engagement with midwifery care if I made a convenient midwifery service available at the clinics. The genesis of my co-located midwifery work began at these two clinics and continues today. The rate of early registration with LMC midwifery care has been positive with 70% of women enlisted by 14 weeks gestation or less (Priday & McAra-Couper, 2016).

By 2011 when the PMMRC began reporting the poor perinatal outcomes for Counties Manukau Health it became known within the region that the midwifery practice I belonged to had good outcomes for a high percentage of Pacifica and Māori women who resided in the most deprived communities. I was approached by the Ministry of Health to analyse our group statistics for the previous year, along with interviewing the health professionals at the GP clinics so they could see how we, the midwives, were delivering care that made a difference. This report was then given by the Ministry of Health to Counties Manukau Health and it informed the External Review of Maternity Care in the Counties Manukau District (Paterson et al., 2012). In light of the midwifery practices, women having a high rate of early registration with antenatal care and positive birth outcomes, the independent review recommended this integrated, co-located maternity service model be replicated and expanded throughout other high deprivation communities in Counties Manukau Health. I was then contracted for three years by Counties Manukau Health Maternity Board to undertake this initiative, along with attracting and supporting new midwives to set up more co-located midwifery clinics in GP clinics which did not already have these services. I continue to offer continuity of care as a self-employed community midwife with co-located clinics at the same GP clinic in Counties Manukau Health and support other midwives to do the same, although no longer contracted to do so by Counties Manukau Health Maternity Board. Because of my work experience my bias is formed by the positive outcomes of co-located clinics.

I also teach at Auckland University of Technology midwifery programme where I am passionate about imparting knowledge and skills of how to empower women and families who are not served well by the current maternity services. Teaching about how to assess, accommodate and empower the women on their childbirth journey is important knowledge that I believe every midwife needs to have to provide high quality culturally appropriate and safe midwifery care. Midwives need to know how to care for women who are marginalised by poverty.

Returning to my research question and aims, I wanted to answer firstly what the experience of women was who have utilised co-located midwifery clinics; and secondly, hear if these co-located clinics actually serve the women's needs. Again, these co-located clinics were developed for the women on the suggestion of the GPs and further recommended by the Counties Manukau Health maternity review (Paterson et al., 2012). Thus, being aware of how the consumer feels about the service is important to inform if continued energy and resources should be given to developing co-located midwifery clinics.

Structure of Thesis

This chapter has aimed to position the content and provide an overview for the thesis. To this end I have provided a rationale for choosing my research methodology and briefly described the New Zealand context and policies influencing the area of maternity health services.

Chapter two: Provides the reader with an overview of provision of early antenatal care and the New Zealand maternity health service system. Existing literature from New Zealand and internationally is reviewed about accessing and engaging with maternity and midwifery services, specifically in countries of high income who have communities of high socio-economic deprivation.

Chapter three: Sets out the research method assigned to this study. This chapter introduces the eight women participants and discusses the data collection and analysis trajectory, ethical considerations and rigour adopted within the research process. The chapter includes a brief review of Te Tiriti o Waitangi [Treaty of Waitangi], a treaty signed between Māori and the British Crown in 1840, Aotearoa New Zealand's founding document that committed the Crown to share power and to respect Māori culture and peoples.

Chapters Four and Five provide an analysis of the women's narratives. Two main themes were identified:

- Chapter Four Findings I: ***'It's a daunting journey accessing midwifery care'***
- Chapter Five Findings II ***'Circumventing the maternity health service maze'***

Chapter Six: The final chapter in this thesis discusses the findings related to the literature, governmental and professional bodies' knowledge. Implications and recommendations for health service are suggested along with the strengths and limitations of the study. Future research possibilities and opportunities for practice bring the study to an end, with suggested implications for policy makers, health service provision and recommendations.

Summary

In this chapter, the research question and aims have been stated along with an overview of the context of New Zealand midwifery, both from a professional and regulatory stance. Explanation and discussion have been offered on what has drawn me to this research topic, with the anticipation that the findings and critique of the findings may inform the reader and future health service development. In the following chapter, literature, governmental and professional body policies are explored in relation to the research question.

Chapter Two: Literature Review

In this chapter I explore women's experiences of accessing and engaging with maternity and midwifery services, primarily in high deprivation communities. Starting with literature relating to antenatal care and maternity services, I then consider New Zealand specific literature before moving onto the United Kingdom (UK), Canada, United States of America (USA) and Australia. While these are all considered high income countries, they also have high-deprivation communities where women are challenged to access pregnancy care in their first trimester.

For all qualitative research approaches, it is important to know whether the topic of interest has been researched previously. Existing literature helps guide decisions underpinning the research process. In step with interpretive description methodology (Thorne, 2008), a review of the literature was undertaken to develop the research question, refine the pathway for interviews and inform data analysis. This reflective process, at the commencement of the research project, has helped guide the study revealing commonalities, differences and gaps in extant literature (Haddrill, Jones, Mitchell, & Anumba, 2014; Smythe, 2012; Thorne, 2008; Thorne et al., 1997; Thorne, Kirkham, & O'Flynn-Magee, 2004).

The search terms used for the literature review were: antenatal / pregnancy care, prenatal care for high deprivation communities, access to pregnancy care, integrated and co-located delivery of health care, midwifery care, poor health and birth outcomes, poverty and health care and models of maternity care. The databases used were Google Scholar, CINAHL Complete, Emcare, MEDLINE and Scopus. Additionally, maternity reports from New Zealand Ministry of Health, DHBs and maternity working groups affiliated with the Ministry of Health or the DHBs have contributed to the literature review. This search predominantly covered the last 30 years as some of the New Zealand literature originated in the early 1990s.

I found a paucity of literature on women's experiences of receiving antenatal care from self-employed midwives co-located at their GP clinic. Connor (2012) researched a variation of this model of midwifery service delivery, whereby a group of midwives were employed by the Newtown Union Health Service in Wellington, New Zealand, providing midwifery care primarily for women registered with the clinic. Connor's research described the challenges and benefits of the midwifery service and the views of the employed midwives but it did not include the women's experiences. Connor noted that this service provided an alternative model for use in other under-served populations. A similar model of midwifery care, to that of Connor's, has been operational since the early 1990s in Counties Manukau, New Zealand (Priday & McAra-Couper, 2016). It is possible that elsewhere in New Zealand self-employed midwives may be

providing their service under the same roof alongside other primary health care providers. A similar midwifery care service model exists in regions of the UK, where midwives are co-located at community-based doctors' clinics (Hatherall et al., 2016; Sandall et al., 2015; Wellway Medical Group, 2018), as well as in Australia where the aim was to strengthen health and social service availability for indigenous women in urban and rural primary health care clinics (Rumbold & Cunningham, 2008).

Antenatal Care and Outcomes

The recent WHO (2017) report, which included data from both developing and developed countries, found increased antenatal care reduced maternal and neonatal mortality. Additionally, the WHO (2016, 2017) has called for more understanding of women's antenatal care experiences within the context of their lives and communities to demonstrate what works for women and to ensure health care services are more acceptable and likely to be accessed with continued engagement. However, the literature predominantly focuses on antenatal care related to health and birth outcomes for women and their babies. Some literature explores maternity services related to women accessing and maintaining engagement with antenatal care. Many of the studies focus on the barriers associated with engagement, not the women's actual reality and experience of accessing and engaging with antenatal care (Bartholomew et al., 2015; Dixon et al., 2013; Downe, Finlayson, Walsh, & Lavender, 2009; Finlayson & Downe, 2013; Haddrill et al., 2014; Hatherall et al., 2016; Lindquist, Kurinczuk, Redshaw, & Knight, 2014; Makowharemahihi et al., 2014; McLeish & Redshaw, 2018; Ministry of Health, 2017a; Paterson et al., 2012; Raatikainen, Heiskanen, & Heinonen, 2007). The commonality within the literature is that it incorporates the discourse of unfavourable social determinants to describe women's lives in association with maternity care (D'Souza & Garcia, 2004; Rayment-Jones, Murrells, & Sandall, 2015; Rumbold & Cunningham, 2008; Sandall et al., 2015; Zadoroznyj, 1999).

The External Review of Maternity Care in the Counties Manukau District described the nature of populations being reviewed as ethnically diverse and socioeconomically deprived (Paterson et al., 2012); factors that make childbirth more complex for this group of women compared to the general population. Further risk factors include young maternal age, multiple pregnancies, underlying medical conditions, language challenges, smoking prevalence, transient living situations and lack of engagement with standardised maternity service models. These risk factors have been identified as making delivery of health services with such communities more difficult. However, Paterson et al. (2012) recommended the provision of antenatal care to accommodate the challenges of women residing in high deprivation communities where

diversity and complexity are elements of their daily living. For these populations early engagement with antenatal care can address or ameliorate some risk factors and make a positive difference.

Early Antenatal Care

Women living in areas of high socioeconomic deprivation in New Zealand are at increased risk of experiencing stillbirth or neonatal death. The PMMRC (2013) suggested that a significant contributing factor is women's lack of access to and engagement with, maternity services. As stated in chapter one the literature supports accessing antenatal care during the first trimester, with a first antenatal assessment by 10 weeks gestation (National Institute for Health and Clinical Excellence, 2017; PMMRC, 2013), which is thought to be associated with reducing perinatal mortality and morbidity. Recommending the first antenatal assessment by 10 weeks gestation aims to help identify obstetric, medical and social complexities contributing to increased risk of low birth weight babies and preterm birth, which are associated with perinatal loss. Commencing early pregnancy care during the first trimester of pregnancy is recommended by health providers worldwide; however, to date, resources to achieve this continue to be limited (Counties Manukau District Health Board, 2011, 2013; Cresswell et al., 2013; Finlayson & Downe, 2013; National Institute of Health and Clinical Excellence, 2010, 2017; WHO, 2016, 2017).

Early pregnancy care also provides women with health service opportunities, timely information and education, health and social risk assessments, medical and social risk identification. These practices result in early specialist referrals, clinical interventions and screening tests (blood and ultrasound dating/anomaly screening). Importantly it also begins individualised women/family centred care planning to address the physical needs of the women's pregnancy health and her emotional, cultural and psycho-social support (WHO, 2017). Socio-cultural implications continue to be a challenge, particularly in high deprivation communities of developed high income countries (Paterson et al., 2012). Early engagement with antenatal care has the potential to reduce health inequities for women and their babies (Counties Manukau Health, 2017; Counties Manukau Health, 2014; Ministry of Health, 2017a; PMMRC, 2013).

The WHO's (2017) analysis of early access to antenatal care between 1990 and 2013 noted that for high income countries four out of five women accessed early antenatal care compared to one out of four women in the lowest income countries. Disparities also exist across Auckland New Zealand. Between 2011 and 2015 one in two women in the wealthier regions of Auckland

accessed LMC care in the first trimester compared to one in three women in the socio-economically deprived region of Counties Manukau (Ministry of Health, 2017a). Corbett et al. (2013) and Jackson (2011a, 2011b), however, found that over 70% of women in the Counties Manukau region sought maternity care from their GP at the beginning of their pregnancy, although not LMC care. These statistics are in line with the WHO for high income countries.

Providers of maternity services

Within the New Zealand maternity system women who have had their pregnancy confirmed at their GP are required, in most cases, to change their care provider from their GP to a LMC midwife. Most GPs elect not to provide LMC maternity service in New Zealand (Ministry of Health, 2015b, 2017b). The transition from one maternity provider to another, a LMC, can be challenging. It can cause a gap in ongoing care and compromise the recommendation that women engage with LMC care by 10 weeks gestation. The transition time between maternity care providers has been identified as a concern and a barrier to women successfully finding and booking with a LMC before the recommended 10th week gestation (Bartholomew et al., 2015; Makowharemahihi et al., 2014; Ministry of Health, 2017a; PMMRC, 2013). Bartholomew et al. (2015), whose claims originate from the renowned '*Growing Up in New Zealand study*' (Morton et al., 2012), identified that Māori, Pacifica and Asian women were least likely to access a LMC in the recommended time, as well as women for whom it was a first pregnancy, were under 20 years and resided in high deprivation areas. The time gap between women seeing a GP and registering with a LMC is between four and six weeks (Bartholomew et al). Furthermore, what women report as 'booking' by phone contact to arrange a face to face appointment with a LMC may be very different to the actual face to face assessment and care; thus extending the timeframe as to when women actually accessed clinical care with a LMC (Bartholomew et al., 2015; Corbett et al., 2013). The Ministry of Health (2015a) maternity consumer survey found 81% of women registered with LMC care before 13 weeks gestation (gestational data collection boundaries are at 7 and 13 weeks, not the recommended 10 weeks gestation). For Māori and Pacifica women only 26% and 36% respectively saw a LMC before 13 weeks. It must be noted the Ministry of Health survey is known to be under represented by responders from Māori and Pacifica communities, young women and those who live in high deprivation regions. Therefore, these statistics may under-represent the true picture of women accessing LMC care during their first trimester (Bartholomew et al., 2015; Ministry of Health, 2015a). Similarly, in the UK disadvantaged women are under-represented in consumer surveys (McLeish & Redshaw, 2018).

Co-location of midwifery clinics with GP clinics

Co-location of health service providers has been previously studied within the primary health care arena. Midwifery services co-located and integrated with other primary health care has been acknowledged as an enabler to accessing midwifery care for women who reside in high deprivation communities often with complex medical and social needs (Goodman, 2015; Priday & McAra-Couper, 2011; Rumball-Smith et al., 2014). This enabling structure, as discussed in the previous chapter, is enhanced by the staff supporting women to access and engage with the health services in a timely manner, finding and registering with a midwife (Carter et al., 2018; J. Henderson, Gao, & Redshaw, 2013; McLeish & Redshaw, 2018).

The New Zealand Maternity System

The New Zealand maternity system is highly respected and revered by many midwives, health providers and consumers, within and outside of New Zealand (Grigg & Tracy, 2013; Guilliland & Pairman, 2010). Today's maternity system is credited by the way consumers and midwives championed as a united force to achieve the 1990 Amendment to the Nurses Act 1977 (Guilliland & Pairman, 2010). It is a choice-based model of care; a health care system whereby women can independently choose their health professional and midwives can be autonomous practitioners, providing continuity of midwifery care with less medical interventions from conception to 6 weeks postpartum. Based on a woman-centred partnership philosophy, this system upholds a wellness focus while integrating health specialists as required (Guilliland & Pairman, 2010).

Grigg and Tracy (2013) upheld the New Zealand maternity system as meeting Davis-Floyd, Barclay, Titten and Davis' (2009) characteristics for 'birth models that work well', at both policy and practice levels. However, some of these characteristics were challenged by Bartholomew et al. (2015) and Makowharemahihi et al. (2014), who asserted that the maternity system is not accessible to all women across all income levels. The challenge to accessing maternity services is the divide between health organisations and services where referrals and communication systems are poor or non-functional, particularly for consumers who reside in high deprivation communities. This divide hinders women independently choosing and accessing a LMC because of limited support and knowledge of how the maternity system functions (Bartholomew et al., 2015; Makowharemahihi et al., 2014; Ratima & Crengle, 2013). This is a real hurdle for many Māori, Pacifica, young and multiparous women who live in the high deprivation communities in New Zealand. It is important to uphold informed choice and autonomy for the consumer, both conceptual corner-stones of the New Zealand midwifery philosophy (Guilliland & Pairman, 2010); however, these corner-stones assume all women can, want and have the financial

resources, time and knowledge to find a LMC in a timely manner (Bartholomew et al., 2015; Makowharemahihi et al., 2014; Ratima & Crengle, 2013).

Ratima and Crengle's (2013) study found that most Māori women started their maternity care with their GP and that information about how the maternity system worked was not actively provided. Subsequently, the women felt vulnerable to communication failures between GPs and midwives, which did not smooth the transition for the women from GP to LMC care. Griffiths et al.'s (2013) qualitative study situated in high deprivation regions in New Zealand explored seven midwives' maternity care experiences. Griffiths et al. reinforced the need for additional support for women to navigate the maternity system and suggested that women in vulnerable situations need additional maternity and social care support. These authors challenged the stance of women independently making choices and decisions about their maternity care suggesting women, in conjunction with a health provider and/or LMC, may abdicate decision making to their trusted health professional. Therefore, the woman may unquestioningly accept the recommendation by her GP of a LMC instead of independently making this decision.

For some women, finding a midwife, in conjunction with achieving their daily living needs, meant this task became a lesser priority (Downe et al., 2009; Hatherall et al., 2016). From a sociological perspective, Zadoroznyj's (1999) qualitative analysis of 50 Australian women's birthing narratives, which crossed all social classes, noted some working class women may have little choice with not affording health insurance. This may be limiting and some women may see themselves as a "self of little knowledge, little choice and having faith in the medical experts" (Zadoroznyj, 1999, p. 284) which gives a fatalistic view to the birth journey. Although Zadoroznyj's findings are based in the 1990s, they may still be pertinent to some communities who have little knowledge of what they need to read and know to inform their decision making and choice of maternity care provider.

Griffiths et al. (2013) and Skinner (1999) furthered the concepts of women's choice and decision making of their maternity care by recommending that midwives explore and know how an individual woman understands her 'midwifery partnership.' For a woman to understand how the partnership is to 'be' is essential to meet her needs and for the midwife to see the woman in the context of her life. One of the first steps to establishing a midwifery partnership involves ascertaining the woman's needs and desires, what decisions she wants to make independently and what help she requires to make decisions. This process is responsive to women's needs and life circumstances and supports women who might prefer health

professionals to take some control (Griffiths et al., 2013; Lovell, 1996; McLeish & Redshaw, 2018).

Numerous New Zealand publications reveal stumbling blocks for women, particularly Māori, Pacifica and teenage women, when finding and accessing LMC care (Bartholomew et al., 2015; Copland et al., 2011; Corbett et al., 2013; Griffiths et al., 2013; Makowharemahihi et al., 2014; Ratima & Crengle, 2013). Bartholomew et al. (2015), Ratima and Crengle (2013) and Makowharemahihi et al. (2014) suggested the New Zealand maternity model needs to address the process surrounding accessing LMC care, resources and cultural competence. To do this, the authors suggested that health practitioners working with vulnerable populations provide more information and practical assistance for women to find a LMC. What appears to be a disconnected process for women in transferring care from their GP to a LMC reinforces Grigg and Tracy's (2013) stance that the New Zealand system is not perfect and there is room for improvement. The 'Growing up in New Zealand' study further affirmed that timely access to antenatal care is an important aspect of the New Zealand maternity system (Bartholomew et al., 2015).

Within the literature, another group of women who may delay access and engagement with early antenatal care are those who socio-culturally or psychologically feel they need to wait until they have traversed the first trimester of pregnancy and beyond. Rothman (1993) referred to these women as having a 'tentative pregnancy'. This may be the case for women who have experienced miscarriage or a fetal anomaly; a sense of caution surrounds the pregnancy coming to fruition (Rothman, 1986). Delayed initiation may be a protective self-preservation mechanism and, in some circumstances, allows time for deciding on continuing with or terminating the pregnancy (Rothman, 1993).

Dixon et al. (2013) noted that registration with a LMC before 10 weeks gestation has been a recommendation reinforced by the PMMRC since 2011. This recommendation has continued each year up until the present year (PMMRC 2017). This practice change recommendation was not well communicated in the primary health care arena bringing unclear direction for women and maternity providers and possibly generating gaps between GP and LMC providers (Dixon et al., 2013; Ministry of Health, 2007; PMMRC, 2012). The New Zealand College of Midwives sought to address the gap between primary health care providers and midwives by designing and releasing a website 'Find Your Own Midwife' (Dixon et al., 2013). Recent data from New Zealand College of Midwives regarding the effectiveness of this website is not available; although statistics from the Ministry of Health (2015a) consumer survey of 2014 show an improving trend towards women registering during their first trimester. This is not the case for

Counties Manukau Health region where approximately 40% of women register with a LMC in the first trimester (Ministry of Health, 2017a).

Whereas the PMMRC and Ministry of Health collect data measuring women's gestation and date of registering with a LMC as the beginning point of antenatal care, Makowharemahihi et al. (2014) and Tanuvasa, Cumming, Churchward, Neale and Tavila (2013) viewed the beginning of antenatal care as when women are provided with care by the GP. Their studies demonstrated most Māori and Pacifica women engaged with health services at their GP or community youth service in their first trimester of pregnancy. The challenge arose at the next step when transferring care from the primary health provider to a LMC. Makowharemahihi et al. suggested that GPs take full responsibility for the first trimester screening and locating a LMC. This solution is what is already expected of a non-LMC carer when claiming from The Maternity Service Notice Section 88 (Ministry of Health, 2007). The expectation is for the non-LMC (GP in this case) "to support the provision of lead maternity care" (Ministry of Health, 2007, p. 1075), inform women of their options for choosing a LMC along with providing pregnancy care and advice. Therefore, 'pregnancy care and advice' for women who live in vulnerable situations could include an offer of a recommendation and support to connect women to a LMC, along with other pregnancy care and advice related to the women's life needs. The Primary Maternity Service Notice Section 88 is written in an open-ended way to allow the practitioner to design the care package that meets the needs of each individual woman.

Corbett et al. (2013) found that crossover of care providers (between GP and midwifery) causes confusion as women who have had their initial care by their GP may be under the impression there is no urgency to find a LMC carer (Bartholomew et al., 2015; Ratima & Crengle, 2013); thus compounding late access. Both the GP and LMC can be paid for care so it is possible one provider may think the other is attending to the care requirements (Ministry of Health, 2007). Poor communication between the two providers was also identified by Bartholomew et al. (2015) as causing care confusion, with the GP seen as the referrer not the care provider. Corbett et al. alluded to GPs being an important facilitator for women to connect with a LMC midwife as they are the health provider with whom most pregnant women first connect. Corbett et al. suggested that GPs use or develop interprofessional network strategies to support the woman's transfer of care to a LMC in a timely manner; and communicate and share health and risk assessments with the LMC. Bartholomew et al. and Corbett et al. have stated that the collection of maternity data in New Zealand needs urgent attention, including connectivity of all women's health data across maternity service systems to improve

communication that reflects when and where women are challenged to find LMC care and to inform future interventions. This is pivotal, given antenatal care is more than just accessing and registering with a LMC, but also about sustaining engagement with care.

It is pointless to examine the phenomenon of early first trimester care in isolation. Engagement with ongoing quality antenatal care is essential for improved perinatal outcomes and good maternal health (Docherty, Bugge, & Watterson, 2011). Antenatal care is meaningless unless the whole of antenatal care service is inviting, effective and inclusive; creating a service with an individual focus. In this context, women are more likely to keep engaged with care throughout the whole of their pregnancies (Docherty et al., 2011).

Access to Antenatal Services

Research critiquing access and engagement with antenatal care from both the consumer and health care provider perspectives has been undertaken utilising both quantitative and qualitative paradigms. From a quantitative perspective numerous studies have focused on birth outcomes related to what gestation women registered for antenatal care, how often they attended antenatal care, or what type of antenatal care services they engaged with. Many of these studies have additionally a review or qualitative focus (Butler et al., 2014; Copland et al., 2011; Corbett et al., 2013; Dixon et al., 2013; Edgerley, El-Sayed, Druzin, Kiernan, & Daniels, 2007; J. Henderson et al., 2013; McLeish & Redshaw, 2018; Raatikainen et al., 2007; Rumbold & Cunningham, 2008). Much of the qualitative literature focuses on the barriers consumers experienced accessing and engaging with maternity care (Daniels, Noe, & Mayberry, 2006; Docherty et al., 2011; Downe et al., 2009; Finlayson & Downe, 2013; Griffiths et al., 2013; Haddrill et al., 2014; Hatherall et al., 2016; J. Henderson et al., 2013; Low et al., 2005; Makowharemahihi et al., 2014; McLeish & Redshaw, 2018; Ratima & Crengle, 2013; Santa Rosa, Hoga, & Reis-Queiroz, 2015; Sword et al., 2012; Tanuvasa et al., 2013). Some studies discussed specific interventions which may enable early access to care or highlighted the women's perspectives about accessing specific antenatal care interventions (Edgerley et al., 2007; Priday & McAra-Couper, 2016; Rumbold & Cunningham, 2008). Other studies focussed on social determinants within a sociological or epidemiological public health realm related to health service delivery (D'Souza & Garcia, 2004; DeSouza, 2014; Lindquist et al., 2014; McNamara, 2012; Zadoroznyj, 1999). I begin with examining the New Zealand literature.

Access to antenatal services: New Zealand literature

I found a paucity of New Zealand studies focusing on early antenatal care prior to 2011. However, a growing interest in this arena, possibly prompted by the work of the PMMRC over

the last nine years, has seen knowledge and specific health service interventions utilised to reduce the poor perinatal mortality in New Zealand high deprivation communities. Four themes can be found within these studies that contributed to women booking late with LMC antenatal care (Copland et al., 2011; Corbett et al., 2013; Dixon et al., 2013; Low et al., 2005; Makowharemahihi et al., 2014; Ratima & Crengle, 2013; Tanuvasa et al., 2013):

1. Socio-cultural: perceptions of pregnancy care and birth, perceptions of who provides maternity care, delay in acknowledging pregnancy, maternity services not suitable or liked, cultural safety, inadequate social support and childbirth beliefs and values (Copland et al., 2011; Corbett et al., 2013; Dixon et al., 2013; Low et al., 2005; Makowharemahihi et al., 2014; Ratima & Crengle, 2013; Tanuvasa et al., 2013).
2. Socio-economic resource challenges: economic hardship, poor employment status, time restraints, childcare provision, transport, phone communication and access difficulties (Corbett et al., 2013; Makowharemahihi et al., 2014; Ratima & Crengle, 2013; Tanuvasa et al., 2013). The full choice of New Zealand LMC providers traverses the continuum of paying a fee for a private obstetrician through to LMC midwifery or hospital care with no chargeable fees. To uphold the New Zealand maternity system as one that promotes a range of health provider options for a woman to choose from is not a reality when socio-economic restraints impact lives. DeSouza (2006) argued that tangible choice of who, when and how to access health care is not a reality for many women living with the effects of poverty. Women prioritise their needs and energy, financially and time-wise, ensuring their family's needs are met first. Consequently the effort needed to access and engage with health care is often a lower priority (Griffiths et al., 2013).
3. Socio-educational challenges: variable maternal education, poor knowledge of healthcare, limited knowledge of pregnancy, childbirth and the maternity system and women expected to navigate the maternity service system independently have all been found to contribute to women's challenges with accessing antenatal care in their first trimester (Bartholomew et al., 2015; Low et al., 2005; Makowharemahihi et al., 2014; Tanuvasa et al., 2013).
4. Psycho-social challenges: women's readiness to access antenatal care such as their reaction to the pregnancy, delayed recognition of pregnancy and lack of social support, cultural inappropriateness of requesting care, inconvenient appointment times, limited or no access to information to make an informed choice, fear of an unknown location or care locations not being culturally comfortable (Low et al., 2005; Makowharemahihi et al., 2014; Priday & McAra-Couper, 2016; Ratima & Crengle, 2013; Southwick, Kenealy, & Ryan, 2012). Priday and McAra-Couper (2016) added midwifery workforce shortages as a barrier to women accessing a midwife while Ratima and Crengle (2013), Makowharemahihi et al.

(2014) and Tanuvasa et al. (2013) specifically called for more Māori and Pacifica midwives to provide culturally connected care as a priority in the midwifery workforce.

The notion of a culturally specific workforce was reinforced by Corbett et al. (2013) who discussed Pacifica LMCs' commitment to identifying language and cultural barriers and to increase knowledge about why early antenatal care is important and how the maternity system works. Such knowledge is often unfamiliar to immigrant women who only know their homeland version of maternity care (Tanuvasa et al., 2013). The pressing need for a Pacifica workforce is apparent in the maternity health service arena and across all of primary health care to facilitate engagement with preventive and early treatment care (McAra-Couper et al., 2018; Southwick et al., 2012; Tanuvasa et al., 2013).

The literature (Counties Manukau Health, 2014; Jackson, 2011a, 2011b; PMMRC, 2013) also identified midwifery workforce shortages and low numbers of ethnically specific midwives in the region (Paterson et al., 2012). To improve the health status of pregnant women and their babies, the PMMRC (2013) recommended further investigation into all factors surrounding women's access and engagement with maternity care. These same factors were noted in other New Zealand studies; although Corbett et al. (2013) added women with less than a tertiary education and women without live-in partners for support were also less likely to access early antenatal care. Furthermore, these studies recommended further research into what is working well for the women in communities that do access and engage with LMC care before the end of the first trimester of pregnancy (Bartholomew et al., 2015; Corbett et al., 2013; Counties Manukau Health, 2014; Finlayson & Downe, 2013; Griffiths et al., 2013; WHO, 2017).

The New Zealand studies all recommended that maternity health care needs to be socio-culturally appropriate for the specific communities of women (Bartholomew et al., 2015; Corbett et al., 2013; Griffiths et al., 2013; Makowharemahihi et al., 2014; Priday & McAra-Couper, 2016; Ratima & Crengle, 2013). Consequently, the focus has moved from the simplicity of financially influenced resource barriers to care, to what has worked well for women who do access LMC care early, including identifying what socio-cultural aspects at play, to enhance understanding of this health delivery concern. Understanding situations from a holistic and life-course stance is more likely to facilitate effective health care engagement and outcomes (Makowharemahihi et al., 2014; Ratima & Crengle, 2013; Tanuvasa et al., 2013).

Tanuvasa et al.'s (2013) qualitative study focussed on 40 Samoan women's attitudes towards antenatal and midwifery care, along with 10 key informants, of which some were midwives, informing the researcher of midwifery services utilised by Pacifica women. This cultural

perspective is vital to understanding and tailoring care that is culturally specific. Over half of the women received maternity care from their GP in the first trimester and were encouraged to seek a LMC in their first trimester. This study confirmed that whether the women access early or late antenatal care they did not experience any birth complications, bringing into question the correlation of late attendance for antenatal care with poor birth outcomes. Although with a small sample of 40 women this is unlikely to produce measurable outcomes; more a descriptive view of Tanuvasa et al.'s results. Findings revealed that the Pacifica women accessed antenatal care later than the first trimester because they did not plan their pregnancies and/or viewed pregnancy and birth as a well, healthy life event and therefore did not need to register early with care. These cultural perceptions are similar to other New Zealand studies that focus on Māori and Pacifica women's perceptions of antenatal care (Corbett et al., 2013; Makowharemahihi et al., 2014; Ratima & Crengle, 2013). Tanuvasa et al.'s study also aligns with McAra-Couper et al.'s (2018) study which found that Pacifica women's experience of choice for place of birth is socially constructed by both their community and their beliefs. Similarly, choice for antenatal care was constructed around the women's previous care history, cultural beliefs and individual experiences, along with that of their family and significant others. The essence of these New Zealand studies is that cultural sensitivity and competence is vital for both providers of the service and the health service environment. Health providers need to listen to the women's opinion to understand their point of view before designing and providing health services aimed to meet their health needs (Ludeke et al., 2012; Makowharemahihi et al., 2014; McAra-Couper et al., 2018; Ratima & Crengle, 2013; Southwick et al., 2012; Tanuvasa et al., 2013).

Elements that may encourage women to engage with maternity care include culturally competent care providers, welcoming care environments and convenience (Griffiths et al., 2013; Ludeke et al., 2012; McAra-Couper et al., 2018; Ratima & Crengle, 2013; Southwick et al., 2012). In Priday and McAra-Couper's (2016) study, the GPs and nurses described appreciating the ease of referral to the midwives co-located at their clinic and the benefits for women of reduced travel and a familiar environment when seeing the midwife. These findings are reinforced by Ratima and Crengle (2013), Pitama, Huria and Lacey (2014), Scott (2014) and Makowharemahihi et al. (2014), who further added that services must be culturally appropriate promoting a welcoming safe integrated maternity service desired by Māori women that is cognisant of preventing communication failures between midwives and GPs.

Ratima and Crengle (2013) and Makowharemahihi et al. (2014) called for increasing the Māori midwifery workforce which has historically been absent or miniscule in many New Zealand communities. Makowharemahihi et al. reinforced the need for more Māori midwives and/or

health care providers to ensure relational partnerships and services that offer respect and flexibility, resulting in individualised care. Corbett et al. (2013) also stressed there is a pressing need for Pacifica and Māori health providers to improve cultural understanding for women from minority populations. This priority for Māori is in line with the Te Tiriti o Waitangi (Treaty of Waitangi), a treaty signed between Māori and the British Crown in 1840, Aotearoa New Zealand's founding document that committed the Crown to share power and to respect Māori culture and peoples. In the context of Te Tiriti, New Zealand literature led by Māori researchers focuses on the need to redress health and education inequities (Durie, 2005).

To address health inequities, the New Zealand government's priorities are with Māori, demonstrating both respect of Māori as the first people of the nation, along with upholding Te Tiriti (Ministry of Health, 2014). Culturally appropriate quality health services, designed and provided by Māori communities and health professionals, are important to actively provide Māori women access to maternity and LMC services. Māori want to use and have ownership over their health care and health services to be able to actively address the high perinatal mortality in their communities (Ratima & Crengle, 2013).

Makowharemahihi et al. (2014) and Ratima and Crengle (2013) highlighted the need to address the poor statistics for babies of women who have the highest rate of perinatal mortality in New Zealand. Māori women are almost twice as likely to have an avoidable perinatal death compared to New Zealand European women. Māori women mostly reside in high deprivation communities in New Zealand, of which Counties Manukau has one of the highest Māori populations in New Zealand (Paterson et al., 2012; PMMRC, 2011, 2017). Along with being Māori, the PMMRC reported that being under 20 years of age and a smoker is associated with babies of small for gestational age and preterm labour: all risk factors that contribute to Māori women's high still birth and perinatal morality rates (Makowharemahihi et al., 2014; Paterson et al., 2012; PMMRC, 2011, 2017).

Makowharemahihi et al.'s (2014) qualitative study of under 20-year-old Māori women noted most women had engaged early for pregnancy care with their teen health service or GP. The few who had not engaged, did not recognise that they were pregnant. This study followed participants along the maternity care pathway. Findings showed the teens found the steps to registering with a LMC fragmented (Makowharemahihi et al., 2014); with most Māori women tending to register in the second and third trimesters (Makowharemahihi et al., 2014). Barriers, similar to what other New Zealand literature has described (Copland et al., 2011; Corbett et al., 2013; DeSouza, 2006; Dixon et al., 2013; Ratima & Crengle, 2013), were cited as a lack of understandable information and knowledge about the LMC process, missed opportunities by

the primary health care provider to assist with the process of finding a LMC, process barriers when the women were given a list of midwives to independently find a midwife, such as not finding an available midwife or not wanting to phone and ask for 'something of someone else' and poor communication with midwives not returning calls. These barriers culminated in women going back to their GP for a referral to the hospital (Makowharemahihi et al., 2014).

Makowharemahihi et al. (2014) examined what enabled young women to connect early with a LMC. Factors included support from the primary health care provider in ascertaining their individual needs to identify and connect the woman with a midwife. In some cases, this supportive and navigating role was fulfilled by family.

Recent focused work by the New Zealand Ministry of Health NMMG (Ministry of Health, 2017a) has prioritised resources to address the provision of maternity health services across New Zealand with a new work programme '*Better public services: Healthy mums and babies'*. The programme aims for 90% of women, by 2020, to be registered with a LMC during their first trimester of pregnancy. The NMMG claimed the Ministry of Health (2017a) data highlighted an improvement in women registering with a LMC during their first trimester over the past six years but that some DHB regions need greater improvements. Counties Manukau Health, is one of these DHB regions. The NMMG reported that the Ministry of Health data are not always complete as not all data are equally entered or interpreted at the DHB source due to the many differing data collection systems. This results in the Ministry of Health data being two years old before it is available. Also, as Bartholomew et al. (2015) and Corbett et al. (2013) pointed out, women's actual pregnancy confirmation and registering with a LMC gestation timeframes may have some subjectivity as past memory recall is not always 100% accurate.

The NMMG data are the most recent in regard to a New Zealand overview of women registering with a LMC in their first trimester. The common themes noted in the data reinforced that the women who are least likely to register with a LMC in this timeframe reside in high deprivation areas (NZDep Quintile 5, where Quintile 1 is least deprived to 5 is most deprived; Atkinson et al., 2014; Ministry of Health, 2017b). Counties Manukau Health has the highest number of women living in Quintile 5, of which a high proportion are Māori and Pacifica, than any other region in New Zealand (Atkinson et al., 2014; Ministry of Health, 2017b). The NMMG data also reinforced the previous New Zealand studies that highlighted it is under 20 year old women who are least likely to register in the first trimester and more than half of Pacifica women do not register during the first trimester (Ministry of Health, 2017a). The latest NMMG report acknowledged what initiatives worked well in specific communities where encouraging early registration with a LMC has been prioritised.

The NMMG 2017 reported successful initiatives in the Hawkes Bay region whereby midwifery leaders visited GP practices to firstly, improve communication between GPs and midwifery services; and secondly, to support the GPs to ensure all pregnant women had an appointment with a midwife before they left the practice when their pregnancy was confirmed (Ministry of Health 2017a). This resulted in a 10% increase for Māori women in the region registered with a LMC during their first trimester and provides evidence that enhancing communication and supporting a strategy that places women's daily living needs first and offers navigation to a midwife was effective. Counties Manukau supported the establishment of two community midwifery clinics in the residential heart of a high deprivation community, although these two clinics are now closed (S. Nandal, personal communication February 20, 2018). These clinics were located a distance away from the main shopping and medical precinct, which meant women had to undertake additional effort and time to access the midwifery clinics, potentially contributing to their demise.

GP clinics

Priday and McAra-Couper (2016), Makowharemahihi et al. (2014), Ratima and Crengle (2013) and Griffiths et al. (2013) asserted that when women have conveniently located and easily accessible health care services, successful access to and engagement of health care is more likely as care can be fitted into the demands of their daily living schedules. This is particularly important in early maternity care when women have a number of children and live with effects of poverty. They may often be at the GP with unwell children, hence convenience and familiarity of place is important for health service uptake, a finding also reflected in the international literature (Finlayson & Downe, 2013; Sword et al., 2012). Convenience and familiarity of care services is discussed in relation to Pacifica women's choice of birthplace, which McAra-Couper et al. (2018) referred to as the common themes for why Pacifica women chose a main hospital over a birthing unit to birth their babies. Convenience equates to less demand on finances and time, which are possibly more important when the daily living needs and survival of one's family are the real priorities for women.

Griffiths et al. (2013) and Priday & McAra-Couper (2011) highlighted the importance of understanding how co-located midwifery care services with primary health care practices can be effective in achieving early pregnancy care and improved pregnancy and birth outcomes. Priday and McAra-Couper's (2011, 2016) mixed methods study included a review and audit of the statistical outcomes from a group of 9 midwives, who provided continuity of midwifery care for 493 women in 2010 and a qualitative description whereby the GP's, nurses,

receptionist and community workers were interviewed about their views of having co-located midwives based at the GP clinics. This study demonstrated that the co-located model of midwifery care based at GP clinics represented an effective enabler for women to access and engage early with midwifery care and provided a seamless maternity service integrated with primary health and social care services. Having a holistic service, in one physical location, resulted in over 40% of the women in 2009-2010 registering with midwives in the first trimester of care and an accumulative 70% of women before 20 weeks gestation. This group of midwives reported having 66% multiparous women whom were known to seek midwifery care later (Tanuvasa et al., 2013). This study was based in high deprivation communities in Counties Manukau and the group of midwives in 2009-2010 cared for a significantly higher population of Pacifica women (62% compared to Counties Manukau Health 38%). Statistics were comparable for Māori women, 15% cared for by midwives, slightly less than Counties Manukau Health at 22% (Priday & McAra-Couper, 2011, 2016). Priday and McAra-Couper (2016) demonstrated that having a convenient link between GPs and midwives at the start of the maternity system process appeared to be advantageous for women to connect early with continuing antenatal care.

International literature showed very similar factors affect women's ability to access maternity care as raised in the New Zealand literature. The next section reviews the UK, Canada, USA and Australian research, although the comparison may not be generalisable as overseas maternity systems are not the same as New Zealand and each has different factors that pertain to their maternity care systems and population differentials.

Access to antenatal services: International studies

Comparably the UK, Canada, USA and Australia have much smaller numbers of midwives providing autonomous continuity of midwifery care to that of New Zealand. Also, these international systems are comparatively complicated as a large percentage of people can purchase health insurance, allowing choice in access to health care (Anderson, 2014; Zadoroznyj, 1999). Of the 2,748 USA women who were surveyed by Anderson (2014), those without health insurance were 77% less likely to access obstetric care than women who had health insurance. Further findings suggested women were less likely to access antenatal care if they had not completed secondary level education and had sociodemographic factors associated with poverty and disadvantaged populations (Anderson, 2014).

The majority of the international maternity health care service systems are similar to what existed in New Zealand prior to 1990 whereby women confirmed their pregnancy at the GP and

the GP referred them to the publicly funded hospital or community health centre for midwifery care or to a private health provider. It is apparent from the international literature that not all women are able to access and engage for antenatal care by 10 weeks gestation and may experience high perinatal morbidity (Downe et al., 2009; Finlayson & Downe, 2013; Haddrill et al., 2014; McLeish & Redshaw, 2018; Raatikainen et al., 2007). Hatherall et al. (2016) interviewed 21 pregnant or postpartum women, 26 health providers and 32 women from minority cultures in East London, United Kingdom. Findings revealed that directly referring women to publicly funded hospital services facilitated early antenatal care and a more proactive stance for this population should be encouraged (Hatherall et al., 2016). However, Hatherall et al. noted barriers existed within this direct referral process; women firstly needed to be registered with a GP for referral, the GP was slow to refer and women did not hear back from the hospital referred to at all or in a timely manner. This poses the question; are the maternity services primarily designed for the institutions' functionality or is it for consumers who access the services (Kirkham, Stapleton, Curtis, & Thomas, 2002)? Thus the 'inverse care law' [that the availability of good medical care tends to vary inversely with the need of the population served], first described by Hart (1971) almost 50 years ago, continues today in the delivery of maternity care. The poorest and most marginalised women are disadvantaged because the needs of governmental health institution requirements are prioritised (Kirkham et al., 2002).

The commonality with these similar high-income countries to that of New Zealand is they all have vulnerable populations who have high perinatal loss, who are more often than not their first nation peoples, immigrant minority ethnic populations, under 20 years old, of high parity and live with degrees of socio-economic deprivation, and who find choice and access to health care challenging (D'Souza & Garcia, 2004; Downe et al., 2009; Finlayson & Downe, 2013; Haddrill et al., 2014; Hatherall et al., 2016; Lindquist et al., 2014; Low et al., 2005; McLeish & Redshaw, 2018; Puthussery, 2016; Rowe & Garcia, 2003). Therefore, to embrace a social science approach, as do D'Souza and Garcia (2004) and Puthussery (2016), is beneficial when reviewing health services for high deprivation communities. Health service design, provision and implementation of services cannot be effective without participation of the people it serves to ensure the population has a health service that is accessible and satisfies their requirements. This is particularly pertinent in countries such as the UK and USA where many ethnic minority populations reside. Additionally, many of these small minority populations are immigrants or refugees with little experience of the health services in their adopted country (DeSouza, 2006; Edgerley et al., 2007; Hatherall et al., 2016; J. Henderson et al., 2013; McLeish & Redshaw, 2018).

Sub-groups of women within these broad high deprivation communities need to be understood both from biological and behavioural stances to address the differentials of access to and utilisation of, health services. Equally, awareness of relational factors, not medical interventions, are essential to the care of women with complex social issues, with which medical complexities often prevail (Aquino, Edge, & Smith, 2015; Butler et al., 2014; Cresswell et al., 2013; D'Souza & Garcia, 2004; Docherty et al., 2011; Downe et al., 2009; Finlayson & Downe, 2013; Haddrill, 2018; Haddrill et al., 2014; Hatherall et al., 2016; Lindquist et al., 2014; Raatikainen et al., 2007; Rayment-Jones, Butler, Miller, Nay, & O'Dowd, 2017; Rayment-Jones et al., 2015; Sandall et al., 2015).

1. **United Kingdom.**

Rayment-Jones et al.'s (2015) non-randomised retrospective study moved away from the more biomedical framework and examined the importance of 'relational care' (consistency of care by a known person) for women who find accessing childbirth care challenging. They compared the care of women from socio-economically disadvantaged communities in the UK. One group of women received midwifery continuity of care, a similar model to the New Zealand autonomous midwifery continuity of care system; while the second group received standardised UK midwifery care (care by numerous people). Findings support that consideration of relational needs, life context and providing continuity of care improved early access to midwifery care. Women receiving continuity of care were more likely to receive midwifery care by 10 weeks gestation, conferring increased benefits and improved health and birth outcomes (Rayment-Jones et al., 2015).

It must be noted the midwives case-loading and providing continuity of care had 35 women per year, quite a small case load in comparison to New Zealand community LMC midwives' recommended average case load of 40 to 50 women a year (Gilkison et al., 2015). Additional benefits for the women who had continuity of care with the case-loading midwives was accessible mental health services. Rayment-Jones et al. (2015) demonstrated that workload, along with accessible mental services and continuity of midwifery care, resulted in measurable and favourable health and birth outcomes beyond early access to antenatal care.

McLeish and Redshaw's (2018) qualitative study of 40 disadvantaged women reinforced looking beyond the actual physical and financial barriers to early antenatal care engagement. This study moved primary health and maternity carers to consider acquiring specialist skills in providing clear, accessible and empowering information, offering guidance and navigation to assist women to access and stay engaged with antenatal care. Fundamentally, McLeish and

Redshaw (2018) discussed the importance of “how personalised, relationship-based maternity care can transform highly vulnerable women’s experiences of care” (p. 6) increasing their knowledge, self-confidence and self-esteem; therefore feeling safe to access and engage with care. McLeish and Redshaw revealed there is a need for a more practical stance to empowering women by offering navigation and support services to increase their confidence to ask questions and challenge providers when the care they are receiving is not appropriate. The evidence from this study challenges health providers to analyse the services they provide and critically evaluate if the service is designed for the people it is to serve.

According to Hatherall et al. (2016) and reinforcing McLeish and Redshaw's (2018) stance, focusing primarily on the challenges and barriers faced by women who reside in high deprivation communities when accessing antenatal care is short-sighted. To also examine the purpose and value of antenatal care from the context of women’s lives will see the antenatal care service function effectively for the women it serves (Hatherall et al., 2016).

In addition to McLeish and Redshaw's (2018) call for improving knowledge of maternity services and why early antenatal care is important, Rayment-Jones et al.'s (2017) multisite clinical audit of 182 women across three National Health Trusts noted that 70% of non-English speaking women did not access first trimester care. English as a second language is a barrier to accessing antenatal care. Rayment-Jones et al. recommended this language-knowledge barrier is addressed to ensure future service development aims to improve access and engagement with antenatal care for women in complex social situations. The basis of equity to a healthy pregnancy is access to maternity health services although this may only be achievable when information is understandable.

When addressing equity of health care services for women across all income levels, continuity of care affords a two-fold positive influence. Firstly, women accessed and engaged with midwifery care earlier and sustained their engagement with maternity services; just under 25% of women accessed the case loading midwife by 10 weeks gestation compared to only 4% of women who received non-case loading care. Secondly, the women had fewer interventions (this may be linked more with continuity of carer) such as less pharmacological pain relief, antenatal admissions, less caesarean sections and neonatal unit admissions, more intact perineum’s, increased normal vaginal births and shorter postnatal stays (Rayment-Jones et al., 2015; Sandall et al., 2015). Stemming from these recent studies focusing on the importance of continuity of care, is a worldwide plea for further studies to focus on local initiatives and interventions which have demonstrated the effective systems that encourage and enable all women to access comprehensive first trimester care (Bartholomew et al., 2015; Cresswell et

al., 2013; D'Souza & Garcia, 2004; Edgerley et al., 2007; Finlayson & Downe, 2013; Griffiths et al., 2013; Haddrill, 2018; Haddrill et al., 2014; Hatherall et al., 2016; J. Henderson et al., 2013; Lindquist et al., 2014; McNamara, 2012; Priday & McAra-Couper, 2016; Rayment-Jones et al., 2017; Rayment-Jones et al., 2015; WHO, 2017). The WHO (2016, 2017) took this call for knowledge further in requesting research to specifically examine the uptake of early pregnancy care to identify communication barriers, gaps in service provision, change requirements and new innovations needed to the current maternity services.

Haddrill et al. (2014) and McLeish and Redshaw (2018) challenged the UK National Health Service to look more broadly at the root causes of poor access and engagement with antenatal care within low income communities and vulnerable populations; which, they argued, can only be achieved by listening to women's experiences of their use of a specific health service. Haddrill et al. (2014) suggested moving the emphasis from socio-cultural and educational needs to encompass issues to do with the women's lives. They identified the following as important: convenience of the service, antenatal care relevance to the particular group of women, familiarity of the service, where the service is and by whom is it provided, the lack of awareness of being pregnant, expectations of pregnancy and pregnancy care and the value placed on pregnancy care in relation to time and resources. To provide a health service that reflects and meets the demands in women's lives, enables women to connect with antenatal care more easily; therefore empowering women's confidence and self-esteem when accessing and engaging with maternity services (McLeish & Redshaw, 2018). Women's knowledge and acceptance of pregnancy and their decision to access early pregnancy care needs to be respectfully considered (Haddrill et al., 2014; Hatherall et al., 2016) from the psychological, social, cultural and demographic contexts of each woman's lives; holistic health care based on the theory of Maslow's hierarchy of needs and the inverse care law (Hart, 1971; Kirkham et al., 2002; Smith & Askew, 2006).

2. Canada.

Sword et al.'s (2012) descriptive study of 40 women and 40 prenatal health care providers, asserted quality prenatal care is multidimensional encompassing the structure of the care services; how services are accessed, clinical care processes and the inter-relational dynamics of the people it serves and the people providing the heath service. Therefore, to see any improvement with perinatal and maternal outcomes moving away from the biomedical frameworks is vital, which is what the New Zealand midwifery 'women centred partnership' model of care has attempted to achieve (Guilliland & Pairman, 2010). Sword et al. demonstrated the importance for future planning of antenatal care services that are

convenient and easily accessed by vulnerable populations, recognising and respecting the daily living needs of women and their families. Such services save on personal costs, financially and time and convenience is valued by women who reside in high deprivation communities (Sword et al. (2012).

Sword et al. (2012) were directive when looking at actual clinical care processes involved in providing antenatal care. They recommended increased information sharing with women in understandable formats and quality seamless information sharing across providers when more than one provider is involved in women's care. These are seen as essential requirements worldwide providing safe quality care for women who reside in high deprivation communities where complexities of medical and social health prevail (National Institute for Health and Clinical Excellence, 2010; Paterson et al., 2012; WHO, 2017).

The women in Sword et al.'s (2012) study wanted their life context to be at the centre of their care and to have meaningful care relationships with care providers where they felt 'trust'. The care providers described how when they placed the women's life circumstances first, trust became the key indicator to the measure of the quality of care they provided (Sword et al.). This symbiotically influenced the women to adopt their health professional's advice, access and engage with planned care and change care-plans as needed.

3. The United States of America.

Edgerley et al. (2007) described an innovative project in Stanford USA, which employed a transport van as a mobile community antenatal clinic. This project provided close to home, easily accessed and convenient antenatal care to an underserved population with excellent outcomes. The women were predominantly (80%) non-English speaking and uninsured. These women registered three weeks earlier and accessed their first antenatal assessment earlier than all other women accessing the local conventional community clinic. The community van helped alleviate barriers such as transport, cost and the need for an appointment. It was suggested that this intervention needs further exploration for similar communities in view of improving access to postnatal care and other maternal and infant health services (Edgerley et al., 2007).

Both Sword et al. (2012) and Edgerley et al. (2007) addressed the importance of identifying and providing for the needs of women, ensuring both convenience and ease of access to the services is paramount for when women are ready. Although a reflective view is needed to understand what is meant by women being ready to access antenatal care; there are women,

as Daniels et al. (2006) discussed, unaware of their pregnancy – either not recognising the signs of pregnancy, with limited knowledge about pregnancy care related to birth outcomes, or have the need to overtly delay disclosing the signs of pregnancy to ensure their safety or respect cultural norms.

Daniels et al.'s (2006) research pertaining to black women residing in the USA and cultural norms influencing their access and engagement with antenatal care, resonates with that of New Zealand researchers Makowharemahihi et al. (2014) and Ratima and Crengle (2013). They found that women who have had previous antenatal care which was insensitive, dissatisfying, or culturally inappropriate were less likely to re-engage with care. These researchers have a common message; early access to pregnancy care is dependent on the women's partners, family and community members. Significant others play an important role in influencing women's attitudes and uptake of pregnancy care. Therefore, they suggested, it is important to include their voices, along with the women's voice, in the planning and provision of the antenatal care service. Having an inclusive attitude towards women, their families and their life contexts will inform antenatal care services when health service development places the woman first and does not prioritise the needs of biomedical or governmental institutions (Daniels et al., 2006; Makowharemahihi et al., 2014; Ratima & Crengle, 2013).

4. Australia.

Rumbold and Cunningham (2008) reviewed 10 antenatal programme's effectiveness at strengthening antenatal services for Australian indigenous women, predominantly women who reside in high deprivation communities marginalised by poverty. They found that only two programmes demonstrated care improvements with women accessing antenatal care in their first trimester. Like Rayment-Jones et al. (2015), who examined birth outcomes when women engaged with continuity of midwifery care or standard midwifery, Rumbold and Cunningham found positive gains for women in the two programmes that provided continuity of midwifery care and included indigenous health workers and GPs who were integrated and co-located at community clinics where the antenatal midwifery programmes were based. These antenatal programmes attempted to address the social determinants of health in conjunction with cultural considerations. The two programmes are similar in their findings to that of McNamara (2012) and Zadoroznyj (1999) recognising that restraints of social stratification, at the same time addressing what makes women's lives complex and unhealthy, influences their ability to access health care services (Rumbold & Cunningham, 2008).

The international literature notes the need for a concerted effort on the part of health care providers to consider local initiatives or interventions that have enabled early access to

antenatal care and involve the women in the design of the service and trial new ideas (D'Souza & Garcia, 2004; Edgerley et al., 2007; Finlayson & Downe, 2013; Rumbold & Cunningham, 2008). The literature brings to the fore the need for accountability and change from the dominant government resourced health services. The most recent research, over the past five years, has exposed the inadequacies of the current way in which maternity services are provided as a 'one size fits all approach' (Bartholomew et al., 2015); probably cost effective to the governments and governing bodies of the health regions but seen within the literature to be inadequate and not addressing the needs of the populations served (Finlayson & Downe, 2013). Research has exposed that antenatal services need to align with all pregnant women's context with dignity, respect and consideration if the service is to be physically and psychologically accessible and importantly continued to be utilised throughout pregnancy (Finlayson & Downe, 2013). Urgent recommendations calling for improved management of antenatal care, include more communication and improved collegial relationships between midwives, GPs, sexual health services and hospital government funded services (Haddrill, 2018). Moreover, women want culturally responsive care, kindness and to feel respected by culturally competent antenatal care providers (Daniels et al., 2006; Ludeke et al., 2012; Makowharemahihi et al., 2014; Ratima & Crengle, 2013; Southwick et al., 2012; Tanuvasa et al., 2013).

Universal recommendations from the literature

Having reviewed the literature, the salient recommendations gleaned throughout have been summarised below:

- increase awareness of what antenatal care comprises and why this care is recommended in the first trimester (notwithstanding there is a need for international consistency for recommending antenatal care before 10 weeks gestation or within the first trimester)
- health care providers need to be aware and understand the barriers challenging women to access early antenatal care
- uncover what works well in response to the specific challenges of each community
- understand and account for women's socio-cultural and psychological needs
- understand the influences of partners and family members to women accessing LMC care
- include women's voices who use the services in the development of their childbirth journey services

- deliver flexible models of care within communities, considering home visits, mobile clinics, after hours clinics and midwifery clinics within primary health care, namely GP clinics
- have medical and midwifery staff of the same ethnicity as the challenged population
- increase awareness of continuity of midwifery care benefits
- GPs and midwives improve their inter-collegial relationships, disseminate knowledge about the maternity system and quality of first trimester care and identifying women who need assistance or a navigator to connect with a LMC in a timely manner

Summary

The international literature has been discussed across both qualitative and quantitative paradigms. Firstly, when examining and connecting women's delayed access and engagement with maternity services to poor perinatal outcomes, consideration must be given to the complex myriad of socio-economic, psychological, demographic contributors and the cultural paucity in the design and service provision of the antenatal care services. Secondly, providers must be cognisant of specific explanatory themes such as poor knowledge of the signs of pregnancy, lack of pregnancy planning, fear, chaotic or pressured lives and knowledge about health and social self-care.

New Zealand literature reveals that some women register for antenatal care late in the first trimester, even into the second trimester of pregnancy, because of the disconnection between GPs and LMC care providers. This disconnection in New Zealand is overtly seen within the literature, with the call by government health agencies to address the disconnect and assist the most vulnerable of women to straddle the gap between these two maternity providers. The recognition of local initiatives that have supported women to connect early for antenatal care is recommended; along with explicitly addressing workforce issues to support more ethnically specific health care providers to work within communities to provide culturally congruous care.

New Zealand and international literature highlight that primary health care and maternity services both need to be responsive to women's needs. Providing support for women to begin their journey into the maternity service system may be essential, if that is what is required for the women to access and start their LMC care before the first trimester of pregnancy ends and preferably before 10 weeks gestation as recommended by the PMMRC (2013), National Institute for Health and Clinical Excellence (2010) guidelines and the New Zealand Ministry of Health (2015b).

A successful community midwifery service co-located with other primary health care and community social services supports positive up-take of early antenatal care and good pregnancy and birth outcomes (Priday & McAra-Couper, 2011). It is no surprise Counties Manukau Health embraced the recommendation to increase the number of midwifery clinics co-located with primary health care practices, replicating a model of continuity of midwifery care where most of the women in these communities confirmed their pregnancy (Paterson et al., 2012). Thus, pregnant women have greater potential to access the right care at the right time to potentially improve their perinatal and maternal health outcomes, which equates to the same goals as the WHO (2016, 2017). In the following chapter the methodology and methods are described in relation to my study.

Chapter Three: Methodology and Methods

Introduction

In this chapter, I provide an overview of interpretive description methodology and methods assigned to explore the research question: "What are the experiences of multiparous women who live in socioeconomically deprived communities of Counties Manukau who have received midwifery care located at their General Practitioners clinic"? I discuss my rationale for selecting interpretive description methodology, along with its associated strengths and challenges. Within the methods section, I introduce the eight women participants and discuss the data collection and analysis trajectory, ethical considerations and rigour adopted within the research process.

Methodology – Interpretive Description

Interpretive description is a non-categorical qualitative research methodology developed by Thorne et al. (1997). As with many qualitative methodologies, interpretive description has its origins within the post positivist paradigm of constructivism; while, as the name suggests, within the interpretivism arm of constructivism. Interpretivism is an approach to knowledge generation which asserts there are multiple truths to creating knowledge as knowledge is constructed from the enormity of differing interactions between humans and their social world (Caelli, Ray, & Mill, 2003; Crotty, 1998; Thorne et al., 1997). A characteristic of interpretive description is the preceding literature review providing a starting point for the investigation (Thorne et al., 1997) which, in this case, demonstrated a paucity of research about women's experience of accessing and engaging with midwifery care from midwives co-located at their GP clinic.

Interpretive descriptive methodology is inclusive and recognises the importance of context (Crotty, 1998); yet, it acknowledges the subjective reality of both the researcher and the participants (Borland, 1990) allowing for explorative questioning surrounding the multiple realities of the particular topic of interest. Henderson (2011) suggested this view allows for a clearer understanding of the lived experience of people. It is grounded in real-life situations, enabling the inclusion of previously unconsidered influences (Guba & Lincoln, 1982). Further, it recognises that reality (ontology) is immeasurable and intangible (Borland, 1990) and accepts the limitations of a contained study while recognising the socio-cultural influences and values (axiology) that act on the studied group (Borland, 1990). By selecting a methodology grounded within the interpretive qualitative realm, this study captures the intricacies, chaos and

contradictions of the real world and allows for flexibility, responsiveness and deeper meanings to the data collected (Braun & Clarke, 2006, 2013).

Interpretive descriptive methodology is a relatively recent approach in the qualitative research paradigm. Its genesis is in nursing knowledge and applied clinical development; yet, it is applicable and increasingly utilised within the midwifery profession (Cluett & Bluff, 2006; Mellor, 2016) to produce knowledge pertinent to applied health disciplines. Interpretive description has links with grounded theory, ethnographic and phenomenologic research approaches; all allow for the in-depth examination of human experiences and life's authenticities (Thorne, 2008).

The philosophical underpinning of interpretive description methodology, as described by Thorne et al. (1997), is the recognition that health and illness experiences are a composition of multifaceted interactions between psychosocial and biological phenomena and occur in the context of individuals' natural reality. Thorne et al. (2004) described the approach as being philosophically aligned with naturalism which is identified by Guba and Lincoln (1982) as reflecting five adages that define naturalistic inquiry:

- multiple intangible realities that can only be considered holistically within their environmental context;
- the researcher and participants react and respond to one another and may therefore influence one another;
- the purpose is to generate context-based knowledge focused on differences and similarities;
- multiple processes, factors and conditions may shape phenomena where researchers can infer from the patterns that profile the phenomena;
- the inquiry is value bound, context sensitive and influenced by both the researcher and process.

Thorne (2008) described interpretive description as an inductive approach designed to interrogate clinically relevant phenomena and develop insight. Theory and knowledge emerge as themes or categories within the data producing findings that may inform clinical understanding.

This methodology will enable me to collect a descriptive summary of the experiences of multiparous women who live in socioeconomically deprived communities of Counties Manukau who have received midwifery care located at their GP clinic**,** illuminating the in-depth examination of human experiences and its realities within this researched experience

(Thorne et al., 1997). Interpretation also allows for the descriptive data to be conceptualised, explained, interpreted, inferred and considered within (Patton, 1990), in the case of this study, the influential interactions of the social and primary health care environments. The research progression of data collection, inductive analysis and interpretation aims to provide credible knowledge of the situation under study to offer possibilities for similar circumstances (Thorne et al., 2004).

Rationale for selection of interpretive description

Qualitative research methodology "aims at contributing to a deeper understanding of human experiences and behaviour and the behavioural world of applied practice" (Berterö, 2015, p. 1); thus giving evidence to inform clinical practice and shape the clinical relationships of consumers and health professionals in the worlds of midwifery and primary health care. Furthermore, interpretive description is particularly applicable for understanding complex experiential clinical and practical phenomena, events or processes (Berterö, 2015; Thorne, 2008), such as this study where women interface with a primary health service specifically designed for pregnant women's health care. Moreover, as humans are social creatures whose lives and behaviours are shaped by social influences (Caelli et al., 2003; Crotty, 1998), interpretive description is apt for knowing about the socio-environmental influences for pregnant women seeking early midwifery care.

Essentially the reason for selecting interpretive description is its appropriateness to allow women to speak freely, the researcher's ability to apply easy language, for the women's voices to be heard and because the data is collected in the practice setting. Therefore, the findings can inform clinical practice and health and wellness services in the primary health care environment.

The flexibility and responsiveness of the interpretive description methodology allows for resultant findings to be produced in easily understood language, aimed at informing clinicians and others, such as consumers of maternity services; additionally allowing the variations of world views to be heard and interpreted. Smythe and Giddings (2007) added that it enables a way to uncover "the issue of concern in its everyday context" (p. 37). To understand behaviours related to supporting health and wellness it is important to appreciate the meanings that have been attributed to that behaviour or action and, in order to achieve this, research must, therefore, interpret the meaning of the behaviours or actions (Grant & Giddings, 2002).

The use of a qualitative descriptive methodology for evaluating health service interventions is additionally recognised as ideal for assessing, developing and refining interventions with vulnerable populations (Sandelowski, 2000; Sullivan-Bolyai, Bova, & Harper, 2005). Further, interpretive description provides a discipline specific methodology that addresses clinical questions and situations in the applied health arena (Thorne et al., 1997; Thorne et al., 2004).

A strength of interpretive description that initially attracted me to this methodology is its "straightforwardness" (Smythe, 2012, p. 6) where the researcher poses questions, listens and then interprets, making sense of the data. Thus, it is an applicable framework for a beginning researcher's thesis; although Smythe (2012) cautioned the "depth of the analysis may vary depending on the 'thinking' of the researchers and the nature of the literature they engage with in unpacking ideas" (p. 6). Consequently, it is important the researcher listens without creating her own opinions, holding steadfast to interpreting the meanings of what is in the data (Thorne, 2008).

Alternative methodologies considered for this study

Phenomenology and grounded theory were two methodologies considered for this study, both within the qualitative research paradigm and intrinsically influential to answering the 'why, how and what' of the experience under investigation (Smythe & Giddings, 2007; Thorne, 2008). As the research question focuses on the experiences of pregnant women interacting with a general practice setting that has a co-located midwifery service it is apt that the chosen methodology assists the description, meanings and interpretation of the women accessing the health service provided and illuminating those at play within this inter-relational triad.

Phenomenological research is narrative based and intended to expose the meaning within the experience rather than recording the experience (Smythe, 2011, 2012). The purpose of this research methodology is to record the first-hand experience of the women. The deeper meanings revealed by phenomenology were not useful for this study as they are strictly not philosophically designed to be applied or applicable to other clinical situations. Moreover, the research question does not fit with uncovering phenomena through the methods of in-depth interviews and analysis of experiential data.

Grounded theory, as described by Glaser, Strauss and Strutzel (1968), focuses on identifying interactions of the phenomena being studied to form a theory to explain the phenomena. As the proposed research focuses on the individuals' experiences the development of an explanatory theory or hypothesis was not a desired outcome (Smythe, 2012). Rather, I

required an interpretation of the participants' experience that could be relatable and applicable to similar clinical situations.

Ethics Approval

All research projects, especially ones with human subject participants, require consideration of ethical matters to ensure the rights of participants are met and the researcher realises her responsibilities and obligations. The key ethical principles relating to research participants are the right to informed voluntary consent, privacy and confidentiality, minimisation of risk, truthfulness, social and cultural sensitivity, commitment to the principles of Te Tiriti o Waitangi (Treaty of Waitangi), research adequacy and an avoidance of conflict of interest. Each of these concepts will be addressed within the methods section, notably the participant recruitment, selection and audit trail sections.

Preceding this study investiture, the research proposal was submitted to Auckland University of Technology, Faculty of Health and Environmental Sciences Postgraduate Research Committee. Ethical approval was granted by Auckland University of Technology Ethics Committee on 17 June 2016; approval number 16/320 (see Appendix A).

Methods – Research Design

According to Crotty (1998), methods are the techniques and processes used to collect then analyse data related to the research question. The methods used within this study are semi-structured, in-depth individual interviews with a manual thematic analysis of data.

Participant recruitment

Thorne (2008) suggested purposive and theoretical sampling are ideal for interpretive description but recommended the researcher uses logic in recruitment to ensure the participants' experiential data is within the context of the study question. Hence, purposive sampling, also known as phenomenal sampling (Thorne, 2008), was used to invite women to contribute to this study. Purposive sampling is a deliberate non-random process; the objective is to select a group of people with sought after characteristics to ensure maximum variation in the experiences of the phenomena being explored (Bowling, 1997; Strauss & Corbin, 1998; Thorne, 2008; Thorne, Con, McGuinness, McPherson, & Harris, 2004; Thorne et al., 1997).

Participants were selected to ensure they came from numerous GP clinics in differing geographical locations of the socioeconomic deprivation regions of Counties Manukau.

Counties Manukau Health has identified communities within their geographical region according to their socio-economic status based on the New Zealand census data (Atkinson et al., 2014; Counties Manukau Health, 2017); it was from this socio-economic classification I invited participants, thus ensuring they identified with communities of high deprivation. Doing so avoided a narrow view of the service model and ensured the data would be participant (women) and not service provider (GP and midwife) dominant. Thorne et al. (1997) suggested it is important to select a variety of participants as some will be articulate, while others will be less confident with recollecting and relaying their experiences. Thus the accounts of the phenomena will reveal maximum categories and themes that are shared by all participants ensuring single representations are avoided (Thorne et al., 1997).

I approached GP clinic personnel and midwives who have co-located midwifery clinics at GP clinics in the Counties Manukau Health region to explain my study and ask if they might offer support by providing participant information sheets (Appendix B) to eligible women. Women interested in the study were invited to then phone or leave a text message for me to return a call. In total 12 women contacted me with eight being recruited. Five decided not to be involved and one other was recruited via my follow-up phone call as explained below. There were a number of instances when the midwives informed me that women were interested in my study but they had no phone credit to contact me and so had given permission for me to contact them. On three occasions, I telephoned such women to explain the study in more detail and, with their permission, I followed up with a further phone call to ascertain if they wished to participate. In two instances, there was no phone reply and after two attempts I abandoned trying to make contact. Eight participants were recruited and interviewed over a three-month period with the last interview being 8 weeks after the first seven interviews.

The inclusion criteria were

- multiparous women who have received previous pregnancy care at a location other than their GP clinic and with subsequent pregnancies have received midwifery care from midwives located at their GP clinic in the last five years;
- conversant in English;
- over 18 years of age;
- residing in the high socio-economic deprivation areas of Counties Manukau Health.

The exclusion criteria were:

- women who, in the past, had received midwifery care from the researcher or her back-up midwife.
- primigravida women, as they would have had no opportunity to have experienced any other model of maternity care, therefore comparative thoughts may have been limited.

Participant selection

Eight women took part in this study (see Table 1, p. 48). They all resided in areas of high socio-economic deprivation in the Counties Manukau Health region; an area classified as quintile 5 which is the amalgamation of the two highest deprivation areas on the deprivation index (Atkinson et al., 2014). All participants met the inclusion/exclusion criteria. In keeping with the emergent design of the study, the number of participants ceased once the stories, themes and topics were consistent between interviews.

Data collection

Data was collected through individual semi-structured face-to-face interviews; a traditional qualitative research technique (Braun & Clarke, 2006, 2013; Thorne, 2008). Semi-structured interviews are a conversation where the participant and researcher actively engage in dialogue using techniques to explore and critique the participant's stories, views and thoughts about the research topic (Thorne, 2008; Thorne et al., 1997). Interviewing in this manner allows for the participants' narratives to be heard within their context, upholding interpretive description methodology by asking what is happening in their lived experience of the particular phenomenon under study (Smythe, 2012; Smythe & Giddings, 2007; Thorne, 2008; Thorne et al., 1997).

Preparation for interviews and cultural safety

The interviews occurred between October 2016 and February 2017. I met with each participant at a pre-arranged destination of her choice. The AUT researcher's safety protocol was implemented during all home-based interviews, see Appendix C. All but one interview took place in the participant's home. One participant elected to meet at a café during her work lunch break. In this instance, I offered to pay for her lunch to honour her time as a participant in my study. Prior to commencing the interviews, the participant information sheet was reviewed, and participants were reminded that they could withdraw from the study at any time; questions were answered and the consent form was signed (Appendix D).

I sought the permission of each participant to digitally audio record the interview. All participants agreed to the audio recorder being used.

Table 1: Participants demographics

Geographical locations, all quintile 5 areas in Counties Manukau Health region (Counties Manuka Health, 2015)	3 Manurewa, 2 Mangere, 2 Otara, 1 Clendon
Ethnicity - multiple ethnicities are reported to honour the women's description of their ethnicity. This also reflects the Ministry of Health data collection system that reports up to three ethnicity codes (Ministry of Health, 2017b)	2 Māori, 2 Pacifica, 1 Pacifica/Māori, 1 Māori/European, 1 Indian, 1 European
Age range	28 to 38 years
Gravida	5 Gravida-2, 1 Gravida-4, 1 Gravida-5, 1 Gravida-6
Locality of participants' home to their GP clinic	All within 1 to 10 minutes' drive. With three women within 10 minutes walking distance, of which two women did not drive
Pregnancy confirmed at GP clinic	All participants had their pregnancy confirmed at their GP clinic
Models of maternity care (for all pregnancies, previous and current)	GP shared care - 8 LMC midwife at a location other than their GP - 6 LMC midwife at their GP clinic - 11
Gestation registered with midwifery care (for all pregnancies, previous and current)	GP shared care - 8 women - 6, 7, 8, 11, 12, 12, 28+, 28+ LMC midwife at a location other than their GP - 6 women – 8+, 8, 12, 12+, 18, 20 LMC midwife at their GP clinic - 11 women - 6, 6, 7, 8, 8, 11, 12, 12, 12, 13, 14

Prior to commencing the interview, I engaged in general conversations about the woman, her family and, for some women, when appropriate, a discussion about family celebrations and church activities. This process demonstrated my respect for the woman's family and spirituality. As most of the participants were of Māori or Pacifica ethnicity the principles of The Treaty of Waitangi and Pacifica cultural respect were uppermost in my mind to ensure cultural competence and reverence of the cultural mores and the collective consultative nature of both Māori and Pacifica peoples (AUT University, 2015; Hudson, Milne, Reynolds, Russell, & Smith, 2010). I ensured consultation, review and advisory processes occurred in

the design and development of the study with midwife Nga Maia chairperson Megan Tahere and Pacifica midwife Ngatepaeru Marsters, Pacifica Midwives Aotearoa, both affiliated with the Auckland and National New Zealand College of Midwives. Consequently, I made certain that any people the participant may want present at the time of the interview were accommodated and food and drinks were taken to the homes, as sharing food together is essential.

Each participant was asked if she wanted to select a pseudonym to protect anonymity within the data and writing up of the study. Six participants selected pseudonyms; the remaining two felt strongly they wanted to use their own names. In line with cultural competence and valuing self this was respected (Midwifery Council of New Zealand, 2012). I began the interviews by asking demographic questions which assisted with placing the woman at ease. These questions also acted as springboards to help move beyond the what was happening to why, how, why not and when, so that relationships, commonalities and patterns could be heard (Smythe & Giddings, 2007). The women often recalled further information from the demographic questions about accessing or engaging with midwifery care. For example, "Where do you live in relation to your GP clinic and where have you accessed a midwife?" was then extrapolated to "How long does it take you to walk or drive to these clinics?" The first interview participant discussed in depth the ability to walk when driving or vehicle transport was not possible, hence I expanded on the initial question.

To ensure the study would not cause harm, participants were informed that they could ask me to stop questioning and/or stop recording at any stage and, if desired, withdraw at any stage. I was aware some women might feel guilty for not booking with midwifery care early in their pregnancies and was mindful that my questions and discussion did not have this negative consequence. It was apparent that for one participant, poverty impacted her ability to easily engage in antenatal care with the midwife from her first pregnancy (as this midwife had left her GP clinic). This caused some distress and I offered to stop the recorder during the interview and take a break. The participant declined the break and said she was happy to keep talking.

I had pre-organised counselling services provided by AUT University if a woman needed to address the distress in a more formal way. This was not required. I feel the opportunity to share their experiences was in itself beneficial and at no time caused harm.

Interview process

The interviews were participant led, although at times guided by use of an interview prompt sheet (Appendix E) to safeguard for congruence between interviews and keep the dialogue on track. I was actively engaged with the participant's dialogue, probing with exploratory questions to tease out descriptive experiences, deconstruct familiar stories, ideas, concepts and notions of the topic under discussion (Sullivan-Bolyai et al., 2005; Thorne, 2008). I reviewed all the open-ended questions after each interview to alter the exploration of the topic with the evolution of the interviews. The emphasis of the open-ended questions focused on the woman's experience of the GP clinic where her pregnancy was confirmed and the relational encounters she had to engage with a midwife at her GP clinic and also when engaging with a midwife not at her GP clinic. Comparative discussions helped the participants to recall their stories across their pregnancies which ensured depth of thought on the topic of interest.

For some participants I needed to use less academic, midwifery, or medical language to ensure understanding and put them at ease. A fine balance was needed to aid understanding and yet not be seen to lead the participants. The prompt sheet, along with tailoring the language, ensured the participants could tell their story as it was for them, within their context.

A challenging issue was a number of the women had never experienced being interviewed for research and were not familiar with this exploratory nature to conversing. Thorne (2008) contended the researcher must suspend her knowledge to elicit the participant's story to ensure the researcher's knowing has no influence. I was most aware as a midwife who has provided LMC continuity of care at two GP clinics for 22 years that my knowledge could be seen as influencing and creating bias. To ensure credibility and transparency of processes I contained my views and body language, to the best of my ability, ensuring neutrality. I had to remind myself a number of times to stop using positive reinforcing dialogue, for example, 'great' or positive body language at the end of the women's dialogue as I was conscious this may have been misconstrued to be what I wanted to hear. With these strategies in mind, although at times challenging, I improved with each interview.

The interviews took between 40 and 70 minutes; the time was determined by the women's need and willingness to talk about her experiences. Some women had their baby, toddlers and relatives present at the time of the interview. All interviews were audio recorded with handwritten notes during the interview to aid management of the record keeping processes. As I became absorbed with the participants' stories and captured in the dialogue I often

stopped taking notes and I felt these interviews had more flow of discussion. Thereafter, as the interviews proceeded, I took fewer notes. However, I ensured that when I left the participant interview I drove to a nearby place to record post interview notes. These notes provided additional information in relation to each interview. The notes supplemented my data and helped to keep me focused on each individual interview and not have it blur with other participant interview data.

As a controlled listener I allowed the conversations to develop and the women expressed thoughts I was not expecting. This provided a rich variety of data, informing the analysis and depth of 'what', although more importantly the 'why and how of what' happens in these women's lives as mothers, home managers and women accessing and engaging with midwifery care. As categories and themes began to emerge the questions were refined to explore and counter check the developing findings (Sandelowski, 2010; Thorne, 2008).

Managing data

All interviews were transcribed verbatim by a transcriptionist who signed a confidentiality agreement. I re-listened to each interview recording with the transcripts to confirm they were transcribed accurately.

The transcripts were offered back to the participant to make any changes, a strategy to ensure the findings truly reflect the participant's experiences (Thorne, 2008). Three participants declined reviewing their transcript as they felt happy with their recollection of the interview noting they were audio recorded. Three participants were not contactable to forward the transcripts. A further two participants were sent the interview transcripts; I did not receive any feedback thus assumed that they did not wish changes to be made (as per the information sheet).

Data analysis

A thematic analysis process was used to analyse the data. Boyatzis (1998), Lincoln and Guba (1985), Thorne (2008) and Thorne et al. (1997) have described thematic analysis as the process of discovering recognisable patterns or themes captured within the subjective perceptions, the participants' recollections about the topic in question. The purpose of which is to see, make sense, synthesise meaning, theorise and reconceptualise relationships into findings to "generate an interpretive description presenting a clinical understanding" (Berterö, 2015, p. 1). Thematic analyses may result in the development of a list of themes,

commonalities and categories or it may be a complex model of themes, indicators, or causality related accounts and declarations (Boyatzis, 1998; Thorne, 2008).

An inductive approach to analysis was used to derive concepts and identify themes or commonalities in the phenomena described, a method affiliated with most qualitative methodologies. A theme is defined as "a pattern found in the information" (Boyatzis, 1998, p. 4). Inductive analysis generates findings from the data rather than imposing a pre-determined structure of analysis (Guba & Lincoln, 1982; Strauss & Corbin, 1998; Thorne et al., 1997).

By using an iterative and inductive method of analysis rich data were generated from the women's experiences of accessing and engaging with midwifery care, co-located at their GP clinic, at the beginning of their pregnancies, while looking for and explaining the complexities of health and social issues during these relational care episodes. I was guided by Thorne, Con, McGuinness, McPherson and Harris' (2004) recommendation to use an iterative approach to interpreting the data, progressing from a micro to macro view. I did this by firstly asking 'what's happening here?' (Thorne et al., 1997; Thorne et al., 2004) to 'what's happening over these relational episodes for the women and the health professionals when confirming their pregnancy and accessing midwifery care?', 'where does this thought or action fit and what else is happening here?' Thorne (2008) described taking the collected data and applying an "interpretive explanation" (p. 164) to yield thematic structures "showcasing the main elements of phenomena in relationship with one another, if not within a new conceptual or theoretical schema" (p. 165).

Audit trail

My analytic process involved:

- Undertaking the first seven of the eight interviews with concurrent analysis.
- Each interview was transcribed professionally after I initially attempted to transcribe the first interview myself, which proved to be too great a challenge. Each transcript was printed twice and with a retained computerised copy. I had a total of 120 pages of data.
- Initially I read each transcript in its entirety to become familiar with the data and the individual's experience. Sandelowski (1995) reinforced this is an important first step to take before attempting any comparative thought processes. I re-listened and re-read the transcripts at least twice to ensure accuracy, this also enabled me to make notes on voice nuances, words, phrases and pauses all very important to hear the

depth of meaning of words. Thorne (2008) recommended this approach for the neophyte researcher undertaking a small study such as this. I was then able to notate any thoughts to the transcripts about 'what's going on here', 'what is the participant trying to say', 'where does this fit' along with, 'what did I sense was going on individually and across the interviews?' This manual line by line analysis approach permits flexibility (Braun & Clarke, 2013; Thorne, 2008) and my personal input and ease of rechecking ensured I had not missed any notations or raw data as the analysis evolved. All process steps were congruent with a small qualitative study. I chose not to use a qualitative research computer programme.

- 17 codes were noted with commonalities between codes.
- I counterchecked my hunches, thoughts and meanings from the analysis and developed the codes into three categories. This audit trail was my springboard to extrapolating my thoughts and drawing connections within the data I analysed.
- A month later I interviewed the eighth participant with refined questions to counter-check what I thought I was hearing from my previous seven interviews.
- The codes were then re-checked by the following process: the eight-interview data on my computer were colour coded highlighting commonalities, synonymous wording, or sentences within each transcript. I began to note patterns of thoughts and data that fitted within a theme or experience. These initial commonalities were given specific titles of which there were 17 by the end of the eighth transcript. I re-read the data each time to see if it fitted under another title, noting some data fitted in multiple places. This process also included 'constant comparisons' with all data verifying authenticity (Thorne, 2008). Re-reading and with constant comparison, I sorted, compared and contrasted the data to refine my commonalities and re-think and amalgamate some titles while constantly hearing the participants' stories and asking 'what is happening here?' This is an essential ingredient to an iterative and inductive method of analysis to maintain the integrity of the participants' experience.

In essence, I went from 17 specific groupings with their own codes to three categories which encapsulated the 17 groupings and condensed the data to a more manageable level. I changed my theme descriptor a number of times trying to accommodate the sub-themes often including some data then excluding other data. Thorne (2008) described this as the 'trying out' part of conceptualising the data. This frustration was continuous and not easily resolved, so I decided to be decisive and the first evolution of my themes was born:

1. Trust and relationships matter
2. Variable factors impacting upon women
3. Knowing about services

After discussions with my supervisors and repeatedly asking 'what is the meaning of this?' I decided on three categories that described the initial themes. The names for the headings evolved over time. These were:

1. Life influences
2. Missed opportunities
3. Relational relationships matter

As the data evolved into the written format the themes were refined to their final categorical themed headings:

1. It's a daunting journey accessing midwifery care
2. Circumventing the maternity health service maze

Discussion notes related to the analysis audit trial

I noted a profound depth of respect and appreciation for the impact the mothering and home management role, along with poverty, has for the women in accessing and engaging with a health care service that has been developed for them but not by them. I often wrote the words 'busy, busy, busy'; the women talked constantly of being so busy mothering, managing their homes and ensuring their family was surviving.

At times, I felt overwhelmed by the amount of data and the pressure to decide on where the data fitted best. The initial 17 sub-codes seemed too much, and I did not see how any sub-codes could be less important than another. Yet, discussions with my supervisors and with reflection and space I had 'aha' moments when I jotted on any piece of paper at hand my new connection that enabled me to merge the sub-codes to three main categories.

- The sub-codes of familiar, comfortable, close, known health professionals, trust GP, connecting with midwife after discharge, flexible, convenient, easier and help with connectivity; all had commonalities with trusted relationships. Therefore, fit within the category 'Relational Relationships'.
- The sub-codes of busy life, knowing and sharing private information, challenges and barriers to accessing midwifery care, what woman wanted from a midwife, multiple services in one place, other family needs addressed and reason for late booking; fitted with 'variables or factors that impact accessing midwifery care'.

- The sub-codes of knowledge of midwives, friend and family knowledge, confidence with self-access, available information, GP and practice knowledge, location and accessibility; fitted with the category 'Missed Opportunities' to access LMC care.

I do believe this was the time when I first realised the data became a base for further research in the health service arena for women who live with health services developed for them yet not with them; and who live with the pressure of mother management demands and poverty. It was also the time I realised the voice of the GP clinic health professionals and the co-located midwives was missing. I became absorbed in thinking how I could include their voices to create a holistic view of what was happening in this whole health service arena. However, after talking to my supervisor I realised this master's thesis was not a PhD and the potential for further research was possible. This allowed me to refocus on the women's voices which re-anchored me back to the research question.

The audit trail, as described here, ensures transparency within the research process used for this study. It is the basis for the trustworthiness of the research findings. "When the reader can see that the product is well-made, the findings arrive at some measure of credibility" (Thorne, 2008, p. 187).

Trustworthiness and Rigour

Hamberg, Johansson, Lindgren and Westman (1994) argued that for research to be viewed as trustworthy and show rigour, credibility must be evident within the findings. Research is deemed sound when the audience can see from the description how the research was carried out (Carcary, 2009). Smythe and Giddings (2007) further argued that research findings can be deemed trustworthy when the audience finds resonance between the findings and their own life experience; as the reader listens or reads he/she feels personally addressed and this moves him/her to change praxis. Oakley (2000) aptly claimed that to promote trustworthiness in qualitative research the audience needs to be able to decide for themselves if the findings are trustworthy. Hence, the use of recognised trustworthiness criteria; in other words, a judgement or procedural framework, against which the qualitative study can be assessed, enables the reader to judge the research findings. Deciding what criteria to include in assessing the validity of qualitative research is challenging (Hamberg et al., 1994); particularly so for this study which uses a qualitative interpretive description framework when the dominant paradigm of the GP clinics is grounded within a

quantitative based medical model. However, the basis of family health care is embedded in relational processes of everyday life; therefore a study focusing on pregnancy and family health issues is well suited to qualitative research describing the processes and context of the health care services that effect health outcomes (Sullivan-Bolyai et al., 2005). Yet, as Hamberg et al. (1994) stated "concepts such as validity, reliability, objectivity and generalization cannot be used in qualitative research"(p. 176) as they are in quantitative research. This is because neither philosophical paradigm can be measured against each other; as both the genesis and epistemology of the paradigms reflects differing purposes, methodologies and the applicability of the findings differ. Hamberg et al. does, however, list four criteria for judging the trustworthiness of qualitative research. Originally described by Guba and Lincoln (1982), these criteria are "credibility, dependability, conformability and transferability" (Hamberg et al., 1994, p. 176). Although Thorne (2008) has suggested that trustworthiness may be better served by specific attention to "epistemological integrity, representative credibility, analytic logic and interpretive authority" (p. 102), Rolfe (2006) asserted the research topic and question influences the selected trustworthiness procedural framework that will best serve the researcher's judgment to ensure trustworthiness of the findings. Thus, Lincoln and Guba's (1985) criteria, as listed above, are applied in this study.

Credibility is concerned with the production of credible and truthful findings and interpretations throughout data collection and analysis. The credibility in data collection is dependent on mutual respect between the researcher and those researched and in presenting the data as described by the participants. Throughout the research process I have been consciously open and clear about my own processes, thinking – including beliefs, biases and values, choices, actions and reflections that may have influenced the study. Thus reflexivity was critical within the research process to show my influence within the research process (Grbich, 1998) and how the findings were reached.

I constantly referred to my research question, asking what is happening here and what am I learning from this participant's story? What am I learning about women accessing and engaging with midwifery care from midwives co-located at their GP clinic? What am I learning about the effects of poverty on accessing and engaging with midwifery care when it is offered at the GP clinic? Asking these questions ensured I kept to the aim of interpretive description methodology as described by Thorne et al. (1997). Equally important for credibility is the use of a well-structured

methodology and analytical method to ensure the data collected is as close as possible to the participants' experience and encompasses accurate critical reflections.

Dependability depicts the concept of the research being "solidly performed" (Hamberg et al., 1994, p. 178) meaning the research adapts to changes in the studied environment and to new inputs during the research process. In this way, the research can explore and respond to the complex connections in people's lives and their surroundings. I utilised note or memo taking throughout the study to enable tracking and verification of the processes used to produce findings which is evident within the audit trail. Lincoln and Guba (1985) stated the audit trail prompts consistency throughout the study, an important element for dependability. Another layer of dependability is seen in the fact that I have discussed the whole process, particularly the analysis, with my supervisors.

Confirmability defends neutrality within the research and endeavours to prevent distorting the reality (Lincoln & Guba, 1985). I have ensured my findings are grounded in the data and not distorted by the analytic process or influenced by preconceived assumptions. According to Lincoln and Guba (1985) confirmability assists the audience to judge the findings as sound by reviewing the data, the systematic methodological processes and the constant questioning, to critically review the entire process. Again, I maintained note taking, memos and undertook two separate analyses of the data, with my supervisors' input, to ensure that the audit trail was independent of my assumptions and beliefs. Thus, there is assurance that the findings are grounded in the participants' data. By undertaking a second analysis I reinforced and counter-checked for errors in the first analyses, this also afforded more reflective time and review of the categories and presentation of the themes. As Oakley (2000) claimed:

> …the distinguishing mark of all good research is the awareness and acknowledgement of error and that what flows from this is the necessity of establishing procedures which will minimise the effects such errors may have on what counts as knowledge. (p. 72)

Transferability refers to the plausibility of the findings, internal logic of analysis and the capacity to communicate the findings. An important question is: are the findings recognisable, transferable or relevant to other situations? (Hamberg et al., 1994; Lincoln & Guba, 1985). Lincoln and Guba (1985) suggested the ability to transfer

findings from one study to another circumstance is dependent on the degree of similarity between the two contexts and the 'thick description' within the data. Patton (1990) suggested depth of descriptions goes beyond the face value of the data to include the meanings, voices, feelings, attitudes and actions of each participant, which I have committed to ensuring is overtly evident as, going forward, it is the participants' cognitive and emotional recollections that will inform midwifery practice and health services in other high deprivation communities. I have also provided numerous data clips throughout the thesis to ensure the rich depth of the women's stories is heard along with the literature review data that demonstrates the transferability from the original Ministry of Health project (Priday & McAra-Couper, 2011). During the analytic and writing processes, I worked as a LMC midwife providing antenatal clinics at two different GP clinics; therefore, I found myself constantly reflecting on the voices within my data related to my own practice and those of health professionals around me. To ensure rigour with transferability I refrained from discussing any provisional thoughts or findings so as to not disrupt my research process.

The description of demographics is important in health research and can assist with transferability of findings for similar communities (Hamberg et al., 1994). Within this study the demographics are provided to enable transferability options.

Further to the work of Hamberg et al. (1994), additional considerations have been offered to promote trustworthiness in qualitative research. Smythe (2012) and Temple (1997) both outlined the importance of researchers being open and honest by declaring conflicts of interest and being aware of their assumptions and prejudices. Dwyer and Buckle (2009) highlighted the 'insider–outsider' phenomenon which can form bias within qualitative research, where the researcher is inseparable from the study. They warned that "the intimacy of qualitative research no longer allows us to remain true outsiders to the experience under study and, because of our role as researchers, it does not qualify us as complete insiders" (Dwyer & Buckle, 2009, p. 61). Consequently, the insider–outsider notion needs acknowledgement to ensure credibility of findings. I have disclosed my values and bias within the following pre-assumptions section.

Pre-assumptions

The beginning reflexivity process for this research project included a recorded and transcribed pre-understandings and assumptions interview with my second supervisor. This was to address the question 'who am I and what do I bring to this research project?'; culminating in the acknowledgement of my beliefs and knowledge potentially impacting the data and outcomes if not kept in check.

I am a woman and a mother who has accessed and engaged with midwifery care on three occasions. I have had numerous roles as a nurse in the primary health care arena; although primarily a midwife for the last 22 years providing care for women in high deprivation communities in the Counties Manukau region with co-located midwifery clinics at two GP clinics. Furthermore and most influencing, I acknowledge I am the co-author of a Ministry of Health commissioned report that describes a midwifery practice whereby all of the midwives have co-located clinics at GP clinics in the Counties Manukau region (Priday & McAra-Couper, 2011). Subsequent to this report, as outlined in chapter one, I was contracted to Counties Manukau Health to establish and support more co-located midwifery clinics within GP clinics in the high deprivation communities of the health board's region. This work culminated with the publication, *A successful midwifery model in a high deprivation community in New Zealand: A mixed methods study* (Priday & McAra-Couper, 2016). These roles have a high risk of influencing the robust nature of my research. Accordingly, the pre-assumptions and understandings interview illustrated my acknowledgement, cognisance and possible bias prior to the creation of the interview questions, interviews and analysis.

From the interview, I identified the following assumptions and acknowledge that I brought these thoughts and views to this research process. I brought to this research pre-conceived ideas of what I think maternity consumers see and feel about co-located ante-natal care. From my experience, I would suggest women in the interview to be open, frank and honest; and they would identify the relationship and the partnership of the GP clinic professionals and the midwife as important but they might not have ever articulated this.

I was conscious of possible power imbalances as the women I wished to interview reside in decile 9 or 10 socio-economic regions and I am well known in Counties Manukau region. This was mitigated by not interviewing any of the women for whom I have provided care. It is my view that often women and their families see health

professionals as people who have more knowledge and power. Additionally, they do not understand the health systems so they rely on the midwife to assist with navigating the services. I also believed the women of this region have a wellness focus of pregnancy and birth. They believe in their body's ability to birth and to be cared for, first by their family and second by a midwife or health professional and often are loyal to their GP and GP clinic. Therefore, midwifery care is not an immediate priority when initially finding out they are pregnant. Also, the women may not be well informed of midwifery roles and services in New Zealand, especially if they are recent immigrants which may be an obstacle to access and engagement. I also felt pregnant women who reside in decile 9 or 10 socio-economic regions often have socio-medical complexities and may need a more holistic medical and midwifery approach to their maternity care.

In light of my pre-understandings and assumptions, there were times when my views and beliefs were challenged throughout the interviews and research process. However, my foundational midwifery knowledge, working in partnership with women and having an illness prevention population health philosophy has provided a strong but not preponderant base for this research project.

Summary

This chapter has discussed the philosophical underpinnings involved with the selection of interpretive description as the methodology of choice that is appropriate to the question and study context. The methods, ethics and rigour were explored to ensure that interpretive description was honoured throughout the study. This was demonstrated with the use of semi-structured in-depth interviews, data collection and analysis with an audit trail and findings well connected to the women's voices and experiences.

The chapter has concluded by discussing my utilisation and application of the well-established trustworthiness framework by Lincoln and Guba (1985) to minimise error and promote rigour of this qualitative interpretive description study that seeks to answer the question: *What are the experiences of multiparous women who live in socioeconomically deprived communities of Counties Manukau who have received midwifery care located at their General Practitioner (GP) clinic?* In the following chapter I present the findings of my analysis.

Chapter Four: It's a Daunting Journey Accessing Midwifery Care

In this chapter I describe two themes that emerged from the data and offer an in-depth analysis of the participants' experience when accessing and engaging with midwifery care at their GP clinic. The participants' beliefs, actions and thoughts about pregnancy care are shown in conjunction with the challenges they experienced and the assistance they received to access and engage with a LMC carer; in the case of these participants the LMC carer is a midwife.

The data showed that there is an expectation for all women to independently find and self-select a midwife, upholding the viewpoint of women's autonomy. This overarching perspective of choice dominates the Primary Maternity Services Notice 2007: Section 88 and midwifery in New Zealand.

I identified several sub-themes within the data and have focussed on the two dominant themes: **'The daunting journey accessing midwifery care' and 'Circumventing the maternity health service maze'**. Their sub themes are then identified and described (see Figure 2).

'It's a daunting journey accessing midwifery care'

- I'm pregnant: confirming the pregnancy, allowing time and being ready to engage with midwifery care
- Engaging in early pregnancy care
- Associating midwifery care: the beginning months of pregnancy
- A daunting process; navigating pathways were fraught with obstacles and challenges
- Traveling to and fro', mission impossible

'Circumventing the maternity health service maze' (Chapter Five)

- Looking out for me and my whānau; helping me take a short cut to find a midwife
- Taking a bit of work off my plate
- Familiarity of care location; receiving midwifery care where they access their general primary health care

Figure 2: Themes and sub-themes

These themes are interdependent; key elements often traverse between the themes depending on the context and how participants interpreted the interview enquiries and told their story. I offer my interpretation of the data using the themes in this and the following chapter.

The Participants

In the interviews, the participants described their beliefs and knowledge about early pregnancy care framed within their life experiences of socio-economic challenges, parenting,

home management and, furthermore, out-of-home employment roles. All participants lived in extended family living arrangements.

Every participant's life was filled with mothering, home management, partner's work obligations, their children's health needs, commitments within their personal relationships, extended family commitments. On top of these commitments, all were either in paid employment at the time of the study or very recently. The data showed that during the interviews the participants made little reference to considering themselves or their general health needs as priorities. Rather, their concerns were with the wellbeing of their babies and other family members.

The participants continually reiterated having busy lives, being pressured for time with competing priorities and the demands of their families being all consuming. Nevertheless, they strived to facilitate smooth-running family dynamics meeting everyone's needs. The context of busyness is seen clearly within the themes 'it's a daunting journey to find midwifery LMC care' and 'looking out for me and my whānau/family'; all participants were challenged by restraints of knowledge, time, finances and transport when trying to access and engage with midwifery care.

The participants were eight multiparous women who had 25 pregnancies between them with varying models of maternity care. One participant had experienced a miscarriage. For eight of the pregnancies the participants had shared care (GP and DHB midwifery care). For 11 of the pregnancies the participants had LMC midwifery care with the midwife having a co-located clinic at their GP clinic. For six of the pregnancies the participants had LMC midwifery care with the midwife not co-located at their GP clinic or providing home-based antenatal visits. The number of pregnancies, model of care engaged with and weeks of gestation at which participants accessed midwifery or maternity care is summarised in Table 2 below.

Table 2: Number of pregnancies, model of care engaged with and gestation point for accessing LMC midwifery or maternity care

Weeks of gestation	6-7	8-10	11-13	14	16	20 -30	30-33
Shared model (n = 8 women/pregnancies)	2	1 + 1 mis	3	0	0	1	0
Non-co-located LMC midwife (n = 6 pregnancies)	0	2	2	0	1	1	0
Co located LMC midwife (n = 11 pregnancies)	3	2	5	1	0	0	0

Findings I: The Daunting Journey Accessing Midwifery Care

This first theme captures the women's experiences of becoming aware that they were pregnant, confirming they were pregnant and then engaging in the maternity system.

I'm pregnant; confirming the pregnancy, allowing time and being ready to access and engage in midwifery care

For the women, confirming their pregnancy and being ready to access and engage with midwifery care was an important experiential theme which explained their experience of taking the first steps on their journey to seeking pregnancy and childbirth care. When they initially found out they were pregnant, participants recounted that numerous facets of their lives affected their readiness and timing to enlist midwifery care. There were many pathways to accessing midwifery care at the beginning of the pregnancy journey. These pathways exposed how time passed inadvertently or purposely between participants finding out they were pregnant and accessing midwifery care.

The participants described how the process of finding out they were pregnant was influenced by whether the pregnancy was expected, unexpected, or desired. Whether the woman had experienced a previous pregnancy loss or anticipated a loss in the current pregnancy (through spontaneous miscarriage or termination) further influenced when each woman accessed midwifery care.

Across all the participants' 25 pregnancies, every pregnancy was either confirmed by a pregnancy test at their GP clinic or the woman accessed their GP clinic to discuss their pregnancy and seek assistance in finding LMC care. This high number of women having their pregnancy confirmed at their GP clinic is echoed by Counties Manukau Health statistics that show over 70% women in the region have their pregnancies confirmed at their GP (Corbett et al., 2013; Jackson, 2011a). While many participants were trying to become pregnant, conversely, some participants were surprised to discover they were pregnant at a visit to their GP clinic for other health related reasons.

For example, Kelly's first pregnancy resulted in a miscarriage influencing her to seek care as soon as she thought she was again pregnant:

> *So, my husband and I had been trying and I had a miscarriage so that's why we were so glad to discover I was pregnant again. So, we were proactive in checking whether I was pregnant. I went to my GP because at that stage [Kelly thought] maternity services [shared care] were still offered at the GP clinic… Um [it was] early in the piece um…. 12 weeks yeah it was early.* (Kelly)

Kelly's fourth pregnancy was a little different and unexpected:

> *I had taken my son to the doctors, being a day-care kid we're frequent visitors and I had a sore back at the time and I just thought while I'm here can you just check I haven't got a urinary infection or something. And apparently as part of their protocol if you're within a certain age, they just go and do a pregnancy test without telling you…. then the nurse came, came along and said "oh can you please come into the room we've got a few questions". And she just said "oh you're pregnant". I said are you sure…. it would have been first trimester… maybe 13-14 weeks.* (Kelly)

In contrast, Rata's desire to connect with midwifery care for her second pregnancy was defined by the prior experience of a friend and she deferred looking for midwifery care:

> *I think I was a little bit cautious this time round. I don't know why, maybe it's because I had a girlfriend that had suffered a lot of miscarriages and stuff so I didn't actually look for a midwife until I'd gone in and you know validated my pregnancy with my dating scan and I think it was like, I don't know, 8 weeks. I was worried to go and see a midwife too early just in case you know my pregnancy didn't come to fruition.* (Rata)

Rata expressed caution with looking for a midwife in view of a friend experiencing several miscarriages. She delayed looking for a midwife until the pregnancy was 'validated' or made real by the eight-week ultrasound. While early engagement with a midwife is recommended, a conscious or sub-conscious fear of having a miscarriage or the lack of 'fruition' to a live baby delayed Rata's finding a midwife. Rata actually registered with the midwife co-located at her GP clinic within the next two weeks of her pregnancy.

For all participants, whether planned or unexpectedly pregnant, there was a time lapse between when their pregnancy was discovered and confirmed and accessing midwifery care. Some participants' approach to being pregnant was tentative. They needed time to become accustomed to being pregnant, speak with their significant others, or assimilate the information about pregnancy and associated care options before they were ready to access midwifery care. Compared to Rata and Kelly, Mohi's delay in enlisting a midwife was due to needing space and time to decide if she wanted to continue the pregnancy:

> *Well when I first found out I was pregnant it was a very big shock and we were extremely early. We went and had a scan done and they couldn't actually see anything so they didn't know if it was a viable pregnancy or not so obviously lots of blood tests and lots of scans, so that was actually quite a stressful time. And at one point I didn't actually know if we were going to keep this little one, it was a bit of a process for 12 weeks. And then, I went back to the GP and then decided obviously we were going to keep him.* (Mohi)

Mohi expressed shock at being unexpectedly pregnant and the perturbing time she experienced waiting to see if the pregnancy was viable. Furthermore, Mohi was not only waiting to see if the pregnancy was going to be viable over this timeframe she also considered whether she wanted to continue with the pregnancy. This thinking and finding out process

took time; in fact, for Mohi, it took the whole of the first trimester. Mohi engaged with midwifery care by the end of the 12th week of pregnancy with a midwife co-located at her GP clinic.

Similarly, Kelly talked of the space and time needed to make decisions; she had concerns for the viability of the pregnancy and how she and her partner would manage:

> *Yeah so, this one was not planned at all. We didn't want to have another baby for at least another one to two years. Yeah and then bit of panic when I found out. Because I remember feeling yuck but didn't think it was associated with being pregnant because we thought we were being careful and we obviously hadn't. Yeah, I was anxious because I've had two C-sections and we were recommended not to get pregnant within a year. And so, my concern was you know is it viable, is it safe to keep you know, to go ahead with the pregnancy and [the GP] you know she, she's experienced and she said you know there are many women that have also been in the same boat and they have held their babies etc, it's gone through fine. So, I just discussed it with my husband and pondered it for a week or so then I got in contact with [the midwife co-located at the GP clinic] at 11 weeks, oh so that's early.* (Kelly)

Similar to Mohi, Kelly took time to discuss the viability and safety of the pregnancy and to consider the information she was given after the last birth. In addition, Kelly has been advised not to get pregnant within a year of her second caesarean birth. She also needed to discuss the situation with her husband. Once she had decided to keep the baby, she connected with the midwife recommended by her GP and booked with the midwife at 11 weeks gestation. Kelly considered this early. For both Mohi and Kelly, reflection and deliberation about their pregnancies were journeys that required time. As evidenced in Kelly's excerpt, she thought she was engaging early with the midwife at their GP clinic although not quite in line with the3 Ministry of Health (2017a, 2018b) guidance of care prior to 10 weeks gestation.

It is recommended that ideally, women should engage with a maternity care provider at the time they confirm their pregnancy which for all the participants, except one, was in the first trimester of pregnancy. However, the participants did not enlist a midwife for some time after their confirmation of pregnancy: they waited until they were 'ready' and further on in their pregnancies.

It appears the participants saw midwifery care being specifically for pregnancies that are viable, that have come to fruition and are to be continued. Moreover, it would appear the participants viewed early pregnancy care as not congruous with midwifery care until the pregnancy was confirmed, continuing and they were ready.

Engaging in early pregnancy care

Each participant's knowledge of early pregnancy care was different and shaped by their previous pregnancy and birth outcomes. Knowledge about first trimester care appeared to vary when the participants reflected on their earlier antenatal care. It was evident their understanding of care and wellbeing in pregnancy was multi-faceted and influential in their timing with accessing and engaging in midwifery care. The participants explored their thoughts about maternity and midwifery care during their first trimester. During the interview process, I had to explain to most participants what early or first trimester care entailed so they understood to what I was referring. The need to explain aspects of first trimester care led me to question whether antenatal screening and wellbeing assessments – dietary advice, accurate body mass index, smoking cessation, folic acid, Iodine supplementation, screening for Down syndrome and other anomalies (*maternal serum screening [*MSS]), dating scans, family violence and diabetes screening – were known to the participants. Kelly described her need for early antenatal care:

> *I didn't think about that (MSS), it wasn't something that made any impact on my decision. It was just a coincidence that it [pregnancy care] was earlier because I was going in there for something else, but my first pregnancy didn't go too well. So, getting in contact with the [midwife] was important to me because I wanted to be proactive if there was anything that needed to be done health wise. Yeah for me I just wanted to be as prepared as I could. But the tests and all that, that didn't play a factor like, you know, it was just more to be on top of anything that may arise that I don't know, rest more or take whatever, you know, to, to help prevent, what happened in my first pregnancy and so she [doctor] had put me on things and I was taking a little mini chemist, you know, aspirin and iron and just all those other things, the [midwife] in conjunction with the doctors. So, I can't remember exactly what the other things were but it was because I had quite high blood pressure and pre-eclampsia and baby was small and came early and it just wasn't a pleasant experience. So, me, you know, getting in touch with her [midwife] was just more around preventative measures so if anything, health wise was to arise, you know, we'd be on top of things.* (Kelly)

Kelly's decision making for this early stage of her pregnancy care was focused on her and the baby's health. Kelly was not concerned about the formal antenatal screening that could be undertaken at this stage; however, she did accept medication in view of her previous history of preeclampsia.

Sui described not knowing what opportunities were available or needed in the first trimester of pregnancy.

> *I wanted [the midwife] to be there and check on me to make sure that everything's okay and to reassure I'm okay and to get the appropriate test done like the bloods and bits and pieces like that just to make sure my levels are okay. I think it is really important, to have someone there right from the start. Yeah because I don't know*

> *what the hell I'm doing!! … To help me, just to having some tips like in regards to constipation and my morning sickness. Um all day sickness. I mean my iron levels was below.* (Sui)

Sui talked of knowing there were tests that needed attending to; although she described these tests as bloods that look at levels she was unsure of the specifics of the screening and assessments at this stage. Sui, like Kelly, was clear she needed support to ensure she received the care to keep well; wellness for herself was paramount and related to midwifery care. Alia focused on an early dating scan:

> *So, they can send me for a scan because I went for my first scan at 7 weeks. To check what was happening, like to hear the baby's heartbeat and to see when I was due. Just to get like an idea. Yeah. (laughter). Yes, to know when the baby's going to come. Just to prepare yourself for like what's going to be coming ahead…. I wasn't really sure then at that stage because it was my first pregnancy I didn't know what it was about or what I had to do and stuff.* (Alia)

Alia also reinforced being unsure in the early stages of pregnancy what care she was meant to have. Her focus appeared to be on having a scan, the baby's heartbeat and when the baby was due. She admitted to not knowing about "what I had to do" with it being her first pregnancy. All participants discussed being uncertain about what they had to do in the first trimester of pregnancy and few participants talked about anyone explaining to them the Ministry of Health recommended care for this beginning stage of the pregnancy journey.

Associating midwifery care in the beginning months of pregnancy

Nisha and Rata discussed the early pregnancy care provided by their GP and how they valued midwifery advice at this time.

> *What was important about my care, was vomiting and nausea. That's when the GP couldn't help me, oh she's just giving me tablets, see what the midwife will say because midwife will be more expert for me. So that's how I just wanted a midwife, I needed help because I was getting really tired vomiting and nausea. I couldn't eat anything. So, I keep asking, when I got the midwife and she called me in the clinic, that's when I start asking [the midwife] what to do.* (Nisha)

> *Having a pregnant woman come through is just something they [GP] were not confident with. I think in the beginning part of pregnancy too you just want to make sure that everything's okay and they [midwife] were confident in what they were giving me in terms of prescriptions and iron tablets and things.* (Rata)

Sarah further discussed the sort of advice and support that she viewed as important at this early stage in her pregnancy and from whom she valued receiving this information:

> *I think they're [the midwife] really important people in terms of support, advice. They're so much more than just a prescription giver or a heart rate taker, you know, they're definitely a support person in your pregnancy. Oh, lots of little things might*

crop up, you know, I've got a pain in such and such, is this normal? I need to go to the bathroom such and such, is that normal? You know just, things you need to go and really see a professional woman about rather than just your GP. Because you feel more comfortable about telling them [midwife] about anyway. With the doctors, honestly, I must say mine, we have two or three doctors that share our care [first trimester]. Their knowledge is really terrible. They wouldn't know, what to do or where to go, or where to point you. (Sarah)

Sarah explained she was seeking reassurance about what is 'normal'. It appears Sarah felt more comfortable with the midwife who she described as a "professional woman". Sarah described the knowledge as "really terrible" regarding the GP's advice when she saw the doctor in the first trimester. Sarah, as with the other participants, received no explanation or navigation of the maternity services needed at the beginning of the pregnancy; nor how to navigate enlisting a LMC carer. What was evident in these women's excerpts was how the GP was seen as not having the specialist maternity knowledge that they needed. Rather they saw the midwives as having this expertise.

Having a scan, a tangible look at the baby, was accepted, welcomed and expected by the participants to confirm when their baby's birth was expected, along with blood tests. The participants' talked of their GP care being for blood tests and scans. Moreover, the participants saw midwifery care for both their and their baby's wellbeing, although more specifically about healthy lifestyle advice not antenatal screening and physical assessments. The data demonstrated the full scope of practice and role of a midwife in the first trimester of pregnancy is unknown for these participants.

Additionally, Ana described her cultural and family values as impacting on when she enlisted midwifery care.

My understanding as an Islander, back home we don't really need a midwife, like my mum, I've seen my little sister and my little brother, my mum didn't need a midwife, she was healthy, she was strong. She only need a person when she went to the doctor, like she went to the hospital she gave birth. That's the only time she had the midwife. I'm here [in New Zealand], to be honest if my mum was alive and here with me I don't think I would need a midwife, she will be the midwife, honest. I'd only go see the doctor, if something happened to me or go for my scan for the progress, but because my mum is not here anymore, so I have to rely on someone to help me, a midwife. My mum she has my grandma, she has my aunties, she has the whole extended family next door to help her. And a lot of experience from my grandmother to help her gave birth of all of us, there were six of us so no need of midwife. Ah yeah, I think that's the difference. They have their own mothers at home. They have a lot of family members, but I know for sure us Island women, it's just the first time that first time pregnant we would need a midwife. But second, I think they will get used to it and they will know the process. And majority I never hear any Islander, never had any death in pregnancy.

Most of my family that I know they gave birth, they're healthy, their babies were healthy. (Ana)

Ana described the caring relationship the women in her family have when a daughter, sister, or aunt is pregnant. The availability of care and advice provided by the women in her extended family would influence her need to connect with midwifery care, especially at the early stage of pregnancy. Ana talked about not being concerned about connecting with midwifery care if her mother had lived close by. Ana's mother would have provided the advice for keeping her and her baby well at the early stage of the pregnancy.

The data demonstrated how Ana perceived what the role of a midwife is and when a midwife is the appropriate carer. Ana's reference points for what a midwife does are rooted in how she has seen the women in her family provide care and support for pregnant women. She stated that she would not have accessed a midwife if her own mother was still alive. She would not have needed a midwife at all for the second pregnancy as the first birth went well and hence she was now familiar with what to expect. More importantly Ana referred to the health and strength of the women she knows who have birthed without concern or death and that if there was a problem then it would be a doctor or hospital that was needed. A midwifery role for pregnancy and birth care seems to have a different relevance for Ana – the women in her family provide the 'motherly family' role needed for a healthy pregnancy and if there are actual problems then a doctor is warranted.

As Ana's mother and other family female figures were not close by to help keep her healthy, Ana saw the need for an 'actual midwife' as the appropriate carer in the first trimester of her pregnancy and birthing journey.

A daunting process; navigating pathways were fraught with obstacles and challenges

The participants valued and wanted midwifery care in the first trimester of pregnancy; although for this to happen they needed to be 'ready' to enlist with a LMC midwife and have some knowledge of the midwifery scope of practice in this early phase of their pregnancies. Highlighted were the challenges faced by the participants in knowing where and how to find information about midwives and how to contact the midwives in their communities.

Mohi, for example, had challenges finding a midwife via the internet route:

I rung my old midwife and I asked her if she had any recommendations and she said to go on a website, I can't even think of the name of the website but it had all the midwives there, so many midwives. It was a long process. Quite daunting having to go through all these ladies and then you look, you'd find one that you thought, oh she looks you know and then she'd be booked out until this date, to be honest I sort of only went on there a few times and I gave up because it was just too daunting yeah. (Mohi)

Mohi described asking her first midwife, who was no longer co-located at her GP clinic, to recommend a midwife and was told to use the web-based system. She described finding a midwife in this manner a daunting process. The system for finding a midwife was assumed to be helpful by Mohi's previous midwife but, in Mohi's case, it was overwhelming and became a road block. Looking at the website, identifying possible midwives, contacting them and then finding they were booked, meant Mohi did not persevere to try to phone or connect with any more midwives. This first step in the process was already an obstacle, a pathway with a dead end. For Mohi the website, although accessible, was not a helpful resource. It is a process that requires time to identify appropriate midwives who offer the birthing options being considered and then seeing if they are available. Mohi needed both the time to keep trying all the possible midwives available and the stamina to take another pathway on this journey to enlist a midwife.

Kelly described the route she used in finding a midwife for her first pregnancy. She was posted a list of midwives' contact details and was expected to make her own decision on which midwife to contact and enlist with.

> *The first one [pregnancy] they had sent a list and I had to you know eeny, meeny, miney, mo and do my own thing, you know to have to look around and not know who they are without asking word of mouth other people who've they seen and that sort of thing.* (Kelly)

Kelly described looking for a midwife independently. The process feels like a lottery, not knowing who these midwives are and needing to seek recommendations from other people.

Sui explained the skills she needed to enlist a midwife which entailed; having the confidence to use the internet, discern who is a 'good' midwife and contact by phone prospective midwives to ask if they would provide this care.

> *Everyone knows that they've got to go to the doctors and ensure that they're okay. So that's your first point. I think, then on there should be like an information sheet or something there for people that are unaware. Like first time mothers, for example, don't know it's quite a daunting thing. You don't know what the next step is. Okay we know that there are midwives but there needs to be probably more information on what the next step is and what we need to do. I, okay call a midwife, well call a midwife, find a midwife, how do I do that? Who do I turn to? Who have you got? Who can you suggest? You know and if that person doesn't, or that doctor doesn't have a lot of information, you know, oh well you just look up online but I'm in Auckland, what area? What you know? Yeah, I guess it's just trying to find a midwife. It is a daunting task and actually finding you know the right person yeah. The fact when I had to make that first initial phone call, what do I do next? Okay I'm ringing up this person and you know explaining I've just become pregnant and bits and pieces, not knowing where*

> *their location is or where they are, knowing the convenience of actually driving to the clinic.* (Sui)

Sui explained her concern at trying to navigate the routes needed to find and connect with a midwife. She was adamant the process started with confirming her pregnancy with her GP but then found the next step an intimidating and discouraging struggle. The paucity of information from step one, having her pregnancy confirmed at her GP clinic, to connecting with a midwife, seemed to have little transparency and was a major obstacle for Sui. The process of finding a midwife, phoning to ask if they could care for her and ascertaining if she could drive to the midwife, knowing the location of the midwife, was also challenging considering not being familiar with the large urban geography let alone if the midwife was the right person for her.

> Similarly, Nisha grappled with the pathways to finding a midwife.
>
> *The nurse gave me a lot of contacts, like I don't know I can't just choose anyone, I don't want to ring them up and ask them are you, how much experience you are, all these things probably waste of time. Because there's a lot of midwives' numbers and name, it's like which one to ring and which one to find, I'm not going to ring three, four of them and I have to decide then how am I supposed to know they're good or bad. And I didn't want, I just don't, I didn't think it was a good idea to ringing all of them up and finding out, all of them because I don't know where, who they are and what I don't know them.* (Nisha)

Nisha described having to phone many midwives challenging, let alone having to ask them judgemental questions to ascertain if they were going to satisfy her quest for an experienced midwife. This process was not easy, nor reassuring and did not instil confidence in Nisha's quest for finding a 'good midwife'. Nisha essentially wanted assurance that her choice of midwife would bring safety of care for her and her baby and she was unable to see how it would happen with this system of finding a midwife.

The practice nurse with all good intentions of allowing Nisha to freely choose, provided a list of midwives' contact details for Nisha to find her own midwife. For Nisha, like Sui, this process did not work and did not feel comfortable. The participants stated that it was too difficult to phone various midwives and ask questions to ascertain who was good or not. Furthermore, Nisha and Sui were possibly fearful of being that bold with people they did not know, asking midwives to qualify themselves and then potentially reject them. This skill of being assertive to phone and ask for a service of a stranger was an uncomfortable task that neither attempted – another dead end on the journey to enlist a midwife.

Mia echoed Nisha's point that for some women having internet access, let alone phoning and asking someone for 'something' – in this case ask a midwife to care for her – could be an obstacle to enlisting a midwife:

> *You know other people sometimes they don't even have access to internet or number or the confidence to want to ring up and ask.* (Mia)

Rata reinforced the challenges to finding a midwife for her first pregnancy. Complicating her journey to finding a midwife was Rata's choice to birth at a hospital in a DHB region outside of her home geographical area.

> *My first pregnancy I just let my fingers do the walking and I did a Google search. I did ask girlfriends but we all live in different regions and when you're looking for a midwife it's actually quite hard to find someone who's in your region who births at the hospital you want to birth at, who believes in what you believe in. So, my girlfriends live out in West Auckland or they lived over the Shore so you know their options were never going to be the same as mine.* (Rata)

Rata was comfortable with the web-based system of finding a midwife for her first pregnancy. She did seek recommendations from her friends but found this limiting due to differing needs. Rata talked of her journey with many turns when trying to find a midwife for her second pregnancy:

> *Oh, second time round, I felt much wiser. I was confident in what I know I can do with my body, so that's a plus. But what was different is that I was a little late off the mark in terms of picking a midwife. You know they say you should pick a midwife as soon as you know you're pregnant. I think it was like, 8 weeks. And then by then every single midwife in the entire Auckland region was booked out and there was no one left. And I wanted to ideally book at Auckland [hospital] again. But there was just no one in my region that did that. And I didn't want to go to my previous midwife. So, I asked my GP, was it possible to go through this process with you guys, like can you put me through the same steps that a midwife would? They said it's not really our area, they weren't confident about the whole process.* [Rata was leaving the clinic] *It wasn't until the nurse at the GP told me there was a midwife operating there that I could get in touch with her. So, thank god for her! I was extremely happy, I just felt like no one knew what to do with me and they were going to put me in a corner and I was going to birth myself! Or I sold my soul and I got an obstetrician.* (Rata)

For her second birth, Rata was seeking a midwife to provide care in another DHB region. She did not want to return to the first midwife. Finding a midwife proved to be difficult as the many ones she contacted were all booked out. Rata also inferred that at 8 weeks it was too late into the pregnancy to have a chance at finding a midwife and that if she had made contact earlier she may have been able to find a suitable midwife. Therefore, Rata went back to her GP to request if they could possibly provide her maternity care – again this care option was not

possible. Rata's GP did not take any extra steps to support her to find a midwife but, to Rata's relief, the nurse did offer support and informed her of the midwife co-located at the GP clinic.

Rata expanded on the daunting task of finding a midwife, comparing the first pregnancy with the second pregnancy.

> *I remember the first-time round, in terms of like the options they [GP] give you, was okay. They said you can see a community midwife or go on Google and find a midwife or go to hospital there's a midwife or whatever the case might be. And then, or you can have an obstetrician. Okay cool. And then the second-time round they just kind of fobbed it off like oh it wasn't too long ago you had your son so whichever option you want to go to. I was really disappointed, I was gutted. I feel like as a GP or medical professional, should probably at least be able to give someone their full options every single time and not just think that someone who's been through it before is automatically going to remember. I'm not going to remember that, that was two and a half years ago. Yeah maybe options have changed. They just didn't really know. I think they just tried to kind of pass it off as you know you remember. No, I don't remember. Does that sound really terrible?* (Rata)

This was Rata's second pregnancy, her second time at trying to find a midwife so it was assumed by the GP that Rata had prior knowledge of what to do and where to go. She explained she did not remember all the options, the system, changes may have occurred; yet the GP appeared to be not helpful in assisting with the process.

Rata's recall of her challenge to find a midwife for this second pregnancy demonstrates that even with her confidence in using the web-based system for finding a midwife, her experience still ended with disappointment and exasperation. Rata was left feeling vulnerable and less confident about being able to care for herself at this time.

Rata also explained how unhappy she was with the GP's lack of imparting knowledge regarding choices for maternity care. Rata felt the GP should have made time to support her in the quest to find a midwife. A pathway between the health services at Rata's GP clinic and enlisting with a LMC carer needed illuminating and Rata possibly would have appreciated help to begin a positive and productive journey between maternity health providers. Rata also explained she expected the GP to give women information and, when this did not occur, she was left feeling lost.

The participants pointed to the need to consider cost of transport, telephoning and the need for convenience within their busy lives. Transport availability along with its associated costs needed to be addressed to assist with the journey between GP clinic to a LMC midwife having a timely and positive result.

Travelling to and fro, mission impossible

Cost of parking, distances to travel and non-drivers are all challenging issues seen throughout the data. Although these inter-relate with the demands of busy lives and the participants needing to prioritise life's demands, it was apparent that many participants were time poor, which impacted on their ability to accommodate the additional needs of pregnancy care. As all participants, except two, were in paid employment, they wanted to find midwifery care that was convenient and accommodated their time poor days. Mia and Kelly described travel and parking considerations:

> *Ah the to and from you know like the travel distance plus parking you know... In the city you pay for parking. At a hospital you pay for parking.* (Mia)

> *I saw the locations. So, location was important to me and I live just around the corner from work, so I factored that in so I could [see the midwife] between work and visits.* (Kelly)

Mia showed the travel distance needed to navigate the pathways to see a midwife and the time involved to get to and from the appointments required consideration. Moreover, Mia cited the cost of parking for the appointments as another consideration and possible hurdle to the location of midwifery appointments. Fitting in midwifery appointments between work breaks or work and home, as Kelly explained when looking at a list and location of midwives, was influential.

Mohi described an additional hurdle to finding a midwife as being her ability to get to the actual midwife's clinic:

> *For starters I don't drive. Obviously where it [the midwife clinic] was with not being able to drive. Yeah because it's so hard trying to find a midwife, being obviously able to go to all my appointments and not have to worry about how I was going to get there um...busy lives.* (Mohi)

Mohi did not drive and this influenced where she looked for a midwife. Not driving was an additional obstacle to accessing a midwife any distance from her home. Mohi liked to be independent by walking to local facilities, retail shops where her GP clinic was located. It might be suggested that Mohi takes public transport, but this does not account for busy lives with time poor concerns, cost of public transport, concerns of travelling unaccompanied and the ability to navigate an unfamiliar geographical location and public transport system.

Ana's first pregnancy care was from a midwife co-located at her GP clinic. For Ana's second pregnancy care the midwife had shifted about 10 kilometres to another suburb and there was no longer a co-located midwife at Ana's GP clinic. The distance to access the midwife was an obstacle for Ana:

Um it's just the beginning [of her pregnancy], the first time [appointment] was too far we like I said we used to live in XXX it's just the distance, it was too far. My doctor's just around the corner. Well it's just that right now my midwife is not there anymore. She moved toward quite far like in XXX area and so I know it will be a different story for next time we interview [midwifery appointment] because there is no doctor there and it's only the midwives there. It will be a lot if something happened to me, for example with this pregnancy and I go to my midwife, it will be a lot of running around because, if she tells me to go to the doctor I have to run from there to the doctor not like before if something was happening with me just walk next door to the doctor. That, that's the only problem now.

We know that in our tradition we're not allowed to drive around, in the first stage of pregnancy. Because we believe that if the road is pondit (pot holed) and it will make the baby inside and it's so easy to get a miscarriage and from now on I have, I know my midwife has moved far from here. And I was surprised last week she didn't visit but she asked me to come visit her. So, I did go because I have to go see her in the first time but, um. I'm waiting because she said now after, my scan she will come visit me home so I hope from now I don't have to drive anymore. Yeah.

It's (the midwife clinic) is quite far for us now. Not like my first pregnancy but I did not think of it because I was only worried of getting there to check on the baby. But now I have learned my lesson, driving the longer distance, so I've learned a lot from the first one [midwife appointment] to now. I think it's quite far now where she is. And I believe, I, I think I should find a new one [midwife] that is closer home you know if I can't manage to drive there, it's long you know, not just around the corner where the [GP clinic] clinic is and she can come over [home visit] yeah…Five-minute walk yeah [from Ana's home]. If I can walk it would be good if I don't want to drive yeah. (Ana)

Ana did not need to independently find her own midwife for her first pregnancy as her GP clinic had a co-located midwife who was recommended for her. Having built trust and knowing this midwife meant Ana was happy to connect with the same midwife even though she no longer had a midwifery clinic at Ana's GP clinic. The midwife had moved to another area which was about a 20-minute drive from Ana's home. The midwife did try to accommodate Ana's reluctance to drive to this new location but, when this did not happen, Ana being concerned that she needed to engage with midwifery care as early as possible drove to the new clinic. However, Ana was not happy on multiple levels which included firstly, her cultural family beliefs around being in a car in the early phase of pregnancy causing a miscarriage and secondly, the additional distance to see her doctor if recommended by the midwife. These challenges culminated in Ana considering finding care closer to her home.

Summary

Stepping from the GP clinic to LMC midwifery care when the pregnancy is confirmed is daunting and, as these participants explained, finding a midwife was a fraught journey – some with dead ends or a pathway with obstacles or constrained by the participant's personal resources and limitations. Finding a midwife took time and energy; both resources which were challenging and limited. The participants further pointed to the need to consider cost of transport, confidence with telephoning midwives to ask for their services, resilience to use the internet and the need for convenience within their busy lives. These issues and barriers all need to be considered and addressed to assist with the journey between GP clinic to a LMC midwife at the earliest time possible in the first trimester of pregnancy; resulting in a positive enlistment with a LMC midwife. Having identified the women's experiences of locating a suitable midwife as a daunting maze, in the next chapter I present their experiences of when a midwife was co-located at their GP clinic.

Chapter Five: Circumventing the Maternity Health Service Maze

In the preceding chapter I revealed that the participants were not ready to enlist with a LMC carer as soon as they had confirmed their pregnancies. Rather, they waited until the pregnancy was viable and or they had decided to continue the pregnancy. They also did not fully equate midwifery care with first trimester care. Moreover, when participants were ready to access and engage a LMC carer they found the process fraught and daunting. Enlisting a midwife who worked around their daily living needs and accommodated choices for their childbirth journey was challenging. The participants experienced trying to independently navigate the maternity health care system. They described this process as taking time, resources and knowledge they did not have or were limited by. The participants' needs were not generic and their requirements for maternity care varied.

The first section of this chapter brings together the participants' experiences when offered assistance from their GP clinic personnel to navigate accessing a LMC midwife. The second section focuses on participants' outward relief when a recommendation assisted them to easily and conveniently enlist a midwife co-located at their GP clinic. The recommendation coming from the participants' GP or nurse at their GP clinic, provided a solution to circumvent a perplexing journey of enlisting a LMC midwife.

Findings II: Circumventing the Maternity Health Service Maze

Looking out for me and my whānau/family; helping me take a short cut to find a midwife

All the participants had their GP or nurse recommend a midwife, who was co-located at their GP clinic, for at least one of their pregnancies. The GP clinic personnel were the key to circumventing the need for the participants to independently find their own midwife and participants appreciated the recommendation and assistance.

Rata described the daunting process of finding a midwife for her first pregnancy; seeking a recommendation without success:

> *I guess it's always a little bit daunting because you're putting your care in the hands of someone who doesn't come with a recommendation and it's my first time round and I just had to go with it and hope that I'd made a good choice, so it was quite scary. There's no one else to say or verify that you know that you're in good care. Um it's not knowing you can read up on the background of a person, I mean you can, how much does a paragraph tell you when you're putting a very raw, very special, scary moment in someone's hands. It's just, I know I've had girlfriends, they live close together and they've had recommendations from others but they wouldn't really tell us because I feel like they know they're in safe hands; whereas for me, I just didn't have that kind of*

guarantee. But I mean there's never a guarantee, but it would have just been nice to be reassured that, someone else's back up or they were going to be really good, that I was in good hands!! (Rata)

Rata found the process of enlisting a midwife fraught. She walked this pathway to finding a midwife independently, a journey that in itself was stressful. Rata continued to describe her experience of wanting a recommendation from friends as this would have been valuable to help her trust someone unknown. For Rata it was about having assurance that the midwife could do her job and do it well; Rata wanted to feel secure in her choice of midwife. Rata explained how this process was daunting and how she needed to put her trust with someone she did not know, who did not come with a recommendation and how she hoped she had made a wise choice. Not having an endorsement likely caused Rata anxiety; she felt she did not have a 'guarantee' regarding the midwife she had enlisted. A recommendation may have reduced Rata's anxiety and fear.

For Rata, finding a midwife during her second pregnancy was even more challenging than the first pregnancy. She had become distraught and explained:

I actually did say to them [GP and practice nurse] I was in a real bit of a panic because it did feel like there was no midwives left at all. It wasn't until the nurse at the GPs told me that there was a midwife operating there that I could get in touch with her. So, thank god for her!! And then I was able to get in touch with her and she had some space to take me on so that was quite a relief. I already had a connection with the nurse and the nurse really rated her [midwife at the GP] so automatically I quite liked her. So probably already came with a bit of a tick, that recommendation as it were. So yeah, automatic, comfort really. And just more down to earth. (Rata)

For Rata, the recommendation from the nurse, whom she knew and liked, at her GP clinic helped to begin building the midwife's profile of capability; moreover, beginning to build trust and feeling a sense of knowing the midwife. The GP clinic nurses were trusted by participants in their recommendations, for example:

Our nurse is young, she's bubbly, she's just a really sweet girl and I find, I feel like that she always looks out for me and my son whenever we come in so, the moment she said this person [the midwife] was good, it was a relief! Was just, she could have said that I could go to Arnold Schwarzenegger and I still would have believed her but you know I think you just build a rapport with someone you know some 15 years, it's basic yeah. It was [the co-located midwife], awesome. And I know exactly where she is now that I've gone and see her so way easier. (Rata)

Rata described her positive relationship with the practice nurse as key to valuing her recommendation and transferring trust to a new person, the midwife. Rata's relationship with the nurse had developed over a number of years and her proven track record of care and communication made the transfer of care to the midwife easier. Rata's faith in the practice

nurse meant she would take any recommendation from her. Positive inter-collegial relationships mattered; in this instance it helped develop Rata's confidence with enlisting a midwife**.**

Interestingly Rata further explained:

I'd probably go through the same process again now. So, I'd go back to my GP which is what I did the first time around. Do the test, get the nurses to confirm that. And then I would ask if they would have any more recommendations or, if there was like a replacement with the same, or a midwife there at the centre and ask them for their gauge on it. (Rata)

From experience Rata would again seek a recommendation from her GP or nurse for a midwife as she valued the collegial association and degree of endorsement by the GP clinic professionals. The data reinforced that the process of having a midwife recommended to Rata was foremost appreciated, followed by the fact the midwife was co-located at her GP clinic.

Alia, Nisha and Mohi shared similar experiences of finding a midwife:

I actually went to my GP first where he confirmed I was pregnant, quite early. I asked him to recommend me someone. And they said they had a midwife who went to the practice. It was nice to have someone actually guide me because I didn't really know of many, of how to find a midwife by myself, how to go about finding one. So, having the GP actually recommend someone, made it a lot easier. (Alia)

I was happy when my GP recommended me a midwife because I wouldn't know anyone else out here… I was very lucky that my clinic actually has midwife and the doctor together. They would know better what midwife is like. Like with my doctor she said, I'm suggesting you this midwife because she's more experienced she's really good and she gave me good words. (Nisha)

I think it [a recommended midwife] was great. Yeah because it's so hard trying to find a midwife. With my last pregnancy before I rung the midwife I spoke to the doctor. I actually did go through to look for midwives and a lot of them were booked out. And then [this pregnancy] I met her [midwife at GP clinic] and then I knew straight away that yeah, she was going to be the one. Yeah well because I kind of knew too that they're not going to have a midwife there [at the GP clinic] that's not good. I mean you know she'd have to be good to be in the practice. (Mohi)

All three participants were guided towards finding a midwife; Nisha appreciated the recommendation from her GP about an "experienced good" midwife. Alia explained that having her GP guiding her, identifying and endorsing a midwife, facilitated her engagement in maternity care. Alia followed up with the midwife who was recommended and co-located at the GP clinic and enlisted the midwife at six weeks' gestation. Nisha was pleased that the two health services were located together. Based on her previous experience, Mohi knew that finding a midwife was not an easy process. For Mohi, as with other participants, finding a midwife to whom she could entrust the care of herself and her baby was important. Both the

doctor's recommendation and the GP's clinic reputation endorsed the midwife; Mohi trusted her GP and assumed that the GP clinic would not work with or have a particular midwife co-located unless the midwife was sanctioned. This endorsement provided a positive and helpful connection for Mohi to begin building the midwife relationship.

Kelly explained her quest for a recommendation of a midwife from her trusted GP:

I've been seeing Dr X and she's, she's got a history in obstetrics…. I've been here I think 7, 8 years now. I trust her, her opinion. Yeah including midwifery, including pregnancy. So, when she said there's this new lovely lady who's working out of our clinic here, give her a call. It felt easy! It felt convenient. Having my GP say this, you know she's really lovely she, she knows obviously all midwives know their thing, their stuff but she [GP] rated her quite highly so that's what made the decision, so much easier and she was highly recommended from my GP. Who I, you know, value her opinion. (Kelly)

Kelly has a relationship of trust with her GP built up over 7-8 years. Possibly because of her GP's past experience in maternity practice and this trust, the midwife recommendation was highly regarded. Kelly described access to the midwife as one of ease and convenience.

Taking a bit of work off my plate

Alongside appreciation at being recommended a midwife, participants were also relieved to be offered assistance that circumvented their need to independently find and enlist a LMC carer. Throughout the data the participants frequently referred to their busy lives, often pressured and overwhelmed by life commitments. Thus, there was a real, almost tangible appreciation of midwifery care that was convenient, easy to access and easy to keep engaging with. Fitting everything into their busy lives, accounting for time pressures and time poor challenges, along with meeting their own health needs was a juggle.

Mia described her pathway to enlist a midwife:

I said yeah gladly I would love that [a recommended midwife co-located at her GP clinic], that's so awesome only because it makes it a lot easier for me. Because the whole environment you know like her office is not far and then, you know, it's just really, a real easy thing. You know like it is a lot easier, it makes life so much easier to have it at your GP. I thought that was the best, I think hers [this midwife at her GP clinic] was my best, I didn't have to travel much and all that kind of stuff, even though I like it, you know, I like to stay active and all that kind of stuff, it just made it really easy. I was feeling tired, like [midwife] she's only at my doctors. So, she [the midwife] would actually like be, are you okay to come to me, I can come to you, you know, like you're only 5 minutes away, you know?

Yeah so, you know it just makes it easier for travel and stress and well if you're a person like me, I don't like to go out looking. My partner he has a business and we still do a lot of extra work. So, the kids have to go or we have to go or yeah that kind of stuff. So, it always, you know, I could ring her up and let her know can we, you know,

alter our time to such and such it would be good, you know, that just worked out perfect… Yeah, I loved it, it was awesome. Really easy, made life really easy. Yeah absolutely, you know it's really, it's just good, it's easy yeah. It was great. (Mia)

Mia appreciated the flexibility of location and the ease of accessing the midwife fitted well with her daily living commitments and the priorities that arose within her roles as a partner, mother to five children and an employee. Essentially for Mia it was about her life being made easier and manageable and the co-location of the midwife at her GP clinic contributed positively to Mia managing her daily living demands.

Mia also discussed the flexibly of the midwifery care and the offer by the midwife to come to her home when she was tired. I noted throughout all the data that every midwife offered home visits and not once did a participant say they were compelled to come to the midwife clinic. Mia further expressed her appreciation:

Yeah so it was really good, it was great, easy getting the vaccinations [whooping cough and flu vaccinations]. Um oh just cause I'm so busy with the kids and you know it makes it a whole lot easier and then like you know, I was carrying a whole another person so you know. Walking around breathless and all that kind of hoo ha. (Mia)

Mia also liked the simplicity of being able to attend to her maternal immunisations, medical primary health care service and midwifery needs during the same appointment, attributing to her ability to manage her daily living needs while simultaneously addressing both her and her baby's health needs.

Kelly built on Mia's view regarding the ease of having the midwife at her GP clinic:

It [midwifery care at her GP clinic] felt a lot easier. That convenience and stress free because, you know, when you're working, you have kids, other commitments, so to have it right there and have someone vouch for you, that, you know, it's so much easier. You know it takes a bit of work off your plate. Yeah, it's very good, it's convenient yeah. Um for me it's the convenience because of the distance between there and work, my primary, you know, goal was to have someone who I trusted and was within minutes away from work because I didn't want to take too much time off work…. having a midwife out of your GP clinic is, convenient and when you have the actual GP you see, recommend them it just makes things easier and much pleasant experience yeah. (Kelly)

Kelly juggled many things in her daily life. Having the midwifery care at her GP clinic made the process of enlisting midwifery services easier and less stressful.

Mia and Kelly were busy women, and both drove cars, fitting much into their days. On the other hand, Mohi did not drive and Alia limited her driving; hence the additional need for midwifery care that fits in with transport restrictions.

> *So, it was just very convenient and it was nice and personal having a midwife because, it's a familiar location you know and I know everyone there and I don't know it was just, it was just nice and convenient really. And I just enjoyed having a midwife really! Obviously where it was with not being able to drive. Just having her at that you know like a familiar location and just really it was just really the convenience of having her so close to me. Um being to obviously be able to go to* ***all*** *[said firmly] my appointments and not have to worry about how I was going to get there. I thought that was great. How convenient for me because I don't drive, um it's nice and close if, if I did need her it was, she was nice and close.* (Mohi)

> *To not drive elsewhere. Yeah and just to have her in the same location because I knew my GP well. With the practice and staff so I thought maybe it will be good to just come here for my midwife appointments as well. Yeah like with the pharmacy and everything being on the same location. Not having to go out of my way to see a midwife. I think it's a good idea, to have it at the same practice. It saves you from going from one place to another. Not that I had to use the doctor at the same appointment as the midwife but it's just that, it's familiar territory like going to the same clinic, but just for different service. And then after my GP recommended and then after going through the first one, I knew with my second one exactly what to do.* (Alia)

Mohi described the convenience of the midwifery care close to her home allowing her to walk to the clinic and therefore attend all her midwifery appointments. In addition to appreciating the close and convenient health care, Mohi and Alia talked about the importance of attending the midwifery clinic in an environment that was familiar and where they knew the other health personnel.

Alia explained the location for the midwifery care was simpler for not having to drive the additional distance. Moreover, she appreciated the GP's recommendation and endorsement of the midwife located at GP clinic which assisted her connection with a midwife. These factors also increased Alia's confidence when seeking care for her next pregnancy.

Familiarity of care location and receiving midwifery care where they access their general primary health care

Rata compared her first and second midwifery care location experiences:

> *Comparatively, this time round it was a lot more relaxed. Think it was in a space which I was familiar with... it's nice to go somewhere where you know all the faces, so I walk into reception, I already know the receptionist so that's lovely. Um and like my whole family's gone there for years so it's just yeah. My mum knows exactly where it is, I know where it is, it's really close to home. Um and it just feels a lot more comfortable walking in there really… I would put it… it's intrinsically important for me. Being part Māori but it's, it definitely is a huge difference like I can't stress enough how, how much better it feels going somewhere where you know, my mum trusts, my dad did, my husband does, my son goes too, you know they know my whole history so. Um yeah, it's like ebony and ivory really, like black and white yeah.* (Rata)

Rata noted the importance of her family connectedness with the GP clinic and in so doing, reiterated the concept of a familiar care location being an enabler to connecting with midwifery care. Rata described herself as feeling more relaxed receiving midwifery care for her second pregnancy in a known, trusted environment which her family frequent and where they too trust the GP clinic. Additionally, being in a place where her health history is known is seen as a positive factor.

Being familiar with the location, the environment and the people at their GP clinic was an enabler to accessing and engaging with midwifery care as participants felt at ease. A known place and people who routinely provided their primary health care and that of their family's health needs reduced fear and stress.

Lastly, Nisha explained her satisfaction with the co-located midwife and her GP being able to easily communicate in person her health, pregnancy outcomes, family planning needs and baby's vaccinations.

> *So even in the last when I did 6 weeks vaccination to her [baby] my midwife told everything to my doctor, she actually went face to face [with her GP], family plan what I have to do. Which one is, she suggested which one is better for me. Also, she had a cord problem, so Lucy (midwife) and my doctor also knows because my midwife went there. And the midwife called me and she goes I spoke to your GP and that's what she suggested, all these things. So, it was easy. I don't have to go to my GP and say everything. So, she did the half of the job for me after postnatal. I know now my baby is good, my family planning what I have to do, at least I know she spoke to my GP and my GP knows it, yes. And it made it easy for me because she said she spoke to my doctor and if I chose someone else she wouldn't go to my doctor and speak and the doctor wouldn't be bothered too much. Yeah and also my GP goes oh I heard about you, Lucy told me all about you, your labour was very good. And I felt good because Lucy, my midwife actually mentioned and my GP she remembered I'll be coming in 6 weeks' time. Yeah. So, it was good because, you feel comfortable.* (Nisha)

Nisha valued the ease of communication between the midwife and her GP; a relationship that created less stress for Nisha and possibly less fear that information might be forgotten or overlooked. Face to face communication took some of the pressure off Nisha having to explain to the GP what had occurred when she was being cared for by the midwife related to the family planning and the baby's cord concerns. When she went for her first GP appointment after the midwife discharged her there was a sense of a handover of care, completion of midwifery care to her GP.

Nisha doubted the efforts by her GP to personally discuss her childbirth care, problems and outcomes if the midwife was not at the GP clinic. It could be thought Nisha saw the midwife

and GP's ability to have face to face communication as an added quality to improving the safety of her maternity care.

Summary

In this chapter I have described how the participants frequently referred to their busy lives, giving a feeling that they were often pressured and overwhelmed by life. The participants, therefore, described their appreciation and relief at firstly, having a recommended midwife and secondly, having the assistance to find and enlist a midwife. Furthermore, having the midwife co-located at their GP clinic where they went for their additional personal and family primary health care enabled the participants to fit much into their day.

The recommendation and the co-location of a LMC midwife worked well for the participants establishing a direct, endorsed, link to midwifery care at the earliest possible time after their pregnancy was confirmed. This also aided their ability to keep accessing their antenatal care easily and conveniently, accommodating their own health needs, their family needs and their work commitments.

It is important to note what appears to be a straightforward process of simple steps to enlist a midwife was not the case. The participants experienced numerous barriers to enlisting midwifery care in their first trimester of pregnancy. For these participants they were most appreciative to have a recommendation, guidance and information from their GP or nurse to take the steps needed between their pregnancy confirmation to finding and enlisting a midwife. Also noted was the strong inter-collegial relationships between the GP and midwives which improved communication. Inter-collegial relationships do matter to these participants and influence early uptake of midwifery care.

Chapter Six: Discussion

This study explored the experiences of women, who live in socioeconomically deprived communities of Counties Manukau, receiving midwifery care from midwives co-located at their GP clinic. This chapter situates the findings in relation to current literature and professional strategies. To begin, I consider the findings pertaining to when the women found out they were pregnant and when they were ready to access antenatal care. The women's decision-making as to who their LMC would be, including the relief experienced when offered a recommended LMC midwife, as well as support to step from their GP care to LMC care, are highlighted. Strengths and limitations of the study are discussed and I conclude with implications and recommendations for primary health care, midwifery practice, health policy makers and considerations for future research.

The study findings: *'The daunting journey accessing midwifery care'* and '*circumventing the maternity health service maze'* cannot be seen in isolation of each other. Looking out for me and my whānau/family, by circumventing the maternity health service maze is the action that meets the needs of women having experienced a daunting journey accessing LMC midwifery care. The findings suggested that the women have experienced challenges with independently accessing LMC midwifery care with previous pregnancies and, for some women, with their current pregnancy. Critically, the women needed to know they were pregnant and be 'ready' to access LMC care, a process that varies in time and actions (Haddrill, 2018). Once 'ready,' however, the women were eager to access LMC care.

Part One - Ready to Be Pregnant

Confirming the pregnancy and being ready to engage with LMC midwifery care

Several of the study participants were unaware of a subsequent pregnancy, discovering they were pregnant during a medical consultation for other purposes at their GP clinic. However, all confirmed their pregnancy with testing at the GP clinic. Not being aware of a pregnancy, as pregnancies just happen, is commonplace for some women (Haddrill, 2018; Tanuvasa et al., 2013). Tanuvasa et al. (2013) described pregnancy as a natural healthy life event that generally does not require health care. Women from minority ethnic communities may not access early pregnancy care because of limited knowledge of their body's signs of pregnancy, the maternity system, busy lives, or already knowing what to expect during pregnancy and childbirth. Thus, early pregnancy care is not a priority (Corbett et al., 2013; Haddrill, 2018; Low et al., 2005).

As described within the current study, pregnancy is a normal healthy life event, especially when women are in families who care for one another during pregnancy and for multiparous

women (Corbett et al., 2013; Low et al., 2005; Tanuvasa et al., 2013). Tanuvasa et al. (2013) extended this view of normalcy asserting Pacifica women who previously birthed without complications tended to birth normally, even if they had other medical concerns. Tanuvasa et al. further challenged the notion that late antenatal care contributes to poor maternal and perinatal outcomes, noticing Pacifica women often access LMC care later than the first trimester and birth naturally without poor outcomes. Numerous studies concur that early antenatal care may not necessarily result in positive maternal and perinatal outcomes; yet propose that regular engagement with antenatal care possibly has greater associative relevance to maternal and perinatal outcomes (Dixon et al., 2013; Docherty et al., 2011; Stacey et al., 2012).

For Pacifica or immigrant women participating in this study, misalignments in their beliefs and their health services were noted. Accessing health care for wellness promotion, which antenatal care may be viewed as, could remain extraneous to many immigrant Pacifica women, particularly those culturally isolated from mainstream New Zealand society (Low et al., 2005). This includes migrants or minority ethnic groups worldwide who share a similar concern. Consequently, pregnancy care services may not be aligned with Pacifica women's cultural beliefs or previous experiences of pregnancy care. Therefore, accessing antenatal care after the first trimester may be commonplace (Ayoola & Zandee, 2013; DeSouza, 2014; Downe et al., 2009; Haddrill et al., 2014; Lawrence & Kearns, 2005; Makowharemahihi et al., 2014).

Haddrill (2018) explained it can be challenging for some women to recognise the complex signs of pregnancy and acknowledge or accept their pregnancy. Women need time to align themselves with an accepted personal 'pregnancy mindset' (Haddrill et al., 2014; Haddrill, 2018) – moving past the tentativeness of the pregnancy and onto antenatal care, a more public acceptance. Haddrill et al. (2014) suggested that there needs to be a balance when promoting the importance of early first trimester care with women's view of an acceptable time to commence antenatal care. This was certainly the case for the women in my study; some women did not recognise they were pregnant until close to 12 weeks gestation or later, some waited to consider advancing or continuing with the pregnancy. Pregnancy readiness was unique for each of the women; however, they were ready to access a LMC midwife once they had confirmed and accepted their pregnancy.

As identified in the literature, it is important for health providers to consider some women's limited health literacy and the ambiguous signs of pregnancy that may obscure the possibility of a pregnancy (Daniels et al., 2006; Finlayson & Downe, 2013; Haddrill et al., 2014). Within my study a woman described how as a teenager she was unaware of what pregnancy signs were

until well after 20 weeks gestation. Lack of awareness may be an issue for some young women (Copland et al., 2011; Haddrill et al., 2014). However, it was also the case for a number of the multiparous women in this study. For some women and also revealed by Hatherall et al. (2016), the busyness of living may take priority over self-recognition and acknowledgement of the pregnancy.

Not getting too far ahead of the pregnancy

In this study, the first trimester of pregnancy was a period of uncertainty, particularly for the women who had experienced miscarriages or had decisions to make regarding continuing with the pregnancy. For a myriad of reasons; emotional, psychological, psychosocial and the implications of the pregnancy on their future, women may not invest time and resources into a pregnancy unless they are certain that it will progress (Hatherall et al., 2016). Some expressed concern about engaging prematurely with midwifery care; they viewed waiting beyond 12 weeks as being careful in case the baby was not viable. Others expressed ambivalence to finding out they were pregnant and whether or not to keep the baby. Late initiation of antenatal care is associated with women considering a termination of pregnancy (Downe et al., 2009; Jackson, 2011a).

In contrast, some women in my study, who had previously experienced miscarriage, sought midwifery care as early as possible after pregnancy confirmation to ensure they had quality care to keep themselves and their pregnancy healthy. There was nothing tentative about seeking pregnancy care; although one woman who was aware that miscarriage can happen up until 12 weeks, waited until after the 12 weeks gestation before trying to access midwifery care. This is a common process for some women who have had previous miscarriages (Rothman, 1993).

Engaging in early pregnancy care

Being unclear about what health care to expect in the first trimester of pregnancy, influenced the participants' timing and access to midwifery care. This was most evident in their recent pregnancies when they needed to independently find a LMC. When confirming their pregnancy at the GP clinic, the women in the study were provided with limited information about pregnancy care and the maternity system. This finding parallels the Ministry of Health (2015a) consumer survey which found 20% of consumers did not know they needed a LMC or did not know how to get a LMC and is supported by Ratima and Crengle (2013) and Makowharemahihi et al. (2014) who noted Māori women face greater barriers to accessing information about choosing a LMC. Communication failures by their GP, along with women having little

confidence in asking the GP about maternity services, compounded the lack of timely access to LMC care (Makowharemahihi et al., 2014). Although these following studies were not undertaken in New Zealand, McLeish and Redshaw (2018) and Sandall et al. (2015) described the attitude of health professionals providing maternity services is crucial to this initial step for women to gain self-confidence in dealing with what appears to be a confusing and daunting health system.

The women in this study consistently expressed that they thought 12 to 14 weeks was early to be accessing and engaging with midwifery care. Yet the WHO (2017), NMMG (Ministry of Health, 2017a) and National Institute for Health and Clinical Excellence (2010, 2017) all recommend that women commence antenatal LMC care by 10 weeks' gestation; a policy built on an assumption that women are informed of their pregnancy. Encouraging early pregnancy care before 10 weeks' gestation needs to be made known to women, their families and communities; It is imperative this knowledge deficit is addressed (Counties Manukau Health, 2017; Ministry of Health, 2017a, 2017b; PMMRC, 2011, 2017).

Enacting the Primary Maternity Notice

The Primary Maternity Notice: Section 88 states the non-LMC GP claiming under this contract needs to provide choices of LMC and support the woman to transition to a LMC provider once the pregnancy is confirmed by the GP or practice nurse (Ministry of Health, 2007) However, my study, as with that of Makowharemahihi et al. (2014), revealed this process was not always facilitated by the GP practice. On the other hand, this study demonstrated that when the women confirmed their pregnancies with their GP they felt actively engaged in maternity care; receiving referrals for ultrasound and blood analysis. As Tanuvasa et al. (2013) explained, the women considered they were doing what was expected with the GP confirming their pregnancy, ordering blood tests, scans and treatment for morning sickness.

Women in my study and in previous studies (Bartholomew et al., 2015; Makowharemahihi et al., 2014; Ratima & Crengle, 2013), had a paucity of knowledge of the maternity care system, the importance of accessing pregnancy LMC care before 10 weeks gestation and where to access support finding a LMC. It appears the women were unfamiliar with accessing midwifery care in the first trimester of pregnancy and that a LMC midwife could provide the same assessments and referrals as their GP. This lack of knowledge may be a perpetuating obstacle to women accessing LMC care before 10 weeks gestation. Although, historically, GPs have provided first trimester care for many years within the Counties Manukau Health shared care system (Paterson et al., 2012), this system, although now stopped, I suggest may have resulted in confusion for women regarding GP versus midwifery care.

Midwifery in the first trimester of pregnancy

The findings in this study revealed the women's choice of maternity care provider in their first trimester was influenced by their understanding of the maternity system, socio-cultural influences, preferences and previous experience of the childbirth journey. The information a GP imparts about pregnancy care and the maternity system, along with any navigational support, also influences what advice and care women engage with (Makowharemahihi et al., 2014; Ministry of Health, 2017a).

The women described their need for midwifery care to keep them and their baby healthy, valuing the midwives' expertise in professional 'womanly and motherly' support, reassurance and advice for health care. This professional health promotion role provided by midwives in the first trimester of pregnancy was sought after and deemed important. However, this was not the care they were seeking from their GP. The findings distinguish the role of the GP being for scans and blood screening.

A noteworthy finding from this study is that women did not fully associate midwives as being the providers of all maternity care required in the first trimester of pregnancy. No supporting literature was found comparing midwifery with GP care, specifically associated with first trimester pregnancy care. However, this study indicates midwifery care is sought after confirmation of pregnancy by their GP. The women appeared to not know that midwifery care could be provided to them from the pregnancy test onwards. It is not surprising the women may not know they could access a midwife for first trimester care as the Primary Maternity Notice: Section 88 (Ministry of Health, 2007) allows for both midwives and GPs to provide first trimester care. Further, as noted above, it has been commonplace in Counties Manukau Health region for GPs to provide first trimester care as they did when they provided the 'shared care' model of maternity care over the 1990s to 2015.

It is in a LMC midwife's competence and scope of practice to provide all first trimester care and referrals to the appropriate services for women, including those experiencing miscarriage or requesting a termination of pregnancy. Increasing the visibility of midwifery care in the first trimester of pregnancy as encompassing all pregnancy care, whether a tentative pregnancy or not, may encourage more women to access and engage with midwifery care earlier in their pregnancy.

Part Two – Decisions: Who will be the LMC?

Once the women were ready to access LMC care they needed to choose and register with their LMC. Making these decisions required women to know the availability and functioning of the New Zealand maternity system. Once ascertained, the decision regarding choice of LMC was determined by their home and work location, financial resources and convenience of the GP clinic. All of the women had prior challenging experiences finding a LMC midwife, which had caused frustration, stress and anxiety. The women felt an enormous burden trying to independently find a LMC.

The maternity care system is complex

Findings in this study identified women encounter challenges at the LMC entry point of the maternity health service system, including knowing why and how to find a LMC midwife. This complexity was an obstacle to accessing early LMC care; compounded when the women did not have a co-located midwife to be recommended. For these pregnancies, the GP clinic did not provide a practical pathway to a midwife.

It would be pertinent to question, is the GP clinic providing maternity care services and supporting women to connect with LMCs when they do not offer practical assistance to pregnant women to find a LMC? It appears from the findings of this study that maternity services are regarded as peripheral within the GP clinic, which has a more medically focused business structure. Therefore, assisting the smooth transition of women from their medical services to LMC services may not be a priority. Pregnancy is not necessarily a medical issue, in fact it is strongly reinforced to be a normal life event – a predominantly well and healthy journey for most women (Guilliland & Pairman, 2010; NZCOM, 2015). Pregnancy is very different to the usual GP clinic work, which focuses typically on illness and refers directly to specialist health services when required. Therefore, it could be argued that when women access their GP for pregnancy confirmation they should be informed by the GP of early pregnancy carer options, which includes a direct LMC referral who can then confirm the pregnancy and order further diagnostic measures along with health promotion. LMC midwifery care may then be more visible as an option for women in the first trimester of pregnancy. It is evident from this study that there is a need to enable the crossover and transition for women from their GP to LMC to happen more easily and possibly earlier in the first trimester.

When faced with the challenge to find a LMC midwife, the women in the current study described their GP as having little interest in helping them with the process. One could question, is the responsibility of the GP different for maternity services to that of any referral they make to other health care specialists? The main difference with the maternity system is

that the women are expected to access their own LMC, independent of the GP clinic (Bartholomew et al., 2015; Guilliland & Pairman, 2010). Therefore, the responsibility for following up the woman to see if she has connected with a LMC may not be an expectation of the GP clinic but navigational assistance is needed. This could be part of the GP team's role, given that the majority of the women had their pregnancies confirmed at their GP clinic.

Preventing women getting lost in the maternity system

Limited support and follow-up of women when they initially confirm their pregnancy is why women can become and potentially remain, lost trying to find and access a LMC (Bartholomew et al., 2015; Copland et al., 2011; Makowharemahihi et al., 2014; Ratima & Crengle, 2013). Makowharemahihi et al. (2014) whose study focused on young (under 20 years) Māori women's struggle to access a LMC, stated "Improving first trimester care and navigation to a LMC will improve access for young Māori women …. primarily general practitioners, would then take responsibility for first trimester screening and navigation to a lead maternity carer" (pp. 52 & 59). However, I would contest Makowharemahihi et al.'s suggestion that GPs be responsible for first trimester screening. From my study I would agree the GP role could be enhanced by offering women navigational assistance to connect with a LMC as soon as the woman is ready. First trimester care is much more than screening; it includes health promotion, identifying psycho-socio-medical risk factors which may necessitate early specialist referrals and care planning for ongoing engagement with antenatal care. I would contend that in order to decrease the time delay between GPs and LMCs, the GP needs to navigate the transfer as close as possible to the pregnancy confirmation, not after the 12th week.

The NMMG in the past two years has focused on understanding the consistency of early pregnancy care provided by non-LMC GPs with the aim of aligning their care with NMMGs' Action 7 of the New Zealand Health Strategy theme, Closer to Home. This action is to ensure the right care occurs at the earliest time (Ministry of Health, 2017a). Similarly, this focus is a priority workstream within Counties Manukau Health maternity services, as with the NMMG, aiming to support GPs with quality early antenatal care and supporting women with timely registration with a LMC (Counties Manukau Health, 2017). Improving the quality of care provided in the first trimester by GPs is positive for women's maternity care. Although the bigger issue needing improvement, as revealed in this study, is the paucity of understandable maternity service information, including the different provider roles within first trimester care.

Even the experienced multiparous women in my study needed information and support to navigate the maternity system as finding pregnancy care is not an everyday occurrence. Yet, the women found their GP expected them to remember how the system worked and what was

needed to access a LMC. To do this independently was daunting and a major barrier to accessing LMC care in a timely manner. Alongside limited support and knowledge of maternity services, the women identified a lack of confidence to access and engage with the LMC service providers.

Barriers to accessing LMC care: Self-confidence and resources

The women spoke about how they found the process of phoning LMC midwives to check availability an exhausting process. The midwife phone list had limited information, providing only the midwife's phone number and geographical location. Even more perplexing, having found an available midwife, was the women were then required to question the midwife to ascertain if the midwife was going to fit their needs and criteria. The women felt uncomfortable with the self-seeking way of finding a midwife; and this was an obstacle for those women who preferred the GP or nurse's help to recommend a midwife. To be able to explore the midwife's reputation and experience with a known and trusted GP or nurse assisted and reassured the women that the midwife was likely to meet the criteria and qualities they were seeking.

The problem of repeatedly trying to contact midwives and the discomfort of putting questions directly to the midwife was identified as a barrier by the women in this study and similarly identified by Corbett et al. (2013), Makowharemahihi et al. (2014) and Bartholomew et al. (2015). These authors further explained that for Māori and Pacifica women, having to actually ask a health professional to care for them is a culturally and socially uncomfortable task and was avoided where possible. Hence, to have their GP or nurse recommend a LMC midwife saved them the embarrassment of having to directly contact a midwife or not making contact at all, thus delaying care. Makowharemahihi et al. described women given a list of midwives, phoning many midwives to find them unavailable, or messages left and no call returned. The women in Makowharemahihi et al.'s study went to extraordinary lengths to find a midwife, became exasperated and self-referred to the hospital or returned to the GP. A similar scenario was experienced by one of my participants who became frustrated with the task of finding a LMC and returned to plead with her GP to care for her.

Pressured busy lives impact on time to access and engage with midwifery care

The women in my study had busy lives which, alongside limited financial resources, impacted their ability to access health care. It could be argued many women have busy lives and are time pressured, but the lives of the women in this study were exacerbated by poverty. Limited financial resources hampered their ability to offset their busyness by being able to pay for some tasks to be done by others.

As stated previously, all the women had recently or currently worked outside of the home, had several children and were the pivotal home managers for the needs of immediate and extended family members. The women expressed their appreciation of help to connect with a LMC midwife and that the midwife was located at their GP clinic. Saving time was important to the women and having help to easily and conveniently connect with a midwife lessened the pressure in their daily lives. This is a significant finding and in line with McLeish and Redshaw (2018), Makowharemahihi et al. (2014) and Hatherall et al. (2016) who reinforced maternity services for high deprivation and/or vulnerable populations need to consider firstly the demands on the women's lives related to their ability to access the current maternity services; and secondly, to offer navigational assistance to enable the women to access early first trimester care if desired.

The importance of other family members' daily living and health needs was paramount to the women. The women needed to fit these demands around their work commitments; therefore, they wanted midwifery or other primary health care close to where they lived and worked. In some cases, because the women did not drive or have transport, they had to be able to walk to access health care. I noted that all the women had a GP clinic close to where they lived.

Poverty

Limited financial and time resources add another layer of constraint and tension in accessing a LMC. The women identified financial limitations influencing their ownership of a mobile or landline phone and limited credit to phone multiple LMCs and ascertain their availability. Limited finances also impacted on their ability to afford petrol and parking costs, especially if needing to drive to a clinic location not on their usual routes. A further complication was some of the women did not drive or did not want to drive, limiting where they could access care. Public transport, while available, was cited as another obstacle for women who were new to the region and not confident with navigating an unfamiliar city. Moreover, for some of the women their cultural beliefs would not allow them to travel alone on public transport and driving was deemed to possibly cause pregnancy health concerns. In these cases, both finances and the physical act of traveling were barriers to accessing a LMC who was not close to their homes.

The women in the study repeatedly acknowledged being time poor which constrained their choice of where they could access LMCs. It would appear the women's needs for antenatal care were important to them, albeit after other family members' needs were met. Thus, the women in my study expressed appreciation at the convenience of being able to access GP care

at the same time as seeing the midwife, specifically for their maternal immunisations, mental health and physical ailments that were not in the midwifery scope of practice. Having this option saved them time and petrol costs.

Much of the New Zealand and overseas literature cites multiparous women often do not prioritise accessing early antenatal care for reasons similar to those raised in the current study – time restraints, prioritising the needs of other family members, financial limitations (Corbett et al., 2013; Dixon et al., 2013; Haddrill et al., 2014; Hatherall et al., 2016; Ratima & Crengle, 2013). These barriers have been cited as high contributors to why women may access antenatal care after the first trimester. However, the current study and more recent overseas research reveals registering after first trimester is due to more than financial and time constraints; it is about socio-cultural and psychological influences. That is, pregnancy may be viewed within the wellness domain and therefore does not need attention unless there is a problem (Haddrill, 2018; McLeish & Redshaw, 2018; Rayment-Jones et al., 2017).

Part Three – Support to Access a LMC

When offered information and a recommended LMC midwife who was co-located at the GP clinic, the women felt supported. Consequently, the women accessed LMC midwifery care easily and in a timely manner once their pregnancies were confirmed at their GP clinic.

Improving the communication of maternity and LMC care information

The majority of women in this study had English as their second language which may have made communicating effectively and confidently a challenge – especially when needing to ask sensitive questions of a person they did not know. Therefore, the women expressed and appreciated the willingness of the GP or nurse to physically offer support to find a LMC; although caution has been advised when imposing choice and decision making on women who may prefer letting health professionals involved take charge (Lovell, 1996).

New Zealand and overseas literature support improving public health communication and interventions to increase specific knowledge on the importance of accessing early antenatal care (Aquino et al., 2015; Copland et al., 2011; Griffiths et al., 2013; Lindquist et al., 2014; Makowharemahihi et al., 2014; Ministry of Health, 2017a). The purpose and processes of the New Zealand maternity system needs communicating in the languages spoken in the communities it is intended to inform, in a format acceptable and understandable to women and their families and at the right time that supports women to be able to make choices about their care (DeSouza, 2014; Griffiths et al., 2013; J. Henderson et al., 2013).

Accordingly, it may be pertinent for GPs to not presume all pregnant women want to make choices and their own decisions of LMC carer; as Lovell (1996) asserted, instead to provide pregnant women with information and support will empower them to have choices and make decisions within their motherhood journey. Therefore, the findings of this study support the need for GPs to instigate conversations with women at the time of their pregnancy confirmation to ascertain what information and support they want and, moreover, their level of choice and decision-making. These conversations need to happen with each pregnancy. As women become more familiar with the maternity services and the region they reside in they may experience increased confidence to navigate independently their health care needs, choices and preferences. However, women's daily living needs and demands are individual; therefore, some women may continue to require knowledge and support to access health care services.

Offering a recommendation to relieve the burden of finding a LMC

The current study revealed that the women trust the information, recommendations and referrals from the GP and/or nurse. This juxtaposition of primary health care personnel with the co-located midwifery services offers, by shared proximity and inter-collegial knowing, an endorsement of the LMC midwife. Transferring from GP to LMC care enables accessible care and increases the confidence of the woman beginning a new maternity relationship with someone she does not know. The women wanted reassurance that they would find a 'good' midwife. When a midwife was recommended by their GP or nurse, the recommendation was perceived to come with an endorsement that the midwife 'must be good'. The women then accessed the midwife easily, with confidence and with less fear and anxiety of the quality of the care she was to receive. Through the endorsed recommendation from the GP or nurse, the women described a sense of knowing the midwife, despite not having met the midwife previously and a confidence to contact the midwife or book an appointment when they were ready to access midwifery care. However, in order for midwives to be recommended to women, inter-collegial relationships are important. GPs, nurses and midwives need to have strong professional relationships to uphold trust and knowing of each other. 'Shared knowing' between health professionals is the basis of a trusted relationship the women then build on when establishing the new LMC relationship (Crowther & Smythe, 2016). This prior 'knowing' helped women feel they could ask the GP or nurse critical questions about the recommended midwife, which enabled them to build a profile of the midwife and inform their decision making of a LMC.

Health care in a familiar environment supports access to a LMC

The women in this study valued the ease and convenience of having their midwifery care at their GP clinic, facilitating a smooth transition from non-LMC GP maternity care to LMC midwifery care. Moreover, this came with the advantages of the environment being a familiar place where they knew the staff, as well as lessening the potential for women to be lost between providers. The model of co-location of midwives at GP clinics enabled the women to connect with a midwife who was available and accessible. As stated in chapter one, co-locating midwives with GP clinics was suggested by Corbett et al. (2013) and Paterson et al. (2012) as a specific health care access strategy for women who live in Counties Manukau Health's high deprivation communities to increase their accessibility of LMC care. Several studies have identified that health services provided within a familiar environment is important to people accessing and engaging with the health service (Corbett et al., 2013; McAra-Couper et al., 2018; Priday & McAra-Couper, 2016; Ratima & Crengle, 2013; Southwick et al., 2012; Tanuvasa et al., 2013). The women reflected the added advantage of feeling their health history was already known and that the GP clinic staff and midwives could, if necessary and with consent, convey health information such as outcomes about the birth and any complications while ensuring a celebratory birth-ethos was conveyed between the midwife and the GP clinic staff. This potential for open dialogue between the health professionals was seen as more personal and valued by the women, giving them an added layer of their maternity care remaining connected with their primary health care providers. The women witnessed and valued this face to face collegiality describing that face to face communication added to their sense of thoroughness of their maternity care; particularly for the hand back process at six weeks post-partum.

Summary: Engaging in Early Maternity Care

Within my findings the women needed and desired support to become involved with LMC midwifery care. The timing of this support requires scrutiny as the women needed to be 'ready' to accept being pregnant or want to remain pregnant; a transition process the women required to traverse before wanting to access antenatal care. Haddrill et al. (2014) argued women need to recognise and accept both their pregnancies and the relevance and need for antenatal care. The women in this study wanted antenatal care from a LMC midwife once they knew they were pregnant. However, they required information and support to make informed decisions about their pregnancy journey, including accessing the LMC midwife along with the relevance of the recommended time frame for beginning LMC care. In order for women to become ready to access antenatal care, McLeish and Redshaw (2018) suggested that women

correspondingly need accessible understandable information and offered assistance and guidance to make informed choices and navigate the maternity care system. Empowering women with information and support may influence their timeliness to accessing antenatal care (McLeish & Redshaw, 2018) and be the catalyst for early engagement with LMC antenatal care; that is, before 10 weeks gestation as recommended by the WHO, National Institute for Health and Clinical Excellence, New Zealand Ministry of Health and the regional DHBs.

Study Strengths, Limitations and Future Research

Strengths

The principle strength of interpretive description methodology is that it entails a small sample study and has specific applicability across today's health practice arena (Thorne, 2008). The methodology is health practice centric and inclusive; therefore, when interpreting the women's experiences the findings cross general medicine, nursing and midwifery, offering insights and informing all disciplines. This study has revealed the experiences of women with different health professionals' care and involvement in the initial phase of their maternity care journey, discussing the socio-cultural life influences related to accessing and engaging with antenatal care. The study practicality is an important strength when health services are being examined for their usability to the target population.

I contend a positive outcome of this study is informing health service modelling and future development as the study highlights the behaviours of pregnant woman accessing and engaging with midwifery care earlier in their pregnancies. The study adds to New Zealand literature regarding local and national health service design and policy; and may inform the need for a larger study in other communities informing health service providers, Ministry of Health, DHBs, primary health care doctors, midwives and women who access and engage with midwifery and maternity care.

More poignantly a strength of this study has been in giving voice to women whose views are not easily accessed and are known to have specific health service and health needs. Although the essence of this study was to focus on women connecting with LMC antenatal care when their GP clinic had a co-located midwifery clinic; this process may be similar for people needing to transfer care from their GP to another specific health care provider.

A possible strength of this study is that my experience of working with women marginalised by poverty enabled rich interview data from the participants. I was open to hearing the woman's voice in its rawness. In turn, I listened intently to the positive and negative experiences during their maternity journey.

Limitations

This study offers insights and understandings into the experiences of multiparous women who live in socioeconomically deprived communities of Counties Manukau who have received midwifery care located at their GP clinic. Thus, there are no claims of 'generalisation' as the findings are specific to these participants residing in this geographical region nor generalisability suggested across ethnicities. However, from the New Zealand and international literature, similarities of experiences and health requirements for women accessing antenatal care are evident within other high deprivation communities and consequently some similarities in experiences may be identifiable.

Time restraints within the expectations of the thesis influenced the recruitment process limiting the number of participants. However, in the interviews, the same factors were reiterated, which enabled thematic analysis and gave power to the women's narratives. This is apt and cognisant to interpretive descriptive methodology (Thorne, 2008; Thorne et al., 1997).

An obvious limitation to the study was the focus given to finding a midwife. This is a consequence of the women's overt need to tell their story about previous experiences of trying to access a LMC midwife. I noted that women needed to tell this story not once but twice. This was possibly the first time these women had been asked about their experience of finding a LMC and the interview process gave them an opportunity to express their feelings and thoughts about their experience. The women's need to tell their stories of trying to find a midwife out-weighed their interest in sustained conversations exploring the rest of the antenatal care journey. The women appeared to have a safe, cathartic experience when retelling the daunting process of finding a LMC midwife and their relief when recommendations and navigational help was offered.

It is possible that women who may have more transient lives or did not have the opportunity to know of the study may have been excluded. Recruitment may have missed other groups of women who had received midwifery care co-located at their GP clinics for prior pregnancies but had now moved to care from a stand-alone midwifery clinic or hospital clinic where the recruitment was not centred. Additionally, this study's focus is on the experiences of women who utilised the co-location midwifery service and does not explore the experiences of the midwives who provided the midwifery care. It must be noted the mixed methods study of Priday and McAra-Couper (2016) does focus on the GP clinic providers' experiences of having midwives co-located at their clinic. A study that includes all people involved in the co-located service would provide a more holistic view of the service model.

Future research

The findings of the current study would benefit from additional research to confirm similarities in other high deprivation communities and populations across other health regions in New Zealand. I would recommend 'in the field' research to understand what works well for women when accessing LMC care within specific cultural groups and that women actively participate in the research, be involved in the change development of such a service and be current users of the services. This is essential if further research is to be productive in changing health services for vulnerable communities. Consideration of what GPs, practice nurses and LMC midwives already use that works well in helping women connect early and easily to LMCs would be beneficial.

The findings reveal the beginning phase of maternity care services required time and effort for the women to go from their GP care to finding a LMC. It would be important to undertake a system and policy review related to how women access the maternity system; exploring the current frameworks that guide this service specifically focusing on feedback from women who use the service, so as to inform service design. Research into the women who book after 20 weeks gestation to inform of factors associated with late booking could further inform health policy.

This study may be applicable for women within the same cultural groups in other high deprivation communities, although further research may challenge this notion. Further research may also find that accessing LMC midwifery care may be prevalent in other societies, such as the 'working poor' communities (Manch, 2018) and/or women with over-stretched daily living commitments, or where midwifery work force shortages dominate. Finally, further research examining the relational dynamics between primary health care providers – GPs, practice nurses and midwives – exploring how inter-collegial relationships influence or impact women's access and engagement with LMC care may be beneficial.

This study could be replicated to explore the experience for people with mental health or chronic conditions needing to find a carer, addiction therapist, oncologist, physiotherapist or other health provider (Goodman, 2015; Rumball-Smith et al., 2014). This study could be transferable to similar scenarios where recommendations and navigation support are required to build people's confidence in connecting with another practitioner and easing their access to another health service and health service provider.

Opportunities for Practice

When women confirm their pregnancy at their GP clinic, supporting them to access LMC care early and easily has implications for GPs, GP clinic personnel and LMC midwives. GPs and nurses need to take time to identify opportunities to talk with women about their pregnancy, the maternity system, why early first trimester care is recommended and where LMC midwives are located, while ensuring the considerations respect the women's daily living demands. Placing women's daily living requirements as 'central' is crucial to ensuring the right support is offered. The GP and clinic personnel could follow-up and offer support to women to connect with a LMC midwife close to where they live, work or at their GP clinic, balanced with allowing women time to attain a pregnancy mindset and readiness to access care (Haddrill, 2018; Haddrill et al., 2014).

GPs and nurses need to establish trust with women at the time of the pregnancy test to ensure the information and support offered is culturally appropriate, empowering and beneficial. Support could include discussion of the full scope of midwifery first trimester care so women who may be concerned about having a tentative pregnancy, feel supported to know midwives also provide care, support and referrals to specialist care if a miscarriage eventuates or if a termination of pregnancy is wanted.

GPs and GP clinic personnel need to increase their collegial relationships with local LMC midwives and/or support midwives to co-locate at their GP clinic, thereby assisting women to connect with a LMC midwife in a timely manner. The findings also suggest GP clinic staff follow-up within the week of the confirmation of pregnancy to see if further assistance is required. GPs, practice nurses and midwives need to commit to supporting women and determining how early pregnancy care needs can be accommodated so as not to become an added burden.

Alternately, it may be suggested that the midwifery full scope of practice could be further utilised by establishing an early pregnancy midwifery clinic at GP clinics in communities where women find it challenging to independently access midwifery care. This initiative may improve both access for women to midwifery care early in their pregnancy and midwifery visibility for first trimester care. These midwifery clinics could focus on pregnancy testing, quality first trimester care, choices of care with assistance and navigation to connect with a continuity of care LMC that meets the women's needs and daily living demands.

Implications for Policy Makers and Health Service Provision

In the New Zealand context there needs to be a commitment to increasing information to communities, including teenage communities, about reproductive health, signs of pregnancy, why early pregnancy care is important for both women and their developing baby, the maternity system functions and how to access LMC carers. Successfully promoting antenatal care before 10 weeks gestation requires a national education programme to inform the general public of the full scope of midwifery practice with a strong emphasis on first trimester care by a LMC midwife as a viable choice of care, increasing the visibility of midwives, highlighting where midwives are located and how to contact them. The Ministry of Health and DHBs could consider promoting inter-collegial relationships between GPs and midwives and resource more midwives to work autonomously from GP clinics, particularly in high deprivation communities.

LMCs, namely midwives, need to attend to the information they have on the 'Find Your Midwife' website to assist women to independently look for a LMC. Additionally, GPs and clinic personnel who may use the website as part of their support strategy to navigate with women when helping them find a midwife would benefit from having updated information, along with a depth of information about the midwives to help women gather more information to inform choice and decisions.

Recommendations

GPs, midwives and health policy makers need to cease making assumptions that women can independently find a midwife, are informed about the maternity system and the timeframe recommended to access LMC care. GPs and nurses at the GP clinic need to 'become involved' with women when their pregnancy is confirmed. They could establish open dialogue that encourages the trust needed to discuss the woman's pregnancy status and promote full discussions on the choices for LMC care. Establishing a relationship that promotes open discussion at this early point in the childbirth journey, along with a recommendation of a midwife known to the GP clinic staff, whether co-located or not, is essential to raise women's confidence in accessing and engaging in their first trimester of pregnancy. Non-LMCs could be made aware of their Ministry of Health funding obligations linked to the Ministry of Health services specifications they are required to provide. It may be that additional funding is required to achieve these service specifications as it is apparent from this study's findings that additional time and effort is required by the GP clinic staff to support women to transfer care to a LMC.

Health providers ought to recognise that for women in high deprivation communities accessing and engaging with LMC midwifery care can take an enormous effort and may not be a priority in their daily lives. Consequently, it is necessary for health professionals to be the active partner, initiating conversations and promoting early care if this is what women want. The findings show the need for health professionals to 'become involved' by a number of means, co-location of midwives, recommendations of known midwives and early pregnancy midwifery clinics. Midwives need to increase their visibility in the community to enable women to access LMC care and, at the same time, be seen to be the choice of providers of first trimester care; although a proviso is necessary as not all women's health status fits a midwife's scope of practice; for example a woman with type 1 diabetes or with epilepsy, such underlaying medical conditions need medical input prior to and at the commencement of the pregnancy.

Recommended practice points from the findings

- Improve women's health literacy regarding: reproductive health and the signs of pregnancy
- Increase depth of discussions between GPs and women, as well as the GP clinic staff and women, regarding choices of LMC care at the time of pregnancy confirmation and why LMC care before 10 weeks' gestation is recommended.
- Information for women and their families should be in the languages relevant to the cultural communities for whom it is intended.
- Increase the visibility of midwifery scope of practice in the first trimester. Midwives need to become more involved with first trimester care.
- Foster collegial relationships between GP clinic staff and the midwives in the community. LMC's to copy woman's GP into test results helps for those already engaged.
- Commence midwifery-led early antenatal clinics at GP clinics and other community venues.
- Navigational support needs to be part of routine practice for the GP clinic staff.

To achieve these recommendations consideration would need to be given to the funding of midwives and GP clinics. More funding of resource and time would be needed to realise these expectations.

Conclusion

In Counties Manukau, access and engagement with a LMC does not always occur within the recommended timeframe – before 10 weeks gestation – due to: lack of collegial relationships and co-ordination amongst professional groups in primary health care; lack of visibility of

community LMC midwives; lack of knowledge of the scope of midwifery practice for the first trimester; a limited number of self-employed and ethnic specific midwives; complex social situations; poor health literacy and limited personal and financial resources.

For the women in this study accessing antenatal care, albeit accessing antenatal care before 10 weeks gestation, is a complex process of inter-related influences between psychological, social and demographic factors in a woman's life which need to be known, respected and negotiated prior to a woman's first antenatal appointment or at the time of the pregnancy confirmation appointment. Enhancing reproductive knowledge and the structure of the maternity system services prior to conception is ideal; but, if this is not possible, dedicated time needs to be allocated by health providers at the time of confirmation of the pregnancy to identify and discuss the women's needs in relation to where and whom she wants as her LMC.

My study revealed the co-location of midwives at GP clinics is an initiative that could assist women to access LMC care before 10 weeks gestation. Furthermore, the co-location of midwives at GP clinics is an example of interconnected collegial relationships between GPs, nurses and midwives. The interconnectedness enables both a recommendation by a known GP or nurse and/or their support to connect with a known LMC midwife; this interconnected knowing was a catalyst that enabled the women when they were ready to connect confidently, easily and opportunely with LMC midwifery care.

Women find they are pregnant at varying times and access LMC care at varying times depending on their life influences and the support they are offered to find a LMC. Each woman's needs are unique; therefore, opportunities for women to access a LMC need to be varied, at different locations, in different ways, independently and/or with support to access care. Access to LMC care has to work for women, their whānau/family and their community. The maternity service provider requirements must be secondary to women's needs. To truly honour all women and their pregnancy journeys, the Ministry of Health, therefore the New Zealand government, must offer services that support women to access LMC services.

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Appendices

Appendix A: Ethics Approval

AUTEC Secretariat

Auckland University of Technology
D-88, WU406 Level 4 WU Building City Campus
T: +64 9 921 9999 ext. 8316
E: ethics@aut.ac.nz
www.aut.ac.nz/researchethics

27 September 2016

Debbie Payne
Faculty of Health and Environmental Sciences

Dear Debbie

Re Ethics Application: **16/320 Accessing and engaging with midwifery care in primary health care settings: Women's experience**

Thank you for providing evidence as requested, which satisfies the points raised by the Auckland University of Technology Ethics Committee (AUTEC).

Your ethics application has been approved for three years until 27 September 2019.

As part of the ethics approval process, you are required to submit the following to AUTEC:

- A brief annual progress report using form EA2, which is available online through http://www.aut.ac.nz/researchethics. When necessary this form may also be used to request an extension of the approval at least one month prior to its expiry on 27 September 2019;
- A brief report on the status of the project using form EA3, which is available online through http://www.aut.ac.nz/researchethics. This report is to be submitted either when the approval expires on 27 September 2019 or on completion of the project.

It is a condition of approval that AUTEC is notified of any adverse events or if the research does not commence. AUTEC approval needs to be sought for any alteration to the research, including any alteration of or addition to any documents that are provided to participants. You are responsible for ensuring that research undertaken under this approval occurs within the parameters outlined in the approved application.

AUTEC grants ethical approval only. If you require management approval from an institution or organisation for your research, then you will need to obtain this.

To enable us to provide you with efficient service, please use the application number and study title in all correspondence with us. If you have any enquiries about this application, or anything else, please do contact us at ethics@aut.ac.nz.

All the very best with your research,

Kate O'Connor
Executive Secretary
Auckland University of Technology Ethics Committee

Cc: Adrienne Priday, apriday@xtra.co.nz; Marion Hunter

Appendix B: Participant Information Sheet

Auckland University of Technology
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Participant Information Sheet

Date Information Sheet Produced:

5 August 2016

Project Title: Accessing and engaging with midwifery care in primary health care settings: women's experiences.

An Invitation

Tēnā koutou, katoa. My name is Adrienne Priday. I am a community midwife who works in the Counties Manukau Health region. I am also a Master's student at AUT University. I would like to invite you to take part in my research study.
This study may help to better understand your experience of accessing and engaging with midwifery care at your Family Health Practice or known as Health Clinic, Doctors or GP's.
Your participation in the research is entirely your choice. You can also choose to not take part in the study at any time. Deciding not to take part or withdrawing from the study will not affect your health care in any way.

What is the purpose of this research?
In this study I want to find out more about the experiences of women who have used the midwifery clinics at their doctor's clinics.

How was I identified for the research and why am I being invited to participate in this research?
You have been identified and invited to take part because:

- Your Family Health Practice is in CMH regions of Mangere, Otara, Manurewa, Takanini, Manukau and Otahuhu
- You received your midwifery care for your latest pregnancy from a midwife based at your Family Health Clinic in the last 4 years. **And** for the pregnancy before that, you received your care at a place that was not your Family Health Clinic
- You are 18 years or older
- You speak English and
- You have not received midwifery care from me, or my back-up midwife.

What will happen in this research?

If you chose to take part in this research you will be asked to take part in a one-to-one interview with me, at a time and place that suits us both. If you prefer not to be interviewed alone, you are welcome to have a support person or whanau present.

Before the interview you will be able to ask me more questions that you have about the study. Once these have been answered to your satisfaction, I will ask you to sign a Consent Form.

I will then ask you to choose a different name that will be used in the study to protect your identity.

I will also ask your permission for me to audiotape record the interview.

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I will ask you about your experiences of receiving midwifery care with your previous pregnancy's and for this most recent pregnancy when you have received midwifery care at your Family Health Practice. The interview will take approximately 60 to 90 minutes.

I may also write notes during the interview. The interview will be typed out by either me or a typist who has signed a confidentiality agreement. The transcript will be returned to you to check that the information is correct and for you to make any changes.

I may need to re-interview you to clarify or follow-up ideas and thoughts from the first interview. You can choose whether or not you want to do this.

What are the discomforts and risks?

I do not anticipate any discomfort or risk before or during the interviews. However, it is possible that you may remember things that cause you discomfort.

How will these discomforts and risks be alleviated?

If you do become uncomfortable or upset during the interview, we can stop the interview for a short break, or you can decide not to go on further and/or withdraw from the research.
I will make every effort to support you in a safe and compassionate way. Your decline or withdraw will not affect your future health services in any way.
In the event of any discomfort related to your birth experience, you can provide feedback via the New Zealand College of Midwives feedback and resolutions service or through the Health and Disability Commissioner. Additionally, you may access AUT counselling services, should you feel the research process has been harmful. AUT Health Counselling and Wellbeing is able to offer three free sessions of confidential counselling support for adult participants in an AUT research project. These sessions are only available for issues that have arisen directly as a result of participation in the research, and are not for other general counselling needs. To access these services, you will need to:

- Drop into their centres at the City (Room WB219) or North Shore (Room AS104) campuses or phone 09 921 9992 for the City Campus or 09 921 9998 for the North Shore campus to make an appointment. Appointments for South Campus can be made by calling 09 921 9992
- let the receptionist know that you are a research participant and provide the title of my research and my name and contact details as given in this Information Sheet

What are the benefits?

The information that you share with me may help to provide changes to services for other pregnant women living in Counties Manukau region. This study will also benefit me professionally by contributing to my Master's degree in Health Science. With your permission I plan to present my study at midwifery conferences and also publish my findings in a midwifery journal.

How will my privacy be protected?

Your name will not be known to others or used in my thesis or at any other times that I share my research with midwives or others. Before the interview starts I will ask you to choose another name by which you want to be known.
A typist, who may transcribe the interview data, will sign a confidentiality agreement. My supervisors will be the only people who may see the interview transcripts. All the transcriptions, audio recordings will be stored securely for 10 years then shredded.

What are the costs of participating in this research?

The only cost to you is that of your time. The interviews will take approximately 60 to 90 minutes. I appreciate your time is given voluntarily. There may be costs in travelling time if you chose to be interviewed at a community facility.

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What opportunity do I have to consider this invitation and how do I agree to participate in this research?

If you would like to take part in this study, I would appreciate hearing from you within two weeks of receiving this information sheet. If you do not contact me within the two weeks, I will assume you do not wish to take part.
If you are interested in the study and wish to learn more about it, please contact me. You can ask me any questions that you have. Should you decide to take part, we will then make a time and place for us to meet and carry out the interview. My contact details are below.

Will I receive feedback on the results of this research?
You will be offered a summary of the findings when the study is complete. The completed written thesis will also be available through the AUT University library.

What do I do if I have concerns about this research?

Any concerns regarding the nature of this project should be notified in the first instance to the Project Supervisor:

Deborah Payne dpayne@aut.ac.nz +64 09 921 9999 ext 7112

Concerns regarding the conduct of the research should be notified to the Executive Secretary of AUTEC, Kate O'Connor, *ethics@aut.ac.nz* , 921 9999 ext 6038.

Whom do I contact for further information about this research?

Please keep this Information Sheet and a copy of the Consent Form for your future reference. You are also able to contact the research team as follows:

RESEARCHER CONTACT DETAILS: Adrienne (Ady) Priday
Email: em51422@aut.ac.nz Mobile 0274809140

PROJECT SUPERVISOR CONTACT DETAILS:

Deborah Payne dpayne@aut.ac.nz +64 09 921 9999 ext 7112

Approved by the Auckland University of Technology Ethics Committee on *type the date final ethics approval was granted*, AUTEC Reference number *type the reference number*.

Appendix C: Researcher Safety Protocol for Interviews

The interviews will take place at a convenient location for both the participant and the researcher e.g. in a community facility or the participant's home, if the participant prefers.

The following protocol will be applied if interviews take place in the participants' home:

- The primary researcher will inform a named work colleague of the time, date and venue of the interview. This information will include the anticipated start and end time of the interview.
- The primary researcher will text/ring her colleague when she arrives at the venue prior to the interview.
- The primary researcher will text/ring her colleague when she is leaving the venue after the interview.
- Should the primary researcher fail to make contact, the work colleague will contact the relevant authorities e.g. the Police.

Appendix D: Consent Form

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Consent Form

For use when interviews are involved.
Project title: Accessing and engaging with midwifery care in primary health care settings: women's experiences.

Project Supervisor: Deborah Payne
Researcher: Adrienne Priday

- ☐ I have read and understood the information provided about this research project in the Information Sheet dated 6 August 2016.
- ☐ I am 18 years or older.
- ☐ I have had an opportunity to ask questions and to have them answered.
- ☐ I understand that notes will be taken during the interviews and that they will also be audio-taped and transcribed.
- ☐ I understand that taking part in this study is voluntary (my choice) and that I may withdraw from the study at any time without being disadvantaged in any way.
- ☐ I understand that if I withdraw from the study then I will be offered the choice between having any data that is identifiable as belonging to me removed or allowing it to continue to be used. However, once the findings have been produced, removal of my data may not be possible.
- ☐ I agree to take part in this research.
- ☐ I wish to receive a summary of the research findings (please tick one): Yes○ No○

Participants signature :
.....

Participants name :
.....

Participants Contact Details (if appropriate) :

.....
.....
.....
.....

Date : .....

Approved by the Auckland University of Technology Ethics Committee on *type the date on which the final approval was granted* ***AUTEC Reference number*** *type the AUTEC reference number*

Note: The Participant should retain a copy of this form.

Appendix E: Interview Guide and Prompt Sheet

Demographic questions

Geographical location

FHP location

Location of antenatal care for previous pregnancies

Gestation when midwifery care commenced for each pregnancy

Gravida

Age

Existing medical and social health concerns

Overview / outline of questions for the individual interviews – informant led.

1. Tell me about your experiences of midwifery care with your previous pregnancies? (pregnancy care not at their FHP; this addresses the inclusion criteria.

2 Tell me about your most recent pregnancy care experience starting with how you found a midwife.

3. How did you find these and this process …... why was that?

Examples of my questions are:

Please tell me about your antenatal care with your first baby, how did that happen……. and where……,

what was it like…….,

did you think anything else could be done……?

Please tell me the same about second, third, babies regarding antenatal care……

Please tell me about what you do when you think you are pregnant? Then what happens?

Please tell me what you do when your family doctor or nurse tells you are pregnant? Then what happens…. why?

How do you feel when you want to find care for your pregnancy? Why?

What were you hoping your midwifery care would be like?

What were you looking for in a midwife?

What were the things that were important to you or things that mattered to you?

How did you get to meet up with the midwife?

Please tell me what it was like the first time you met your midwife….

What happened the first time you had a visit with your midwife……

What happened next, anything else…….

Tell me about the care you received from your midwife?

Tell me more about that?

Can you tell me about a time the midwife explained some tests to you, what happened, what did she say, what did you say, what did you think (prompt questions include, do you remember her talking about a scan, diabetes testing…….)

How was that for you?

Is there anything else you think I should know to help me understand that better?

Were there any times that the midwife talked to the doctor or nurse in the practice while you were with her?

Can you tell me what happened?

How do you feel about coming here for all of your antenatal visits?

Is there any other place you would like to meet the midwife or like antenatal visits to happen?

What went well?

Was there anything you would have liked to go better?

What could have helped that be a different experience for you?

How was this for your family?

That's interesting, tell me more about that? ……. What happened next?

Walk me through that step by step

What did you think about that?

Can you share a time that the midwife spoke with a doctor or nurse in the practice when you were there about your care, or referred you etc (just to fill out the "handiness" if that is the term regarding co-location)?

After these experiences what advice would you give to a woman who is pregnant and needed to find a midwife?

Would you choose to see a midwife at the health service if you had another baby?

What other places could have been good to have your antenatal visits?

Round up – reflective review questions:

What worked well,

What didn't work for you (compare and contrast data)

Researchers reminders:

May need to repeat some previous questions for reflection and confirmation of what was heard/said.

***NOTE**: probing, open ended questions, Silence, Echo or uh -uh u's*