Working through complexity: How women living in areas of high
socioeconomic deprivation in New Zealand
access and engage with midwives

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Abstract

Women living in areas of high socioeconomic deprivation in Aotearoa/New Zealand experience significantly higher rates of stillbirth and neonatal death than women living in other areas. This is potentially related to access to, and/or engagement with, maternity services. Constructivist grounded theory methodology was used to explore the research question '*How do women living in areas of high socioeconomic deprivation in New Zealand access and engage with midwives?*' In total, 24 individual interviews were undertaken with 11 women living in areas of high socioeconomic deprivation in three North Island cities, and 10 community Lead Maternity Carer midwives working in those areas.

How women accessed midwifery care was complex and varied. Entering the maternity system exposed women to complexity additional to that they constantly navigated through their daily lives. Women navigated a shifting landscape to find a midwife, where midwife location and availability were inconsistent. The complexity of the women's lives meant they were often prioritising their needs in a range of changing conditions, consequently risking missing midwifery care. The degree and nature of the support available through the maternity system to meet their complex requirements was limited, and shifted, depending on contexts. Midwives responded in a number of ways to a maternity system which was not working for women, aiming towards keeping women engaged with care, working towards an optimal pregnancy outcome.

Building effective relationships enabled women and midwives to work together to effectively address the woman's care requirements within a maternity system that did not readily meet their needs, and encouraged women to remain engaged with pregnancy care. If women missed an appointment with their midwife, following up was crucial, as midwives knew this was a group of women who traditionally fell through the gaps in the maternity system. Staying connected was dependent on the midwife's knowledge of the woman's connections, and took time, and energy. When a woman did not develop an effective relationship with her midwife, while midwives went to some lengths to remain connected to ensure she remained engaged with midwifery care, there were limits to their resources.

Once a midwife was accessed, women relied on her support and advocacy to negotiate solutions that would facilitate an acceptable pathway for them through the maternity system. The effective relationships women had built with their midwives and the provision of continuity of midwifery care enabled negotiations. Elements

influencing the negotiation included the facility resources of staffing and funding, and the resources women and midwives had available. When women developed complications, depending on the context and the conditions operating at particular times, they were caught between a maternity system which divided their one continuous pregnancy journey into care categories, and the midwifery model of care supporting continuity centred on the women. To sustain themselves in practice midwives negotiated solutions around how they worked.

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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 written or published by another person (except where explicitly defined in the acknowledgments), nor material which, to a substantial extent, has been submitted for any other degree or diploma of a university or any other institute of higher learning.

Signed:

Dated: 25 March 2019

Acknowledgments

"Come to the edge," he said.
"We can't, we're afraid!" they responded.
"Come to the edge," he said.
"We can't, we will fall!" they responded.
"Come to the edge," he said.
And so they came.
And he pushed them.
And they flew.
-Guillaume Apollinaire. (2018, April 24). Retrieved from Goodreads website: https://www.goodreads.com/quotes/17760-come-to-the-edge-he-said-we-can-t-we-re-afraid

A PhD? Me? Who would ever have thought? So much has happened since I began this degree.

To the women and midwife participants in my study, thank you. This thesis would not have been possible without you sharing your experiences with me. Thank you for trusting me with your words. Whenever I felt frustrated or despondent at my progress with writing up, I would remember sitting talking with you all–that made me keep going. Your voices will be heard.

Judith and Barbara, my PhD supervisors: I do not have enough words. Your support through the challenges I had while doing this degree was fundamental to me being able to complete. Your constant belief that I could do this surpassed my own, many times. Thank you for your positivity and for always believing in me. I am truly grateful. You have been amazing supervisors.

Balancing working full time at Otago Polytechnic with working on my PhD, along with my other professional and personal responsibilities, has been a constant challenge, especially over the last three years. I needed to sustain myself and remain intact. Mostly I did this well. Other times I wobbled. I could never have completed this PhD without the people close to me who surround me and keep me safe. To the friends and colleagues who have supported and encouraged me, especially when I felt really afraid that I was not capable of completing this degree, words have power, and your words certainly affected me. You know who you are. Thank you is not enough, but sincerely thank you, thank you, and thank you.

Mum, you promised me you would live to 85 to see me complete this degree. Thank you for upholding your side of the bargain! I know you are proud of me and I know Dad would have been really proud too.

I dedicate this thesis to the three Selby sisters;

my mum, Jennifer;

her identical twin, Joan–my very own fairy Godmother;

and their sister, my other glorious aunty, Jocelyn, who died 24.1.18.

It is done!

25 March 2019

Explanatory Comments

The term 'midwife' in this thesis refers to a community Lead Maternity Carer (LMC) midwife (see Glossary, p. 252). When referring to a core midwife (see Glossary p. 252), the term 'core midwife' or 'hospital core midwife' is used.

Of the 3023 midwives holding an Annual Practicing Certificate with the Midwifery Council of New Zealand on 17 August 2016, only six were male (MCNZ, 2016). Therefore, the term 'midwife' may also be referred to by the feminine pronoun 'she' in this thesis.

When quoting women or midwife participants, the quote is given in italics followed by the participant's name in brackets, followed by a 'W' to denote a woman participant or 'MW' to denote a midwife participant. The following example is of a quote from Lily, a woman participant: "*I didn't call the second midwife until around 8am on the morning I gave birth to my second child*" (Lily W).

At times *[square brackets]* have been added to participant quotes to provide clarity.

Words or small phrases that do not detract from the meaning inherent in a quote, such as *'um'*, *'you know'*, or *'like'*, have been removed.

Please note that the findings in all chapters relate to all midwife participants, even though they may work in different settings.

Chapter 1: Introduction

The proportion of potentially avoidable perinatal related deaths increases with increasing socioeconomic deprivation, due to increasing contribution from barriers to access and/or engagement with care. (PMMRC, 2017, p. 82)

In Aotearoa/New Zealand, women living in areas of high socioeconomic deprivation experience significantly higher rates of stillbirth and neonatal death than women living in other areas. This may be related to access to, and/or engagement with, maternity services. How women living in areas of high socioeconomic deprivation in New Zealand access and engage with midwives is the subject of this research.

This chapter commences with an introduction to the research; the aim and purpose of the research, the significance of the study undertaken, and the impact being a midwife has had on me personally and professionally. Te Tiriti o Waitangi (the Treaty of Waitangi) and its influence on the midwifery profession, the history of midwifery in New Zealand, and a description of the New Zealand health system, maternity system, and midwifery model of care, follow. Partnership, legislation, and the socio-political context are discussed next, followed by my assumptions underpinning the research, and how socioeconomic deprivation was defined in this study.

1.1 Introduction to this Research

In New Zealand, perinatal mortality is defined as fetal and early neonatal death from 20 weeks gestation (or weighing at least 400g if gestation is unknown) until midnight of the sixth day of life (Perinatal and Maternal Mortality Review Committee (PMMRC), 2018). In 2016 the perinatal mortality rate in New Zealand was 10.1/1000 live births (PMMRC, 2018). This represents approximately 600 perinatal deaths a year and 1 percent of all births. The PMMRC is an independent committee that reviews and reports on the deaths of babies and mothers in New Zealand (Health Quality & Safety Commission New Zealand (HQSCNZ), 2018). The PMMRC was established in 2005 following a survey of maternity sector key stakeholders who had identified concerns that perinatal and maternal mortality were not audited in New Zealand and that there were areas where mortality could possibly be reduced. A national review of perinatal and maternal mortality was required (PMMRC, 2007). The purpose of the PMMRC is to review and report on perinatal deaths with the aim of reduction while continuously improving the quality of systems through policy (HQSCNZ, 2018). The PMMRC has developed a process for the national collection of data on each perinatal death; and since

2007 has produced an annual report of its findings to the Minister of Health (HQSCNZ, 2018). The first report analysed information available from the New Zealand Health Information Service (NZHI) data from 2000-2003 and identified several themes:

> *Perinatal mortality rates appeared to be on the increase from 2000 to 2003 for all ethnic groups in New Zealand but were higher in New Zealand Māori (26%) than in New Zealanders of European descent (8%). Approximately 70% of perinatal deaths were stillbirths, but the rate of stillbirths increased in all groups except New Zealanders of European descent, and Māori rates increased by 24% from 2000 to 2003.* (PMMRC, 2007, p. 6)

The report also identified that several risk factors had been associated with perinatal mortality, including biological, social, economic, cultural, environmental, and behavioural factors; but that medical causes and *quality of care* [my emphasis] must also be considered. In 1999 less than 40 percent of perinatal deaths had undergone post-mortem examination, thus supporting the perinatal specialists request for promoting post-mortem examination to explain unspecified deaths. The 2007 report noted that there was a *marked socioeconomic gradient* [my emphasis] in the unspecified deaths, which may be due to lower rates of post-mortem examination among women from more deprived populations, including Māori (PMMRC, 2007).

In 2012 I began developing ideas for my PhD research. In June 2012, the PMMRC report was published. This report, and each of the reports since (PMMRC, 2013, 2014, 2015, 2016, 2017, 2018), identified that rates of stillbirth and neonatal death were significantly higher amongst women living in the most socioeconomically deprived areas of New Zealand, and that this may be related to barriers to access to, and/or engagement with, maternity services. The PMMRC recommended that the factors around deprivation and access to maternity care needed to be addressed to respond to the stillbirth and neonatal death rates for women living in these areas. This became the focus of my PhD.

1.2 Aim of this Research

The aim of this research was to explain how women living in areas of high socioeconomic deprivation in New Zealand access and engage with midwives. The research question was '*How do women living in areas of high socioeconomic deprivation in New Zealand access and engage with midwives*?'

1.3 Purpose of this Research

Using constructivist grounded theory methodology, the purpose of this research was to develop a substantive theory explaining how women living in areas of high socioeconomic deprivation in New Zealand access and engage with midwives. To do so, this study explored the perspectives of childbearing women living in areas of high socioeconomic deprivation in three North Island cities, as well as community Lead Maternity Carer (LMC) midwives working in these areas. Knowledge generated by the explanation of processes in the substantive theory developed from this research will inform midwifery practice, research, and education around the care provided by midwives to women living in areas of high socioeconomic deprivation, to facilitate women receiving appropriate and adequate care. Findings from this study have the potential to make a difference to the midwifery care received by women and families who are most at risk for a range of less than optimal pregnancy outcomes, particularly stillbirth and neonatal death. Findings will inform what constitutes an appropriate maternity service for this group of women, and illustrate how the women and midwives develop relationships with each other. Findings will also inform decision making and policy, contributing to current discussions around compensation for travel and time for midwives. This will therefore address some of the complexity of working with socioeconomically complex women.

1.4 Significance of this Study

When I first began working on my ideas for this study, in 2012, rates of stillbirth and neonatal death, and other less than optimal pregnancy and birth outcomes such as preterm birth and babies small for gestational age (SGA), were significantly higher for women living in the most socioeconomically deprived areas of New Zealand (Corbett, Okesene-Gafa, & Vandel, 2013; Gardosi, Madurasignhe, Williams, Malik, & Francis, 2013; PMMRC, 2012). This was deemed to be unacceptable in a high-income country such as New Zealand, whose maternity system is held up as being a world leader and one of the most supportive internationally (Guilliland, 2013a, 2013b, 2015a). A factor potentially contributing to these rates was lack of access to, and/or engagement with, maternity services (PMMRC, 2012). Yet little was known about how the current model of maternity care, including the care midwives provided, facilitated engagement with maternity services for women living in areas of high socioeconomic deprivation. In the succeeding years, rates of stillbirth and neonatal death have continued to remain higher for women living in these areas, with lack of access to, and/or engagement with,

maternity services remaining a potential contributing factor (PMMRC, 2013, 2014, 2015, 2016, 2017, 2018). There is an urgent need for knowledge and explanation in this area about how the current model of maternity services operates to inform maternity service policy and practice, and the care this group of women receive.

For my Master of Arts (MA) thesis I explored the care processes used by midwives in their work with women living in areas of high deprivation in New Zealand (Griffiths, 2002). At the time, I was working as a community based caseloading midwife employed as part of a health service targeted to provide care for women living in these areas. I had noticed that this group of women had extra needs in addition to the midwifery care I was providing. For my study I interviewed a small number of midwives about the care they provided to these women. The conceptual model I developed was based around the four categories identified: 'forming relationships with the wary', 'giving an 'awful lot of support'', 'remaining close by', and 'ensuring personal coping'. The midwife's continued involvement with the woman increased the potential for an optimal pregnancy outcome for her and her baby. The results of this study began to address factors regarding access to, and/or engagement with, maternity services, and informed the care provided by midwives who work with women living in areas of high socioeconomic deprivation. Results of this study were published (Griffiths, McAra-Couper, & Nayar, 2013), and recommendations included prioritising continuity of care for women living in areas of high deprivation as it increases their satisfaction with maternity care; that midwives take the time to build a relationship of trust with each woman and develop close links with community groups and government agencies they will be liaising with; and implement processes to sustain themselves for the demands of working with this group of women. Further research was recommended on interventions midwives initiate to improve the health and wellbeing of childbearing women living in high socioeconomic deprivation, and the sustainability of midwives for working in these areas (Griffiths et al., 2013).

In the years since this study took place, up until participant interviews commenced late September 2014, only four reports or articles had been published about the midwifery care received by women living in areas of high socioeconomic deprivation in New Zealand (Griffiths et al., 2013; Pacific Perspectives Ltd, 2013; Priday & McAra-Couper, 2011; Ratima & Crengle, 2013). Other authors had reported barriers to accessing and/or engaging with primary care (Southwick, Kenealy, & Ryan, 2012), and pregnancy care (Corbett et al., 2013; Health Partners Consulting Group (HPCG), 2012; Mc-Ara-Couper, 2012; Tanuvasa, Cumming, Churchward, Neale, &

Tavita, 2013). To effectively address the disparity in the stillbirth and neonatal death rates, the factors around high socioeconomic deprivation and access to, and/or engagement with, maternity services had to be addressed (PMMRC, 2014). This is important because unless these factors are identified and understood, there is the risk that this group of women will continue to experience significantly higher rates of stillbirth, neonatal death, and several other less than optimal outcomes.

1.5 Being a Midwife

I am a midwife! I write that with pride. Midwifery has nourished and sustained me through 33 years of full time practice. I am proud to be part of the midwifery profession, and of the care I have been able to offer to women, babies, and their families throughout this time. Midwifery has enabled me to take up opportunities that I could never have dreamed of when I became a midwife in 1985. These include working with women and families I may never have met in my daily life and with midwives who have become lifelong friends, undertaking research, teaching midwifery students, and travelling and presenting at national and international conferences. My career has taken me in many directions, including practising as a hospital core midwife, a community LMC midwife, having hospital management positions, and currently working in midwifery education. I have been able to do all this through being a midwife. Being a midwife is the core of me and largely how I define myself. My career has been shaped by the history of the midwifery profession, and events occurring around the time I became a midwife.

1.6 Te Tiriti o Waitangi and Its Influence on the Midwifery Profession

Aotearoa/New Zealand's founding document is Te Tiriti o Waitangi (the Treaty of Waitangi). Te Tiriti was first signed between Māori and the British Crown on 6 February 1840 in Waitangi, New Zealand, by over 40 Māori chiefs (Pairman & McAra-Couper, 2015; State Services Commission (SSS), 2018a, 2018b). Originally written in Māori on 4 February 1840, the Māori text was translated into English prior to the 6 February signing (SSS, 2018b). It was presumed that the Māori text and the English translation of Te Tiriti had the same meaning, however in some places the meaning in the resulting two versions is significantly different (SSS, 2018b) and therefore subject to different interpretation. Once the first copy of Te Tiriti was signed, other copies were printed and used for signature gathering throughout New Zealand (SSS, 2018a, 2018b). Nine signed copies of Te Tiriti have survived since 1840 (SSS, 2018b).

Te Tiriti represents the bicultural nature of New Zealand–the tangata whenua (indigenous people of the land) and tauiwi (non-Māori). Since the signing of Te Tititi, there has been continued debate about its meaning and the meaning of biculturalism within the diverse multicultural population of New Zealand (Pairman & McAra-Couper, 2015). As a country we are bicultural based on Te Tiriti. While being bicultural as a nation, New Zealand is multicultural, with a population comprising many different resident ethnicities. All these people, tauiwi, have a place due to New Zealand being a bicultural country based on Te Tiriti. The 1980s and 1990s saw increased efforts made by Māori and the New Zealand Government to honour Te Tiriti obligations, and address Te Tiriti claims (Pairman & McAra-Couper, 2015). Current references to Te Tiriti seek to bridge the differences by referring to the "principles" of Te Tiriti, these being the core concepts that underpin both texts (SSS, 2018c). Under Te Tiriti o Waitangi the three principles of partnership, participation, and protection underpin the relationship between Māori and the New Zealand Government. As a consequence, increased effort is being put towards constructing a bicultural relationship based on these Treaty principles (Ministry of Health (MoH), 2018a; SSS, 2018b) and equity (Pairman & McAra-Couper, 2015).

The three principles of Te Tiriti o Waitangi form the basis of the New Zealand midwifery model of care. Te Tiriti is about recognising Māori as tangata whenua and being guided in all interactions by the principles of partnership, participation, and protection, as an affirmation of Te Tiriti. Midwifery, being a partnership between the woman and the midwife, is central to New Zealand midwifery philosophy (Guilliland & Pairman, 1995, 2010b). The midwife working in partnership with women is one of the tenets of the Midwifery Scope of Practice (MCNZ, 2007, 2015; NZCOM, 1993, 2008, 2015) and the Standards of Midwifery Practice (NZCOM, 1993, 2008, 2015), as well as being the first of the four Competencies for Entry to the Register of Midwives (MCNZ, 2007, 2015).

Embedding the three principles in the midwifery model is demonstrated through midwives working in partnership with women, encouraging women's active participation in planning care that is relevant, ensuring protection of women's autonomy, cultural values, and birth practices, and supporting/protecting normal birth.

1.7 The History of Midwifery in New Zealand

Midwives in New Zealand provide a woman centred continuity of care maternity model within primary health. Nationally and internationally there are efforts to enhance health

care continuity for people across a variety of disciplines, including women receiving maternity care. Haggerty et al. (2003) reviewed 583 documents whose focus was defining the concept of continuity. Two themes emerged which distinguished continuity from other healthcare attributes; care of an individual and care delivered over time, with both elements required for continuity to exist (Haggerty et al., 2003). Three types of continuity were identified; informational, management, and relational. Relational continuity, defined as an ongoing therapeutic relationship with one or more providers (Haggerty et al., 2003), has direct relevance to midwifery and maternity care in New Zealand. Continuity had several features for patients (read women) and their families, and for health providers:

> *For patients and their families, the experience of continuity is the perception that providers know what has happened before, that different providers agree on a management plan, and that a provider who knows them will care for them in the future. For providers, the experience of continuity relates to their perception that they have sufficient knowledge and information about a patient to best apply their professional competence and the confidence that their care inputs will be recognised and pursued by other providers. The experience of continuity may differ for the patient and the providers, posing a challenge to evaluators.* (Haggerty et al., 2003, p. 1221)

When applied to maternity care, the quote above shows relational continuity to be a trusting relationship which has been established over time, involves reciprocal responsibility, and highlights the importance of effective collaboration and communication between the woman, the midwife, and other members of the maternity team in all contexts.

To understand the context of midwifery in New Zealand in 2019, it is necessary to look to our history of midwifery. Prior to 1904, maternity services in New Zealand were provided mostly by lay midwives. Some had received tuition from other midwives or doctors, and a small number had some maternity training from overseas hospitals. However, there was no training school available in New Zealand (Stojanovic, 2010). Māori had their own whanau-centred birth traditions, and wahine (women) were attended by women, and some men experienced in attending birth, while Pākehā women were attended by women experienced in childbirth (Guilliland & Pairman, 2010a). The Midwives Act 1904 (New Zealand Government, 2018a) formalised the beginning of midwifery regulation in New Zealand (Guilliland & Pairman, 2010a). The Act established midwifery registration, state maternity hospitals (later becoming St Helens Hospitals) and a state midwifery service, a national structure for training midwives through the formation of the St Helens Hospitals and Training Schools for Midwives,

and a knowledge base for midwifery practice (Guilliland & Pairman, 2010a; Stajonovic, 2010).

> *There shall be established in New Zealand one or more State Maternity Hospitals, where pupil nurses can, on payment of the prescribed fee, be carefully instructed in all duties required for the welfare of mother and infant during and immediately after childbirth.* (New Zealand Government, 2018a, p. 190)

The first of seven St Helens hospitals was established in 1905 in Wellington, followed by six more nationally by 1920 (Stajanovic, 2010). While there was a Medical Superintendent who was called on only when needed, each St Helens hospital was otherwise managed and staffed by midwives (Stojanovic, 2010). These hospitals were responsible for the training of all midwives in New Zealand until the last St Helens hospital closed in 1979 (Guilliland & Pairman, 2010a). In addition to home birth, women could birth in the state funded St Helens hospitals, the small maternity homes owned by doctors or midwives, and the general hospitals in most main centres (Guilliland & Pairman, 2010a). Women received continuity of midwifery care when birthing at home, St Helens hospitals, or in maternity homes (Guilliland & Pairman, 2010a).

The next 85 years of New Zealand's maternity history were marked by struggles for the control of childbirth, with childbirth increasingly taking place in hospital with the associated increase in medical intervention (Donley, 1986; Guilliland & Pairman, 2010a; Papps & Olssen, 1997). Papps and Olssen (1997) identified three specific struggles:

> *One is between midwives and medical practitioners for midwives to retain a place in the provision of care to women during pregnancy and childbirth; a second concerns a struggle between women and the medical profession for control over their bodies during childbirth, and another is between midwives and nurses.* (p. 18)

To reduce the high maternal mortality rates, due to puerperal sepsis, septic abortion, and toxaemia, and encourage women to have more babies, women were enticed to the state funded St Helens hospitals to receive safer birth care (Guilliland & Pairman, 2010a). Pain free childbirth using 'twilight sleep'–a cocktail of Nembutal (Pentobarbitone) and Scopolamine–began to be offered first at non-St Helens hospitals and then by the mid-1930s was also incorporated into the St Helens hospitals (Stojanovic, 2010). This medicalisation of the birthing process diminished the midwife's role, knowledge base, and skills, and led to increased medical intervention

such as use of forceps for birth, with a corresponding increase in rates of puerperal infection (Guilliland & Pairman, 2010a; Stojanovic, 2010). To combat the increased rates of puerperal infection, strict aseptic techniques were introduced requiring all woman, even those who had not had analgesia, to be confined to beds in a special delivery room to birth their baby in order to meet the requirements for a 'sterile field' (Stojanovic, 2010). By the 1950s birth took place in a room very similar to an operating theatre, under conditions similar to a surgical procedure. Smaller maternity hospitals closed and services were redirected to the larger hospitals where midwifery autonomy disappeared with midwifery increasingly coming under the control of hospital nursing structures (Guilliland & Pairman, 2010a).

Women received fragmented care firstly in public hospital medical and surgical wards, and eventually in separate antenatal, labour and delivery, and postnatal wards. Women were separated from their family and friends during labour and birth. Their babies were placed in nurseries (Guilliland & Pairman, 2010a) and brought to them for feeding. When I did my junior placement in the maternity unit as a second year nursing student in 1978, women still had to be admitted into the preparation room to be 'prepped' for birth despite how their labour was progressing. They were given a perineal shave and an enema and changed into a hospital gown before moving to the labour room. Their partners wore hospital gowns, hats, and masks. All women were moved to the delivery theatres to birth.

In 1920, 65 percent of New Zealand mothers were still birthing their babies at home or in small unlicensed one-bed maternity homes; 26 percent of births occurred in private hospitals, five percent in hospital board and charitable hospitals; and four percent occurred in the St Helens hospitals, although the St Helens midwifery students also attended homebirths (Donley, 1986; Stojanovic, 2010). Seven years later 58 percent of New Zealand births took place in maternity hospitals, rising to almost 82 percent by 1936 (Donley, 1986; Stojanovic, 2010). The move to hospital birth was slower for Māori, with only 17 percent giving birth in hospitals by 1937 (Donley, 1986; Guilliland & Pairman, 2010a). Many continued to birth at home until the 1960s, when penalties imposed by the restrictions to Māori medicine and spirituality, enacted by the Tohunga Suppression Act of 1907 (New Zealand Government, 2018b), prohibited highly skilled male and female tohunga (specialists) or tapuhi (midwives) (Wepa & Te Huia, 2006), who provided care during childbirth, from practicing traditional birthing, resulting in the colonisation of Māori childbirth (Guilliland & Pairman, 2010a). As Māori women learned to birth in hospital the Pākehā way, their traditional birth practice

knowledge was lost and replaced with medical and hospital based maternity practices and protocols (Donley, 1986; Guilliland & Pairman, 2010a). By 1962, 95 percent of Māori women were birthing in hospital (Donley, 1986). In this way both "*Māori and Pākehā women and midwives lost control over their childbirth practices to hospital-based medicine*" (Guilliland & Pairman, 2010a, p. 13).

In 1957 the six month maternity nursing programme, the precursor for non-nurses being able to apply to the St Helens midwifery training programme, began being gradually phased out when the nursing curriculum was changed to incorporate maternity (obstetric) nursing into each general nurse's three year general training programme (Donley, 1986). A person qualified as both a Registered Nurse and a Registered Maternity Nurse (later to become a Registered General and Obstetric Nurse, as I became), would be eligible to apply for admission to the six month midwifery training programme at St Helens. In this way midwifery remaining a separate profession from nursing began to slowly erode (Donley, 1986).

In 1971 the Nurses Act (New Zealand Government, 2018c) removed the right of midwives in New Zealand to practice autonomously, requiring doctors to take responsibility for women's care from pregnancy through to the postnatal period (Guilliland & Pairman, 2010a). It disestablished the Nurses and Midwives Board, previously set up by the Nurses and Midwives Registration Act 1925 (New Zealand Government, 2018d). The Nursing Council of New Zealand was established, and all reference to a midwife removed (Guilliland & Pairman, 2010a), reducing the midwife to the status of a maternity nurse (Donley, 1986). Midwives were regulated to practice under the supervision of a medical practitioner or risk a fine of up to NZ$200 (New Zealand Government, 2018c). The Nurses Act 1977 consolidated and amended the Nurses Act 1971 increasing the fine; "*Every person commits an offence and is liable on summary conviction to a fine not exceeding $1000 who carries out obstetric nursing in any case where a medical practitioner has not undertaken responsibility for the care of the patient*" (New Zealand Government, 2018e, p. 49). When working in the maternity unit, on junior and senior student nurse placements in 1978 and 1979, I was aware that there were midwives working in the community who were direct entry midwives, not nurses, and that they could no longer take responsibility for care of women wanting a homebirth, needing to now have General Practitioner (GP) oversight. The local domiciliary midwives worked with homebirth supportive GPs to enable them to continue to offer homebirth to women. While GPs could claim from the maternity benefit schedule, domiciliary midwives were funded separately at a lower rate from the

Department of Health, for three antenatal visits, labour and birth care, and 12-14 postnatal visits in the first two weeks postpartum.

By the 1980s midwifery in New Zealand had been completely subsumed by nursing. Midwives were regulated by the Nursing Council and midwifery education had become an unfunded post registration nursing specialty qualification (Guilliland & Pairman, 2010a). When the last St Helens hospital closed in 1979 (Guilliland & Pairman, 2010a), responsibility for midwifery education was passed into the tertiary education sector (Stojanovic, 2010), specifically polytechnics (Papps & Olssen, 1997). Midwifery training then became 18 or 19 weeks of a year-long Advanced Diploma in Maternal and Infant Health course (with midwifery option) run at a technical institute (Donley, 1986; Papps & Olssen, 1997).

The Nurses Amendment Act 1983 (New Zealand Government, 2018f) legislated that only midwives who were registered nurses could provide a homebirth service or maternity care, ending the ability of direct entry midwives to provide continuity of care (Guilliland & Pairman, 2010a). Under the Act, it became an offence for direct entry midwives to practice midwifery outside an Area Health Board facility (Donley, 1986; Papps & Olssen, 1997); so they were unable to continue offering homebirth to women. In response, a group of Auckland home birth consumers established the 'Save the Midwives' Society. They attracted a national membership and disseminated information to the public about midwifery training (Donley, 1986). As a result of their protest, changes were made to the 1983 Act, including adding a 'grandfather' clause protecting the practice of those domiciliary midwives already working. Importantly, the Act united hospital and domiciliary midwives to save midwifery as a profession, and politicised midwives belonging to the Midwives Section of the New Zealand Nurses Association (NZNA) (Donley, 1986).

Like many other registered nurses at that time who were not prepared to do a short postgraduate nursing course to become a midwife (Donley, 1986), I travelled to the United Kingdom to undertake my midwifery education, while others travelled to Australia to do the same. We returned to practice in New Zealand in the mid-1980s to find that midwives had a largely invisible role (Guilliland & Pairman, 2010a) and were threatened with extinction. The Obstetric Regulations 1986 Amendment (New Zealand Government, 2018l) only applied to domiciliary midwives, constraining their practice further by supporting the role of obstetric nurses, rather than midwives, supervised by doctors. The Amendment imposed extensive documentation and practice requirements, including the maintenance of clinical registers, which the rest of the maternity service–

hospitals, hospital midwives, and doctors–did not have to abide by. Maternity units no longer needed to be supervised by midwives (Guilliland & Pairman, 2010a). Midwives belonged to the Midwives Section of their professional body, the NZNO, to represent their collective voices. However, NZNO's view was that midwifery was a specialty area of nursing (Guilliland & Pairman, 2010a). When I did the Advanced Diploma in Nursing (Maternal and Infant Health) at Wellington Polytechnic in 1989, I was already a midwife. No-one in that cohort did their midwifery training as part of that course at that institution in that year.

From the mid-1980s working together, women, as consumers who were becoming increasingly dissatisfied with a maternity service which left them feeling they had little control over their childbirth experience, and midwives, began lobbying the New Zealand Government to 'save the midwife', fighting for a change in the law to return autonomy to midwives and control of childbirth back to women (Pairman & McAra-Couper, 2015). Joan Donley famously challenged midwives during her presentation at the Midwives and Obstetric Nurses Special Interest Section of the NZNA national conference in August 1988 in Auckland about whether they were midwives or moas (an extinct native bird of New Zealand). She challenged midwives to reclaim midwifery, beginning by forming our own national professional association to represent midwifery's professional interests, with the task of "*reclaiming midwifery as an independent profession to meet the needs of women as they define those needs*" (Donley, 2018, p. 22). This rallied midwives into more action. I was a new midwife at this, my first conference, and was present to hear Joan speak. Those at the conference who paid $50, including myself, became founding members of the Aotearoa College of Midwives (established in 1989 as the New Zealand College of Midwives (NZCOM)), the professional organisation for midwives in New Zealand (Pairman, 2010), something else I continue to be proud of. It was a heady time to be a midwife in New Zealand! It was impossible not to get caught up in the excitement of the changes that were about to come.

Helen Clark, then the Labour Prime Minister of New Zealand, supported the law change and, with the addition of the words 'or Registered Midwife', late on the night of 28 August the 1990 Amendment to the Nurses act 1977 became law (New Zealand Government, 1990) returning autonomy to New Zealand midwives and giving women a choice of maternity care provider to lead their care (Guilliland & Pairman, 2010a; Pairman & McAra-Couper, 2015). Midwives were once again able to take responsibility for providing care to women experiencing a normal pregnancy, labour, birth, and

postnatal period without the need for medical supervision. In addition, amendments were made at the same time to the Social Security Act 1964 (New Zealand Government, 2018g), the Misuse of Drugs Act 1975 (New Zealand Government, 2018h), the Medicines Act 1981 (New Zealand Government, 2018j), and the Area Health Boards Act 1983 (New Zealand Government, 2018k). Midwives were able to claim maternity benefits from the MoH for providing maternity services, and to continue to provide care to women and babies during labour and birth if women chose to birth in maternity facilities by applying for an access agreement to the facility. This gave them access to beds in public maternity units, medical and obstetric specialists, and other services such as laboratory and scanning, equal to medical practitioners. The amendment also gave midwives prescribing rights for pregnant and postnatal women, and babies up to six weeks of age. They were able to request laboratory tests and scans and refer women and babies to other health practitioners. The passing of the Act set the scene for the development of midwifery undergraduate education programmes, finally separating midwifery from nursing, and midwifery education from being a postgraduate nursing course. Beginning in 1992, Otago Polytechnic was the first tertiary facility in New Zealand to offer a three year midwifery degree without the requirement to first be a Registered Nurse.

1.8 The New Zealand Health System, Maternity System, and Midwifery Model of Care

The New Zealand public health system is a range of free and subsidised services generally only available to New Zealand residents. Accessing some health services, such as visiting the family GP, requires making an appointment. Others do not; for example accessing the emergency department of a public hospital. New Zealand has a unique model of maternity care. Maternity care is one part of the public health system and is provided at no cost to eligible women during pregnancy, labour, birth, and for the first six weeks following the baby's birth (MoH, 2018d). Since The Section 51 Maternity Notice (MoH, 2018c) was issued in 1996, during pregnancy each woman chooses a LMC to be responsible for ensuring she receives the care she requires. While most women in New Zealand choose a midwife to be her LMC, this could also be a GP or an obstetrician. Care from a LMC midwife or LMC GP is funded by the public maternity system. There is a charge to women who choose a private LMC obstetrician.

The LMC is responsible for the continuity of care provided to the woman throughout her pregnancy and postpartum period, including the management of labour

and birth (New Zealand Government, 2007). LMCs work under contract to the MoH utilising the Primary Maternity Services Notice 2007 (New Zealand Government, 2007). Primary maternity services are expected to provide women and families with maternity services that are safe, evidence informed, and based on partnership, information, and choice, and ensuring referral if appropriate, recognising that pregnancy and childbirth are normal life events for the majority of women (New Zealand Government, 2007). LMCs may provide all maternity care themselves or share the care with one or more practitioners. LMCs also provide information to assist with decision-making during pregnancy, preparation for the birth, and early parenting. Information includes a wide range of topics such as nutrition, exercise, the risks of smoking and drinking alcohol when pregnant, labour and the birth process, managing pain in labour, breastfeeding, baby care, immunisation, community services, and contraception (MoH, 2018d).

Eligible pregnant women are entitled to receive free primary, secondary, or tertiary maternity-related services, including all maternity services provided by District Health Boards (DHBs). Most pregnancy and childbirth services are 'primary maternity services' delivered in the community by a LMC, with some primary maternity services being delivered in hospitals. Women are referred to secondary and tertiary maternity services if they or their baby have a condition that a LMC determines will significantly impact on the pregnancy or its outcome. Secondary and tertiary services are funded by the public maternity system to ensure that the baby of an eligible woman has the best chance of being healthy. Maternity related services include miscarriage services and terminations of pregnancy for fetal abnormality (MoH, 2018d).

If it is recommended that a woman see an obstetric or medical specialist during pregnancy, if the woman consents her LMC will refer her to a public hospital specialist. Unless it is an emergency, there will usually be a wait for an appointment. Referral to a public hospital specialist is free to eligible women, as are pregnancy related blood tests. Ultrasound scans are paid for by the public maternity system but the provider may add a surcharge. Prescriptions are subsidised by the public maternity system but there is a small charge. Women may be charged for preparation for birth and early parenting classes. Once a woman and baby have been discharged from midwifery care at six weeks, the public health system funds the ongoing support of a Well Child provider until the child is five years old (MoH, 2018d).

Midwives are the main providers of New Zealand's maternity service. Most midwives work within the maternity system as community LMC midwives or work

shifts in core maternity facilities (hospitals and primary birthing units). Other midwives work as educators, researchers, or in leadership or advisor positions. The most recent midwifery workforce results from MCNZ (2016) show the distribution of the midwifery workforce;

- 38% caseload (either self-employed or employed by DHBs, publicly owned trusts, or other organisations)
- 50% core (employed in maternity facilities working shifts)
- 10% educators/researchers/leadership/advisors
- 2% not working in midwifery.

In 2010, of women giving birth who registered with a LMC, 91.6 percent chose a midwife LMC (MoH, 2012a). By 2014 this figure had risen to 93.4 percent, with 85.2 percent of women overall in New Zealand registering with a midwife LMC (MoH, 2015), an increase from 60.7 percent in 2003 prior to the implementation of the Primary Maternity Services Notice 2007 (MoH, 2015, 2017). The most recent Report on Maternity (MoH, 2017) focuses on births in 2015. In that year 93.6 percent of women giving birth who registered with a LMC chose a midwife, with 86.4 percent of women registering with a midwife LMC overall (MoH, 2017). The rise in women choosing midwife LMCs was partly due to the number of GPs who chose to withdraw from providing LMC maternity services following the passing of the 1990 Amendment. This was happening at the same time as women came to understand the midwifery model of care and increasingly chose to have continuity from a known midwife.

There is currently no restriction on caseload size for a community LMC midwife offering continuity of care throughout pregnancy, labour, birth, and the postnatal period. From originally recommending a guideline of a caseload size of 50-75 women per year (NZCOM, 1993), for some time the NZCOM has recommended a guideline of 40-50 women per year for optimal midwifery care to be maintained (NZCOM, 2002, 2005, 2008, 2015).

With the passing of the 1990 Amendment to the Nurses Act 1977, I, along with many other midwives, began working in the community, building a caseload of women for whom I was responsible. Initially, like many of my colleagues, I began by working in the community with women in shared care arrangements with local obstetricians. This did not last long, however, as women voted with their feet and chose to have 'midwife only care'. Within a year most 'independent' midwives (as we were then called) were working with a case load of women providing midwife only care, meaning they were taking responsibility for the care provided to normal childbearing women. We

were paid for the care we provided by claiming from the MoH maternity benefit schedule. As independent midwives, we were available to women 24/7, providing continuity of midwifery care through pregnancy, labour and birth, and then for six weeks of home visits postnatally. Most midwives undertook antenatal care in the women's homes. Many of us worked long hours and rarely had any time off. We juggled caseload numbers as we tried to figure out what was reasonably doable. We formed midwifery group practices and worked together with a variety of success. We grappled with using pagers and having to find the nearest phone box or midwife friendly dairy owner who would let us pay him 20 cents to make a phone call to women who paged us. Cell phones had only recently become available and really were the size of a shoe! Their cost prohibited purchase for most midwives at that time. Texting was not yet invented. The Internet did not exist. I was not to have a home computer for another 10 years. It was a different time, and a wonderful time. It really felt like women and midwives were working together. We felt strong and united.

1.9 Midwives and Women Working in Partnership

Women maternity service consumers and midwives working together to lobby for the law change (1990 Amendment) resulted in midwifery recognising the political partnership it had with women consumers, and the commitment to enact this partnership at every level of midwifery's professional structure through the NZCOM (Pairman & McAra-Couper, 2015).With partnership embedded in New Zealand society, as identified by one of Te Tiriti o Waitangi principles, the New Zealand midwifery profession drew on this understanding to describe the relationship between the woman and the midwife to be one of partnership (Guilliland & Pairman, 1995; 2010b). Midwives' partnerships, and exploration of the relationships between women and midwives, led the NZCOM to identify partnership as one of three philosophical frameworks underpinning the practice of midwifery in New Zealand (Guilliland & Pairman, 1995, 2010b; Pairman, 2010), a standard for practice, and an ethical principle (Pairman & McAra-Couper, 2015; NZCOM, 1993, 2015). The other two frameworks are cultural safety and Turanga Kaupapa (a framework for culturally safe practice for Māori wahine/all women) (NZCOM, 2015; Nga Maia, 2018). In midwifery, cultural safety ensures respect for the woman's social and cultural contexts in the provision of midwifery care that meets her individual requirements (MCNZ, 2012a). This is enabled by working in a negotiated partnership with her.

The conditions that support the formation of a midwifery partnership (Guilliland & Pairman, 2010b) are incorporated in midwives' scope of practice. The first is that midwifery practice is directed by clinically based, evidence informed decisions, supported by the knowledge that pregnancy and childbirth are normal life events for most women. This defines the role of the midwife as one of companion and guardian of the normal. The second is about the professional role of the midwife: Midwives are autonomous health professionals who work in partnership with women to provide midwifery care throughout their pregnancies, labours, births, and the postnatal period, working collaboratively with allied health professionals, for example, pharmacists, sonographers, and laboratory staff. The third is that midwifery provides continuity of caregiver, meaning a small group of midwives, one who is identified as the woman's primary practitioner, providing midwifery care throughout the woman's entire childbirth experience. Continuity follows the woman wherever she chooses to birth (Guilliland & Pairman, 2010b), including experiences that could be defined as normal or abnormal (Davis & Walker, 2010, 2011). The midwife, therefore, follows the woman if she shifts between settings. Ethically, within a partnership model, continuity of care must be available to all women regardless of their health status. The fourth condition is that midwifery is woman-centred, meaning "*that the midwifery relationship is with the woman*" as the person who has the primary relationship with the baby and is responsible for decision-making affecting herself and her baby (Guilliland & Pairman, 2010b, p. 39). Guilliland and Pairman (2010b) described the midwifery relationship as being woman-centred because

> *The midwifery relationship can only occur with a woman.*
> *Each woman brings with her a unique set of characteristics and circumstances.*
> *The woman identifies and defines all other relationships within her childbirthing experience and identifies the priority of these relationships. The midwife has access to these relationships through the woman.*
> *The midwifery service is dictated by each woman's identified needs*. (Guilliland & Pairman, 2010b, p. 39)
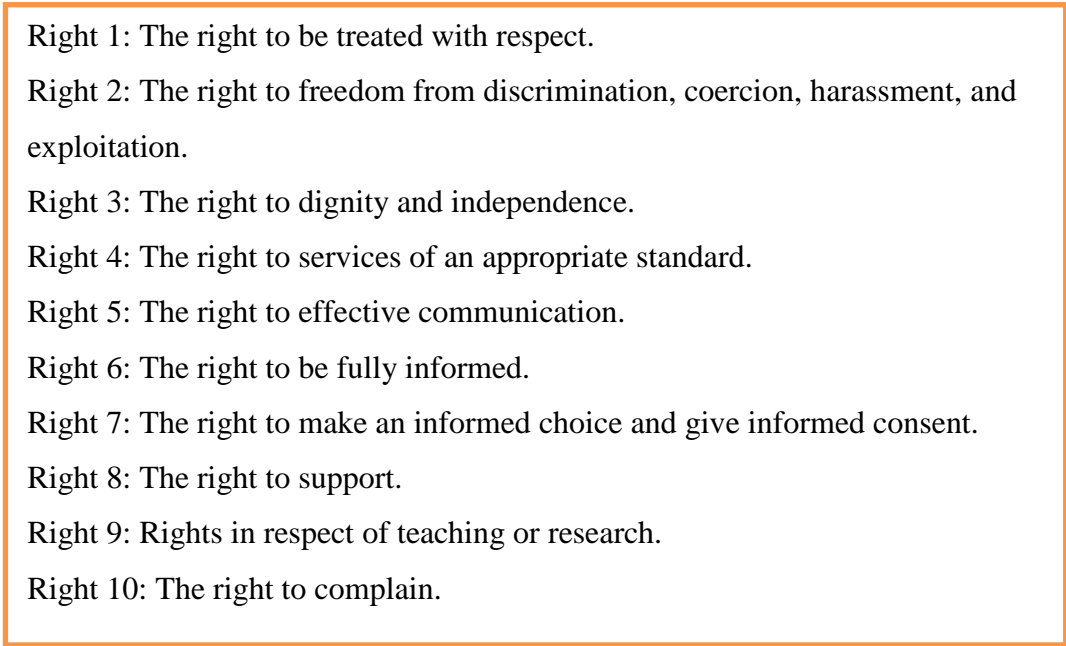
The midwifery model of partnership, when it works well, is reciprocal; both the woman and the midwife benefit from the relationship (Pairman, 2010). Through it they develop mutual respect and trust which enables them to have confidence in their shared processes and decision making (Guilliland & Pairman, 2010b). Partnership "*remains a relationship of sharing between the woman and the midwife that is built on trust, mutual understanding, and shared control and responsibility*" (Guilliland & Pairman, 2010b, p. 70).

It is Kenney's (2011) view that despite introducing Turanga Kaupapa as one of the philosophical frameworks of the New Zealand model of midwifery practice, as there is no representation of Māori world views in the partnership model (Guilliland & Pairman, 1995, 2010b), Turanga Kaupapa represents a form of cultural tokenism which may contravene health legislation; and therefore contradict midwifery ethics, professional competencies, and standards of practice. One example, of several Kenney gives, is that the Standards of Midwifery Practice (NZCOM, 1993, 2002, 2005, 2008, 2015) which position the individual woman as the focus of midwifery care ignore other perspectives, such as those of Māori who commonly see pregnancy and birth as a whānau (family) responsibility. Minimising the presence of whānau by having maternity care reflecting Euro-centric perspectives, suggests a power imbalance in the woman-midwife relationship and does not reflect an equitable partnership, making it difficult for whānau and women to negotiate partnership boundaries (Kenney, 2011). Receiving culturally inappropriate care will negatively impact the health and wellbeing of whānau (Kenney, 2011). The partnership model excludes the two other principles of Te Tiriti o Waitangi–protection and participation–from the midwifery model of practice. In addition, Kenney believed that unquestioned discourses and practices that marginalise Māori have influenced the ability to retain Māori students and midwives in the midwifery profession. Instead, Kenney proposed a model of partnership drawing on philosophies and theoretical concepts from and applicable to both Māori and European world views, as a contextually relevant bicultural practice framework to positively enhance the experience of midwifery care for women and whānau in New Zealand (Kenney, 2011).

1.10 Subsequent Legislation and Its Impact

The Health and Disability Commissioner (HDC) Act 1994 set out the duties of health providers when working with consumers accessing health and/or disability services. Under the Code of Health and Disability Services Consumers' Rights Regulations 1996 (New Zealand Government, 2018i), every consumer using health and/or disability services was given the protection of the following 10 rights in a 'Code of Rights' which every health provider has a duty to provide (see Figure 1, p. 19):

Right 1: The right to be treated with respect.

Right 2: The right to freedom from discrimination, coercion, harassment, and exploitation.

Right 3: The right to dignity and independence.

Right 4: The right to services of an appropriate standard.

Right 5: The right to effective communication.

Right 6: The right to be fully informed.

Right 7: The right to make an informed choice and give informed consent.

Right 8: The right to support.

Right 9: Rights in respect of teaching or research.

Right 10: The right to complain.

Figure 1: HDC (2018) Code of Rights

For midwives, the Code of Rights established informed consent as a mandated right for every woman who the midwife had in her care (Guilliland & Pairman, 2010b). The Code of Rights and The Section 51 Maternity Notice (MoH, 2018c), issued in the same year, closely aligned with the NZCOM philosophy of partnership. By keeping the woman at the centre of care, midwives were able to practice autonomously in partnership with women (Guilliland & Pairman, 2010b).

The maternity payment schedule has undergone refinement since 1996, resulting in the current Primary Maternity Services Notice ('Section 88') (MoH, 2007). A woman still chooses a midwife, GP, or obstetrician LMC, to take responsibility for ensuring she receives the care she requires within a continuity of care model, providing primary care and referring women to secondary or tertiary services if required, continuing to work collaboratively with the obstetric or medical team. A capped fee is attached to the woman for her primary maternity care requirements and paid to her LMC in modules (MoH, 2007).

The next piece of legislation that significantly affected midwives was the Health Practitioners Competence Assurance Act 2003 (HPCAA) (New Zealand Government, 2003). The principal purpose of this Act was to protect the health and safety of members of the public by providing mechanisms to ensure the life-long competence and fitness to practice of health practitioners (MoH, 2018b). The Act applied to all health practitioners, not just midwifery. It mandated the establishment of the Midwifery Council of New Zealand (MCNZ) to be the regulatory authority for midwives, their role

being to enact the legislation for midwives. The midwifery scope of practice, describing the care provided by midwives under their own responsibility or in collaboration with other health professionals, was clearly defined and a generic statement published in the New Zealand Gazette (MCNZ, 2010). Midwives were required to demonstrate ongoing professional competency across the midwifery scope of practice in order to continue to practice. Each midwife was responsible for ensuring she met specific recertification requirements in order to apply for an annual practising certificate. Overseas registered midwives new to New Zealand are required by the MCNZ to complete an approved registration competence programme within 24 months of having their New Zealand registration confirmed (MCNZ, 2018). This requires them to learn new skills such as undertaking an examination of the newborn baby, and the requirements of providing six weeks of postnatal care, as this information has not been part of their original midwifery education programmes.

In addition to setting standards for clinical competence, under the Act the MCNZ was also required to set standards for cultural competence and ethical conduct for midwives (MCNZ, 2012a). While the HPCAA did not define cultural competence, the MCNZ has interpreted this as the midwife integrating the practice frameworks of midwifery partnership, cultural safety, and Turanga Kaupapa into her practice. Midwives are required to draw on these practice frameworks to enhance their relationships with women and their families with the aim of improving health outcomes through the development of positive health care relationships (MCNZ, 2012a).

1.11 The Socio-Political Context

Between 2007 and 2016, NZCOM was unable to meet with the MoH to renegotiate the terms of Section 88, and community LMC midwives only received one small pay increase in that time. In addition, since 1990, many midwives had continued to provide continuity of care to women when they have moved from primary to secondary care, with no financial compensation. This, along with the rise in acuity of the women to whom midwives provide care, the increase in the amount of health care information midwives are expected to provide to women, poor staffing of maternity units impacting core midwives, and increasing difficulty recruiting and retaining midwives into the profession, has led to New Zealand midwifery being currently in crisis. Many midwives have stopped practising citing the financial impact of unpaid work as unsustainable (Preston & Wiggins, 2017).

As a result, in 2016, NZCOM took the MoH to court with a pay parity claim. Mediation resulted and the NZCOM and the MoH reached agreement to co-design a model for the maternity service based on the current model of continuity of care, and to present it to the newly elected Labour Government for resourcing. The Government agreed that the sector was underfunded, that midwives needed better pay and conditions, and that the co-design process highlighted the urgent need for a community LMC midwives to have a sustainable way of working (NZCOM, 2018a). While the Government did not agree to fund the full co-designed model, community LMC midwives were given access to funds to compensate calling in a second midwife for relief, and to cover some business expenses. The negotiation process is still in mediation in March 2019.

In 2018 the Midwifery Employee Representation and Advisory Service (MERAS), the New Zealand union for 85 percent of hospital employed midwives, lost their attempt at achieving a payrise for their members. MERAS had taken strike action following unsuccessful attempts to engage with the DHBs to negotiate the terms and conditions of their members' employment following their MECA expiring almost 18 months beforehand (MERAS, 2018).

Midwives in New Zealand are aware they are not alone is seeking additional funding from services which had been allowed to run down in the last nine years under the previous National Government. Nurses, early childcare workers, residential carers, and teachers, are amongst those who have been lobbying the current Labour Government for improved conditions and financial rewards.

1.12 Assumptions Underpinning the Research

I came to this research study as an experienced midwife. I therefore had midwifery knowledge and practice experience that I brought to every encounter with each of the women and midwife participants. I was clear that my role in this study was that of a researcher, and that I wanted to explore the women participants' experiences of accessing and engaging with midwives in areas of high socioeconomic deprivation in New Zealand, and the midwife participants' experiences of accessing and engaging with this group of women. However, it was inevitable that some of my questions and comments would be shaped by my own experiences as a midwife. I understood midwifery contexts, having worked in the field myself, so had to be clear to ensure that the meaning some women and midwives gave to words was explicit to me in the

meaning they held for them. This included being mindful of not putting my own interpretation on these alone.

In my 15 years of working as a community LMC midwife, the midwifery practice I most enjoyed was when I worked with women who lived in areas of high socioeconomic deprivation. This has remained my main area of practice interest. Much of my caseload when working as an LMC has continued to be women living in these areas. I do carry some assumptions from my experience of working with this group of women and reflected on these as my research proposal began to take shape. I believed strongly that this group of women deserved to receive high quality continuity of midwifery care, and that this could impact their pregnancy and birth outcomes positively. I was also aware that the negative interactions they had experienced previously with health professionals meant it took time to build a trusting relationship with me, their midwife. I believed that supporting a woman to have a normal birth and to mother her child well in the first six weeks afterwards could change her family, the society she lived in and, ultimately, the world. Seeing the look of empowerment in a woman's eyes when she has successfully achieved a normal birth after failing at so many other things in her life, such as school, relationships, and employment, is an amazing moment. I loved seeing that look.

Working with midwifery students in my current role as a midwifery lecturer is wonderful and amazing, and has its challenges. Students debrief their practice experiences with me. Sometimes their stories are uplifting and make me really proud to be part of a profession that supports women in such a profound way. Other times the students' stories are difficult to hear. These are often stories involving women living very complex lives, with minimal support, and challenging social, medical, and obstetric circumstances. The stories demonstrate, I believe, the lack of understanding by some health professionals about the woman's context, and the day to day challenges she faces. These are women like the woman participants in my study. Getting students to reflect on what they have seen and been involved in, and to think about how they could do things better when they themselves are midwives, is important to me. I want these students to be midwives who make a positive difference to these women in every interaction they have with them. But above everything else, I want them to be kind to these women. That will make a big difference to how some of them are used to being treated, and to the midwifery care they receive.

My midwifery experiences have shaped my thinking about childbearing women, midwives, midwifery as a profession, and other health professionals. Sometimes, while

interviewing participants, I had to be mindful that my own reactions to topics or incidences they reported were, to a certain point, contained, so they did not change their willingness to share these with me. I did not want to have my interpretation of those experiences clouded by my own feelings. For example, when a woman participant told me that she felt dismissed by her midwife, I wanted to support the woman as she related a story which was clearly very upsetting for her. The woman's story evoked several feelings in me towards the nameless midwife, a midwifery peer nonetheless, whose actions resulted in a woman she was providing care for feeling this way. I felt let down by the midwife and felt she had let down the midwifery profession. I had to remind myself that this was the woman's experience, and I was there as a researcher with my own perceptions. But I could not separate myself from also being a midwife. I would wait until I returned home and deal with the effect hearing some of the stories had on me personally by writing, walking, and reflecting.

Whenever I worked as a community LMC midwife I offered continuity of midwifery care to women, visiting them or, in the last three years of my community LMC midwife practice, having them visit me antenatally, staying with them through their labour until they birthed, whether they required secondary care or not, and visiting them for six weeks postnatally. That is how I wanted to work as a midwife, and what the 1990 Amendment to the Nurses Act 1977 mandated me to do. Currently we have a situation in New Zealand where, increasingly, midwives are handing over the care of women with complexity to their secondary care core colleagues, resulting in the women who most need continuity receiving fragmented care. This is despite the knowledge that continuity of care from a midwife they have come to know during pregnancy appears to improve a number of pregnancy and childbirth outcomes for women and babies living in areas of high socioeconomic deprivation, such as the women in my study (Bohren, Hofmeyr, Sakala, Fukuzawa, & Cuthbert, 2017; Hatem, Sandall, Devane, Soltani, & Gates, 2008; Hicks, Spurgeon, & Barwell, 2003; Hodnett, Gates, Hofmeyr, Sakala, & Weston, 2012; Homer et al., 2001; Homer, Leap, Edwards, & Sandall, 2017; Howarth, Swain, & Treharne, 2011; Leap, Sandall, Buckland, & Huber, 2010; McLachlan et al., 2012; Rayment-Jones, Murrells, & Sandall, 2015; Tracey et al., 2013; Sandall, Hatem, Devane, Soltani, & Gates, 2009; Sandall, Devane, Soltani, Hatem, & Gates, 2010; Sandall, Soltani, Gates, Shennan, & Devane, 2013, 2016; Zachariah, 2009).

In this study midwives clearly voiced their struggles around their desire to continue to provide continuity of midwifery care to women and the impact this has on their caseload of primary women, their colleagues, and their ability to sustain

themselves as a midwife, both personally and financially. Practicing within a maternity service which divides a woman's single pregnancy journey into primary, secondary, and tertiary care categories, while being a midwife committed/attempting to provide continuity of care to women with a woman centred focus, is challenging. Practicing as a midwife within this system, when working with women living in areas of high socioeconomic deprivation, has additional challenges when the health system is organised in such a way that means while many maternity care requirements can be met for this group of women, those arising out of the complexity of the women's context are more challenging to address. Determining how to negotiate that space is a challenge facing midwifery in New Zealand today.

While rates of stillbirth and neonatal death have improved for women living in high decile areas in New Zealand, women living in the most socioeconomically deprived areas continue to experience the highest rates of stillbirth and neonatal death, and other less than optimal pregnancy and childbirth outcomes (PMMRC, 2018). Undertaking this research will address how women living in these areas access and engage with midwives to respond to factors that put women at risk of stillbirth and neonatal death.

1.13 Defining Socioeconomic Deprivation in New Zealand

This study commenced using the 2006 New Zealand Deprivation (NZDep2006) Index to define deprivation (White, Gunston, Salmond, Atkinson, & Crampton, 2008). This Index was created from the 2006 New Zealand Census of Populations and Dwellings data, and described the socioeconomic deprivation experienced by groups of people living in small areas of New Zealand. The Index has a scale of deprivation from 1 to 10, dividing New Zealand into 10ths, with a score of 1 being the least deprived areas, and 10 being the most deprived. The NZDep2006 Index showed that 42 percent of Māori, 57 percent of Pacific, 18 percent of Asian, and 12 percent of European/Pākehā peoples lived in areas assigned a score of 9 or 10, indicating the most socioeconomically deprived 20 percent of small areas in New Zealand (White et al., 2008).

During the late 1990s it was estimated that 17-20 percent of New Zealand's population lived in relative poverty; being considered poor by the standards of the country in which they live (National Health Committee, 1999; Waldegrave, King, & Stuart, 1999). In 2010, 28 percent of women giving birth in New Zealand lived in deprivation quintile 5; areas with a NZDep2006 index score of 9 or 10 (MoH, 2012a). By 2014, this figure had risen slightly to 29 percent (MoH, 2015). Almost half of all

Māori women (45%) and 58 percent of Pacific women giving birth in 2010 lived in deprivation quintile 5 (MoH, 2012a). By 2014, this had risen to 51 percent of Māori women and 61 percent of Pacific women (MoH, 2015).

Defining poverty as exclusion from the minimum acceptable way of life in one's own society due to inadequate resources, the New Zealand Living Standards 2004 Report (Ministry of Social Development, 2006) showed there were one million New Zealanders–one quarter of New Zealand's population at that time–living in some degree of hardship, with 25 percent of these living in severe hardship. The report stated that in addition to there being a slight increase in the number of people living in poverty between 2000 and 2004, since the neo-liberal reforms and benefit cuts of the late 1980s and 1990s, primarily due to an increase in income inequality, those with the most restricted living standards had slipped further into poverty. The New Zealand Living Standards 2008 Report (Ministry of Social Development, 2009) showed that deprivation rates remained relatively unchanged from 2004-2008, with the relativities among population subgroups remaining very similar to the 2004 results. The unchanging deprivation rates, together with an increase in living costs, impacted on childbearing women living in these areas.

While more people were in employment, it was often low paid employment, and benefit levels had not recovered from the cuts of the late 1980s and 1991 (Carroll, Casswell, Huakau, Howden-Chapman, & Perry, 2011). The effect was a large discrepancy in salaries between the highest and lowest quintiles, resulting in those earning less spending larger proportions of their income on housing, so having less money to spend on other household necessities. This had a resulting effect on health and social outcomes. Carroll et al. (2011) reported the findings of the New Zealand Values Survey undertaken to look at perceptions of poverty and inequality, and the implications for health and social outcomes, including government responsibilities in responding to disparities. Computer assisted telephone interviews were undertaken on two random samples of 2,500 New Zealanders aged 18 and over in the four month period to March 2005. Results showed that two thirds of participants believed people were poor because of personal deficits and could get out of poverty if they tried, so did not support any increase in government assistance for those less well off, unless they were the 'deserving poor'; the elderly and disabled (Carroll et al., 2011). These findings had implications for government policies working to achieve more equitable health and social outcomes by reducing inequalities (Carroll et al., 2011).

On 22 February 2011, the Canterbury region of New Zealand experienced a major earthquake which caused widespread damage across Christchurch and killed 185 people. As a result, the national New Zealand census planned for 2011 was postponed until 2013. The 2013 New Zealand Deprivation Index (NZDep2013) (Atkinson, Salmond, & Crampton, 2014) was created from data gathered from the Statistics New Zealand 2013 Census of Populations and Dwellings, and described the socioeconomic deprivation experienced by groups of people living in small areas of at least 100 people usually resident in New Zealand on census night. Information on nine variables reflecting eight dimensions of material and social deprivation were gathered. These dimensions reflected lacks in: income, employment, communication, transport, support, qualifications, owned home, and living space (Atkinson et al., 2014). No access to the Internet at home was included for the first time in the 2013 census, as Internet access was considered to be as much an integral part of day to day living in 2013, as the telephone was considered to be in 1996 when communication information was obtained from the census dwelling forms for the first time (Atkinson et al., 2014). Lack of access to the Internet is strongly correlated with other variables, from no access to a car or other means of transport, to no qualifications. Therefore, lack of access to the Internet at home had both face and statistical validity as a deprivation characteristic in 2013 (Atkinson et al., 2014). There had been little change between the previous deprivation Index results (NZDep2006) and 2013 (Atkinson et al., 2014), with the NZDep2013 Index showing that 50 percent of New Zealand's population lived in the most socioeconomically deprived 20 percent of small areas in New Zealand. A proportion of these populations were women of childbearing age (15 to 49 years old). Using the NZDep2013 Index to define areas of high socioeconomic deprivation in New Zealand was, therefore, valid, and employed for this study.

1.14 Conclusion

Chapter 1 has presented an introduction to the research study, including the aim, purpose, and significance of the study undertaken. The impact being a midwife has had on me has been addressed. This was followed by discussion about the signing of Te Tiriti o Waitangi and its influence on the midwifery profession. The history of midwifery in New Zealand was explored, leading up to a description of the current New Zealand health system, maternity system, and midwifery model of care. Partnership, legislation, and the socio-political context impacting this research were discussed, followed by exploration of the assumptions underpinning the research that I held. The

definition of socioeconomic deprivation used in this study was given. It is within this background context that my research was undertaken.

1.15 Structure of the Thesis

Chapter 2 explores the place of the literature review in a grounded theory study. The initial literature review was undertaken prior to participant interviews commencing and focused on access to, and/or engagement with, maternity services for women living in areas of high socioeconomic deprivation, and the effects of high socioeconomic deprivation on birth outcomes, specifically stillbirth and neonatal death. Once data analysis had been completed and categories identified, I updated the literature to place the research findings from my study into the context of current knowledge. Literature which may support the identified categories was also searched. This literature is critiqued.

Chapter 3 presents grounded theory, the research methodology used for this study. After presenting an overview of grounded theory methodology, pragmatism and symbolic interactionism are explained as the two theoretical perspectives underpinning grounded theory, along with consideration of constructionist and constructivist approaches. This is followed by a discussion on the development of grounded theory, and the variant of grounded theory used in this study, Kathy Charmaz's constructivist grounded theory. How the methodology for this study was followed and how the theory was evaluated is then demonstrated.

Chapter 4 explains the research methods used in the study, showing how the grounded theory methodology was put into practice for data collection and data analysis. Ethical considerations are introduced, followed by the positioning of myself as researcher. Data collection methods are then presented. How data were analysed, and an evaluation of the quality of the research follow.

Chapter 5, the first of four chapters presenting the findings from this research, introduces the theory of **working through complexity**, and presents it in diagrammatic form. This is followed by an overview of each of the three theoretical categories and their subcategories. The theoretical categories and subcategories are discussed in greater detail in the following three findings chapters.

Chapter 6. the second findings chapter, presents **navigating a shifting landscape**, the process women living in areas of high socioeconomic deprivation in New Zealand undertook as they entered a 'one size fits all' maternity system.

Navigating this shifting landscape was complex and affected all decisions women made, including accessing a midwife for midwifery care.

Chapter 7, the third findings chapter, presents **building effective relationships**. It was through building effective relationships with midwives that women were encouraged to remain engaged with midwifery care.

Chapter 8, the last of the finding's chapters, presents **negotiating a pathway** to explain the process women participants found themselves in when moving through the maternity system. Once they had accessed a midwife, women relied on midwives to negotiate a pathway through the maternity system, wherever their pregnancy journey led. The effective relationships women had built with their midwives and the provision of continuity of midwifery care enabled negotiation a pathway to occur.

Chapter 9, the discussion chapter, presents a discussion of the study findings. This is followed by identification of the strengths and limitations of the study. Recommendations for practice, research, education, and maternity system development follow.

Chapter 2: Literature Review

In this chapter the place of the literature review in a grounded theory study is explored. In the initial literature review I searched what was already known in my area of interest to identify a gap in the literature and, therefore, aid the development of my research question. The initial literature review focused on access to, and/or engagement with, maternity services for women living in areas of high socioeconomic deprivation. Literature demonstrated the benefits of increased midwifery support, identified facilitative models of midwifery care, and situations influencing women accessing and engaging with maternity services. There is a relationship between less optimal birth outcomes–specifically stillbirth and neonatal death–and socioeconomic deprivation. While this is not an outcomes study, there is literature demonstrating that the ability to access pregnancy care and form effective relationships with caregivers could make a difference to birth outcome for women living in areas of high socioeconomic deprivation. Examining how women access and engage with midwives may assist in understanding part of the process that influences less optimal birth outcomes. Therefore, the effects of high socioeconomic deprivation on birth outcomes, specifically stillbirth and neonatal death, were also a focus of the initial literature review. The literature in these areas is critiqued.

Once data analysis had been completed and categories had been identified, I updated the literature to place the research findings from the current study into the context of current knowledge (Charmaz, 2014a; Glaser & Strauss, 1967). I also searched for other literature which may support the identified categories (Charmaz, 1990, 2008a, 2011) and to complete and enrich my research (Stern, 2010). Additionally I accessed literature post-study to ensure I had the latest research. While occasional literature from the subsequent search is critiqued in this chapter, most subsequent literature is presented and used in the discussion, Chapter 9, to support the critique of my findings.

2.1 The Place of the Literature Review in a Grounded Theory Study

The place of a literature review within a grounded theory research study has been debated for some time. Some grounded theorists (Charmaz, 2014a, 2014b; Clarke, 2009; Lempert, 2010) have suggested not delaying the literature review. It was Charmaz's (2014a) view that researchers hold knowledge in, and perspectives of, their professional disciplines before deciding a topic to research. Charmaz encouraged

researchers using grounded theory to use the initial literature review as an opportunity to become familiar with what is currently known in the subject area. Assessing and critiquing the literature enables clarification of ideas in order to identify gaps requiring research. Literature is then reviewed to develop theoretical sensitivity about concepts identified from data analysis, and at this point may be wide ranging from many disciplines (Charmaz, 2014).

Literature is one data source (Glaser, 1978, 1992; McCallin, 2003) and becomes a tool to stimulate thinking as data analysis progresses (McCallin, 2003). The literature used is determined by the concepts that are constructed during data analysis (Charmaz, 2014), helping to enrich the developing theory (Charmaz, 2014; Glaser, 1978, 1992). The ideas from the most significant works are integrated into the researcher's developing theory (Charmaz, 2014; Glaser, 1978, 1992). Review of the literature is, therefore, seen to be an integral part of grounded theory research methodology (McCallin, 2003); an ongoing process conducted to fulfil analytical needs (Glaser, 1978, 1992). In discussing the timing of a literature review in grounded theory research, Giles, King, and de Lacey (2013) concluded that a preliminary literature review could enhance the research undertaken if used reflexively.

In contrast to other research studies, where an extensive literature review is often seen as one of the initial steps of the research process, classic grounded theorists advocated not doing a literature review until data analysis was completed (Glaser & Strauss, 1967, Glaser, 1978, 1998). This was to ensure the researcher did not see his/her data through another's ideas. Without preconceived ideas about what concepts may be relevant, the researcher ensured that categories and theoretical codes clearly emerged from the data (Glaser, 1978, 1992).

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

In the study presented in this thesis, an initial narrative literature review was undertaken, commencing in 2012, to discover current knowledge in the field of midwifery care for women living in areas of high socioeconomic deprivation, to aid the formulation of the research question, and to meet provisional university doctoral requirements regarding the proposed research study and research design. At the time the literature review was conducted, a narrative method was considered an appropriate approach for reviewing, critiquing, and summarising the available literature. If I were to

conduct a current literature review (in 2019), I would use an integrative review method. Literature was then sourced and updated as concepts were identified from data analysis and categories began to be developed. How I used the literature in this way will be demonstrated in Chapter 4: Research Methods.

2.2 Search Strategy

A search strategy was employed when undertaking the initial literature review to ensure important studies in the area under study were identified. The following databases were searched: The Cumulative Index to Nursing and Allied Health Literature (CINAHL), Medical Literature Analysis and Retrieval System Online (MEDLINE), ProQuest, Cochrane Library, National Institute for Health and Clinical Excellence (NICE), Midwifery Maternity and Infant Care (MIDIRS), Joanna Briggs Institute, and the Nursing Reference Centre; using combinations of the following words: pregnancy, poverty, midwifery, midwifery care, socioeconomic, low socioeconomic, deprivation, high deprivation, and midwifery service. Both national and international literature were reviewed. The search was limited to publications written in English. Publications searched had been either published in the previous 25 years (1990-2014) or were older benchmark publications which were required to inform the study; for example, Davies (1988) and Glaser and Strauss (1967). Table 1 shows the results of a search of two databases undertaken on 22 November 2012.

Table 1. Results of 22 November 2012 search of two databases

Search combinations	CINAHL	Cochrane Library
pregnancy & poverty & midwifery care	60	3
pregnancy & low socioeconomic & midwifery care	24	1
pregnancy & high deprivation & midwifery care	2	0
pregnancy & deprivation & midwifery care	11	1

Initially all the titles were read and either retained or discarded. The abstracts of those retained underwent the same process. This left those articles retained for analysis.

Those retained were read and reread, and gathered into themes addressing the following; access to, and/or engagement with, maternity services for women living in areas of high socioeconomic deprivation; and the effects of high socioeconomic deprivation on birth outcomes, specifically stillbirth and neonatal death.

Once data analysis had been completed, the literature from 2014 onwards was searched around the identified theoretical categories. Literature was sourced around accessing/initiation of antenatal care, maternal inequity and maternity service delivery/organisation of maternity care, the perspectives and experiences of women living in deprivation about midwifery/maternity care, midwives' perspectives of providing care to women; and, interprofessional collaboration in maternity care. In addition, reports and other publications relating to the topic were also reviewed; for example, the PMMRC reports (2007, 2012, 2013, 2014, 2015, 2016, 2017, 2018), and colleagues occasionally emailed me articles they thought may be relevant to my study. Reference lists of articles I read were also a source of additional literature. Post study I accessed literature to ensure I had the latest research. I did not keep a record of the number of the many articles sourced, discarded, or retained for analysis throughout this study.

2.3 Women Living in Areas of High Socioeconomic Deprivation: Access to, and/or Engagement with, Maternity Services

2.3.1 The benefit of increased midwifery support

The initial literature review revealed that little was known about the care midwives provided to women living in areas of high socioeconomic deprivation, or how women received that care. Two benchmark studies from the United Kingdom (UK), however, showed the benefits on birth outcomes and perception of care of increased midwifery support during pregnancy for women living in poverty (Davies, 1988; Oakley, Rajan, & Grant, 1990). Oakley et al. (1990) considered the effects of poverty and attempted to measure the benefits of midwifery care. In total 509 socially disadvantaged women, with a history of a low birth weight baby, were recruited from the antenatal booking clinics of four hospitals, and randomised to receive either standard antenatal care or standard antenatal care with extra social support. In standard antenatal care, care was shared between each woman's GP, hospital employed community midwives, and obstetric and midwifery staff in hospital antenatal clinics. Extra social support referred to standard antenatal care plus 24 hour social support intervention via phone from a research midwife, in addition to home visits from a midwife (Oakley et al., 1990). Pregnancy outcomes were measured using information collected from clinical notes and

postal questionnaires sent at six weeks post birth. Compared to the control group, the women in the social support group had fewer babies of low birth weight and fewer antenatal admissions during pregnancy (Oakley et al., 1990). The number of women experiencing spontaneous onset of labour and normal births was also higher, with women using epidurals less frequently (Oakley et al., 1990). Women's attitudes to the social support intervention were very positive with the majority of women highlighting the fact that the midwives 'listened' to them, to be most beneficial (Oakley et al., 1990). The results of the study showed that the provision of social care to pregnant women may positively affect a range of pregnancy outcomes, including women's reported satisfaction with care.

The Newcastle Community Midwifery Care Project was funded to research the effect, if any, of providing enhanced midwifery care to women in low socioeconomic groups in two areas of Newcastle, UK. Several publications have been generated from this one project (Davies, 1988, 1997, 2000; Davies & Evans, 1990, 1991; Hughes, 1992). Enhanced midwifery care involved midwifery continuity of at least four home visits; conducting antenatal classes; visiting women admitted to hospital antenatally, during labour, or postnatally; the occasional attendance at a birth; and postnatal visiting for a minimum of four weeks (Davies, 1997, 2000; Davies & Evans, 1991). As part of the study the midwifery service became neighbourhood based, so the midwives were also accessible at the local clinic. The women receiving standard care attended their GPs and hospital clinics for antenatal care. Data for the study were collected through ante and postnatal semi-structured questionnaires with 263 women, review of case notes, and interviews with the health professionals involved.

Findings revealed that women liked having a known midwife who would see them throughout their pregnancy. Results also showed a reduction in preterm births, a slight decrease in analgesia used, and a tendency for women receiving enhanced midwifery care to have fewer low birth weight babies, compared to the standard care group (Davies, 2000; Davies & Evans 1991). The midwives in the study enjoyed working in an autonomous way in an area in which they became known as the midwives in the community (Davies & Evans, 1990, 1991).

In both studies (Davies, 1988; Oakley et al., 1990) women responded positively to the extra midwifery support provided, especially the increased access to midwives who became known to them. Midwives reported experiencing more job satisfaction, and several pregnancy and birth outcomes were improved.

Findings from a self-reported survey collecting data from 5,333 women in the UK (Henderson & Redshaw, 2013) were that good social support was associated with women feeling physically "very well" and having no problems at three months postnatally. Women who felt they had been given information at the right time to help them make decisions about care, and who had as many home visits from a midwife as they wished postnatally, reported feeling cared for and treated well. Living in the most deprived areas was found to have no effect on women reporting positively (Henderson & Redshaw, 2013). An earlier Swedish study (n = 2,424) found women who were dissatisfied with partner support during pregnancy more likely to experience poorer physical and emotional health at two months postnatally, and that this was not related to socioeconomic background (Schytt & Waldenstrom, 2007). It would appear that much of the social intervention promoted by previous researchers was already considered part of the day to day practice for the midwives providing care to women respondents in the Swedish study, benefiting women and their continued engagement with pregnancy care.

2.3.2 Facilitative models of midwifery care

In another UK study two specialised models of midwifery care were introduced with the aim of optimising the physical and emotional wellbeing of 199 teenage women and their babies, and reducing the level of social exclusion associated with teenage pregnancy (Mead, Brooks, Windle, Kukielki, & Boyd, 2005). The interface model incorporated a midwife supplementing the normal care provided to the women by either their community midwife or the local hospital midwives. The midwife had the time to act as an interface and advocate for the woman at the primary/secondary interface, to social workers, family planning associations, schools and various other agencies (Mead et al., 2005). The community based midwife providing continuity of care had a specified caseload of women for whom she provided care throughout pregnancy, labour, birth, and up to four weeks postnatally (Mead et al., 2005).

Evaluation after six months showed there were no significant differences in the birth outcomes between the two models. However, although this study was small, findings showed that the interface model was associated with significantly more potentially helpful interventions and outcomes than the continuity model, such as employment advocacy, access to social benefits, increased duration of breastfeeding, and use of contraception (Mead et al., 2005). This is an example of the improved outcomes possible when a model of care is implemented to address the specific needs of a particular group of women, in this case the social exclusion generally experienced by pregnant teenagers. It was because the interface midwife was supernumerary to normal

midwifery care that she had the time to make contact and liaise for this group of women (Mead et al., 2005). These results concurred with previous research which showed that the needs of these women are greater than what is considered to be within the bounds of normal midwifery care (Mead et al., 2005). These findings suggested that a midwife who had the time to focus on the non-midwifery needs of a particular group of vulnerable women may achieve more benefit long term (Mead et al., 2005). This is only achievable through a maternity system which is correctly funded to enable the midwife to meet the specific needs of a particular group of women.

Priday and McAra-Couper (2011, 2016) reported a successful community midwifery service achieving good pregnancy and birth outcomes in Counties Manukau– a New Zealand city of high socioeconomic deprivation. The midwives within the midwifery service provided continuity of midwifery care to women and their families within a partnership model, working alongside other health professionals and community services, to enable seamless access to, and provision of, integrated maternity and primary health care and social services. This model was well accepted by the local population and led to good pregnancy outcomes for women, including increased normal birth and a reduction in the perinatal mortality rate. Priday and McAra-Couper recommended increasing the number of midwifery practices incorporating this integrated approach as it ensured access to, and engagement with, maternity services.

In one New Zealand study, women living in areas of high socioeconomic deprivation were interviewed about their experiences of a model of midwifery care (Pullon, Gray, Steinmetz, & Molineux, 2014). Participants comprised 11 women of minority ethnicities. The midwifery model consisted of a group of five midwives, one of whom was the woman's main midwife providing continuity of care, integrated with primary care services to enable access to a coordinated range of health professional expertise. Results indicated positive endorsement of the model of care. Exploring women's experiences of receiving midwifery care is important, as demonstrated by a National Institute for Health and Clinical Excellence (NICE, 2010) guideline which recommended ensuring women living in socioeconomic deprivation presenting for antenatal care are asked about the services provided and had their responses recorded which were then used to guide service development and facilitate them accessing and engaging with care.

Wright and Woods (2012) reported on the establishment of two posts for public health midwives to provide enhanced community midwifery in a socioeconomically

deprived community in the UK. They developed a pathway for early access to maternity services which resulted in an increase from 7% to 74% of women booking before 10 weeks and to 93% before 12+6 weeks gestation. Assessment tools were developed with support available accordingly. The midwives provided a one-to-one stop smoking service, parenting education, and breastfeeding workshops; in addition to working closely with a wide range of organisations and groups to help provide for example self-esteem, literacy and numeracy courses.

Continuity of midwifery care provided within a context that enables seamless access to a range of health professionals and government services, enhances the care and pregnancy outcomes of women living in areas of high socioeconomic deprivation.

2.3.3 Facilitators and barriers to women accessing maternity services

Accessing maternity services is dependent on those services being accessible to women. In the United States of America (USA) studies have examined the barriers to accessing early antenatal care. Daniels, Noe, and Mayberry (2006) used focus groups to research facilitators and barriers to accessing early prenatal care amongst 32 Black women of low socioeconomic status. Barriers included unsatisfying clinic experiences (long waiting times and insensitivity of staff), unwanted pregnancies, lack of knowledge around the importance of early pregnancy care or pregnancy signs and symptoms, lack of social support, stress or depression, and having had multiple pregnancies. Park, Vincent, and Hastings-Tolsma's (2007) study, of 439 women receiving continuity of care from nurse-midwives, found women of colour often had difficulty accessing antenatal care resulting in booking late in pregnancy or receiving no antenatal care. Low educational attainment was associated with not accessing care. The reasons for women experiencing difficulty in accessing antenatal care were not reported.

Cubbin et al. (2008) used data from a population-based surveillance system (Pregnancy Risk Assessment Monitoring System) covering 62% of births in two USA states, from 1997-1998, to determine whether neighbourhood socioeconomic deprivation had any effect on several indicators of maternal and infant health, including access to prenatal care, low birth weight, and not breastfeeding. Results from 8,359 respondents of a range of ethnicities showed that in one state living in high deprivation neighbourhoods was associated with delayed or no prenatal care more amongst European (not women of colour/white) American women. Rates for Asian/Pasifika women were elevated but not significantly. The authors speculated there may be other factors to health care access for European American women in highly deprived areas, such as location of the health centres, not accounted for in data analysis. In the other

state, African American women living in the least deprived areas had a higher possibility of delaying or receiving no prenatal care (Cubbin et al., 2008). The authors speculated this may be due to problems accessing acceptable prenatal care sites when living in areas where few African American women lived. A UK study of 5,332 women found that women living in high socioeconomic deprivation were less likely to turn up for antenatal care or a routine postnatal checkup (Lindquist, Kurinczuk, Redshaw, & Knight, 2014).

The socioeconomic variations in the organisation of pregnancy care, and the extent that these factors affected women's experience of access to pregnancy care within the funded public health care system, were explored in two Australian states (Sutherland, Yelland, & Brown, 2012). Results from survey data of the 4,366 participants found a relationship between ratings of care and social and economic disadvantage. Across all social and economic indicators, women at greatest risk of socioeconomic disadvantage were significantly more likely to receive models of care least likely to provide positive experiences. They mostly received antenatal, labour, birth, and postnatal care by hospital employed doctors and/or midwives rather than midwifery led care. The model of care was found to be a salient feature of how women viewed their care. Women receiving care from a combination of hospital doctors and midwives were less likely to rate their antenatal care as 'very good' compared to those receiving midwife led care (Sutherland et al., 2012). Not having access to midwife led care, a model not well supported in Australia, when that care has been shown to be advantageous to women remaining engaged with pregnancy care, can be a barrier to women living in areas of high socioeconomic deprivation accessing antenatal care.

An earlier meta-synthesis of eight studies explored factors affecting access to antenatal care for 583 marginalised pregnant women in high-income countries such a New Zealand, Australia, UK, and the USA (Downe, Finlayson, Walsh, & Lavender, 2009). Results showed that access was influenced by late pregnancy recognition and subsequent denial and acceptance, with women weighing up the benefits and risks of continuing to attend antenatal care. Abrahams, Jewkes, and Mvo (2001) interviewed 32 pregnant women investigating their health seeking practices. The researchers reported that antenatal care attendance was dependent on weighing up the perceived benefits and anticipated costs. Personal resources such as time, money, and social support, were considered alongside service provision including the perceived care quality (Abrahams et al., 2001; Downe et al., 2009). Knowledge of the role of antenatal care, perceived health needs, and booking system were also considerations for antenatal care attendance

(Abrahams et al., 2001), as was the trustworthiness and cultural sensitivity of staff, including the feelings of mutual respect (Downe et al., 2009).

Phillipi (2009) undertook a literature review of access to antenatal care in the USA between 1990 and 2009. Results of 42 articles showed similar demographic trends to New Zealand around factors associated with late or inadequate number of antenatal care visits. Similar barriers to antenatal care access were also reported.

Southwick, Kenealy, and Ryan (2012) responded to a joint Ministry of Health and Health Research Council of New Zealand initiative seeking to improve knowledge about the most effective ways to improve Pacific peoples' access to, and use of, primary care; and ultimately Pacific health outcomes. Their study used cultural methodologies and frameworks developed by the research team to involve, engage, and capture the views of Pacific peoples. The results from 36 national focus groups and interviews with 50 mainstream non-Pacific (n=29) and Pacific (n=21) providers gave a comprehensive summary of current barriers to accessing and/or engaging with primary care across a range of health disciplines, underpinned by poverty and limited resources, and was pertinent to women accessing and engaging with midwifery care (Southwick et al., 2012). Barriers included a lack of financial resources leading to unhealthy lifestyles and less ability to make better choices, rather than a lack of knowledge. Transport problems, the cost of health care, and poor experiences of the health services were also barriers to seeking assistance. There was a connection between high levels of stress and poor health.

Barriers to the initiation of antenatal care for Pasifika women in Counties Manukau District Health Board (DHB) were researched following a report showing over one third of women in the area were not booking for antenatal care before 18 weeks gestation (Corbett, Okesene-Gafa, & Vandel, 2013). A written questionnaire was completed by 826 participants; a convenience sample of unselected women of a variety of ethnicities seeking care at DHB facilities during a three month period. Interpreters were provided for women who did not speak English. The odds of booking late were six times higher amongst Māori and Pacific women compared to European and other ethnicities (Corbett, Chelimo, & Okesene-Gafa, 2014). Results demonstrated factors significantly associated with late booking (after 18 weeks gestation) of Pasifika women were multifactorial, including lack of knowledge about the importance of getting pregnancy care, the need to book an LMC, and how or when to access care. Women were significantly more likely to book later than 18 weeks gestation for antenatal care if they had limited resources such as lack of transport, childcare, and money (Corbett et

al., 2014). Societal factors including difficulty with English, being unable to get an appointment at a suitable time, being too busy to attend, and concerns about the involvement of government childcare agencies, also contributed. Concerns related to eligibility for free maternity care and not finding out they were pregnant early were key findings. Additional findings reported that 11% of Pasifika women participants did not try to get pregnancy care, suggesting that maternity service provision was problematic for respondents. Women perceiving they could look after themselves during pregnancy was also associated with late booking (Corbett et al., 2013). A small study of 40 women and 10 key informants (Tanuvasa, Cumming, Churchward, Neale, & Tavita, 2013) concurred, reporting that while most Samoan women had their first antenatal appointment before 12 weeks gestation, the reasons given by those who did not do so until 15 weeks or later was that they felt well and healthy and thus perceived there was no need to seek care earlier. This was particularly true with older women having subsequent children, who felt they knew enough about pregnancy and birthing, and would only seek early antenatal care if there were pregnancy complications.

Cultural and communication barriers during the care process, plus some having different health beliefs which impacted on their health care seeking behaviours and choices, including when they accessed maternity care, were findings of a report aimed at identifying areas for health improvement for Pacific people (Health Partners Consulting Group (HPCG), 2012). The high level of gifting and remittances with 5-13% of disposable income being sent overseas by an estimated 85% of Pacific families, and many tithing 10% of their income to churches, impacted available income and, therefore, access to resources necessary for pregnancy care (e.g. public transport). The finding that along with Māori women Pacific women were more likely to register with a LMC later in pregnancy (HPCG, 2012), was supported by Dixon et al. (2014) in their study of 81,821 women who registered with a midwife LMC between 2008 and 2010. Dixon et al. also included women under 20 or over 40 years of age in this group.

A literature review on the experiences of Māori women of antenatal, labour, and birth care in New Zealand was undertaken by Ratima and Crengle (2013). Links between access to care and health outcomes for Māori were also considered. Results of the review supported the maternity care requirements of Māori women being greater than those of non-Māori women, and highlighted the ongoing inequalities between Māori and non-Māori-birth outcomes (Ratima & Crengle, 2013). In addition, Māori experienced persistent ethnic inequalities in their experiences of, and timely access to, high quality maternity care. They were less likely than New Zealand European or Asian

women to attend antenatal education classes, and had fewer antenatal visits than is considered best practice (Ratima & Crengle, 2013). Identified key barriers to adequate antenatal, labour, and birth care included access to information to make informed choices (choosing an LMC, what to expect during pregnancy, and making decisions about pregnancy care that would meet their needs), insufficient numbers of community-based practicing Māori midwives to provide their care, and inadequate access to culturally responsive care including family centred services. Cost barriers, especially to attend antenatal classes and access antenatal care, were also identified.

In addition to reviewing the literature on antenatal, labour, and birth care for Māori women in New Zealand, the results of which have been reported above, Ratima and Crengle (2013) also considered the literature on the links between access to care and health outcomes for Māori babies. This was as a result of research findings from international studies proposing that the determinants of ethnic inequalities in birth outcomes are multifactorial and accumulate over the lifetime of the mother. Findings implied that poor access to antenatal, labour, and birth care, may be one of a number of factors contributing to inequalities in birth outcomes for Māori. There is strong evidence that adverse birth outcome, especially low birth weight, affects a baby's health outcomes in later life; for example, there is a link between low birth weight and hypertension, Type 2 diabetes, and coronary heart disease in adulthood (Ratima & Crengle, 2013). There are persistent inequalities between Māori and non-Māori in birth outcomes, particularly for babies of low birth weight, preterm birth, small for gestational age (SGA), stillbirth, and neonatal death. One of the risk factors identified in this discrepancy is that Māori women are more likely to be of low socioeconomic status than women of other ethnic groups (Ratima & Crengle, 2013). In addition to being of low socioeconomic status, another contributing factor is the high prevalence of risk factors in Māori women; for example, greater likelihood to start having babies in their mid-teens to early 20s, more likely to have high risk pregnancies so requiring specialised medical or obstetric advice, more likely to smoke, and more likely to have health problems such as diabetes during pregnancy (Ratima & Crengle, 2013). An American study reporting on the outcomes of 62,816 births in 25 birthing facilities, noted ethnicity, number of prenatal visits, and low education attainment as significant predictors of adverse perinatal birth outcomes (Wilson, Gance-Cleveland, & Locus, 2011).

The multiple complexities women living in deprivation experience daily makes them more likely to experience delayed or no access to maternity services. Access is

impacted by a number of factors including resources, experience, and health knowledge. Receiving less than the recommended amount of antenatal care is associated with less than optimal pregnancy outcomes.

2.3.4 Facilitators and barriers to women engaging with maternity services

Engagement with maternity services is dependent on whether women want to engage with those services. A Scottish study involving 21 participants (Docherty, Bugg, & Watterson, 2011) explored whether pregnant women's perceptions of antenatal care differed dependent on their socioeconomic background. There was little difference in access to antenatal services between women ranked as least and most deprived–they all attended clinic appointments as requested. However, how they perceived their levels of engagement differed. The more socioeconomically deprived women described less personal connection to their own care, less effective communication, and less opportunity for shared decision making. Results demonstrated that women who did not feel engaged (connected to their care, effectively communicated with, and involved in decision making) by the first trimester were more likely to never feel engaged with the antenatal service provided. Identifying women at risk of non-engagement therefore, may be one method to predict and improve health outcomes. Personalising care and using strategies that involve women in their antenatal care were suggested (Docherty et al., 2011).

Ratima and Crengle (2013) reported that when a Māori woman experienced a non-Māori maternity provider, communication problems were a concern. Lack of information and empathy from providers meant that information was not clarified. Women felt vulnerable to communication failures, particularly between midwife and GPs, which influenced their engagement with pregnancy care. These results are supported by a UK study of 5,332 women which found that with increasing socioeconomic deprivation women were more likely to report that midwives and doctors did not treat them respectfully or speak to them in a way that they could understand (Lindquist et al., 2014).

One project collated the views of Māori and Pacific mothers, and women of childbearing age, who lived in areas of high socioeconomic deprivation in a New Zealand DHB about what was working well within the area's current maternity care system, and what could be improved (Pacific Perspectives Ltd., 2013). Focus groups were attended by 54 women, and a further 10 women were interviewed individually. Results showed that teenage, young, Māori, Pacific and other vulnerable mothers,

perceived significant shortcomings in the quality of the maternity services they received. Concerns related to staff attitudes towards this group of women, with young mothers reporting feeling stereotyped, judged, and stigmatised in their interactions with staff. In addition, a DHB culture focussed on timeliness and efficiency, rather than nurturing and care, and lack of additional resources to meet the needs of women with English as a second language or low health literacy, contributed to the unsatisfactory experiences reported. Tensions between LMCs and hospital staff impacted on the confidence and trust this group of women had in the services, and subsequently their willingness to engage for future needs (Pacific Perspectives Ltd., 2013).

Socioeconomic deprivation, highest amongst Māori and Pasifika, is a leading cause of poor health and wellbeing outcomes in New Zealand (New Zealand College of Public Health Medicine (NZCPHM), 2013). The social determinants of health impact significantly on the perinatal mortality rate. If the perinatal mortality rate is to be reduced, the social and health needs of Māori, Pacific, and socioeconomically deprived mothers needed to be addressed (McAra-Couper, 2012). McAra-Couper (2012) recommended effective interventions be centred around a multidisciplinary infrastructure of service provision and delivery that is responsive to the needs identified in research data from previous studies; for example, Corbett et al. (2013) and Priday and McAra-Couper (2011).

In New Zealand, there had been no significant documentation or research of midwives' experiences of providing care to childbearing women living in areas of high socioeconomic deprivation at the time the initial literature search was undertaken. Griffiths (2002) explored the care processes used by seven midwives in their work with women living in areas of high socioeconomic deprivation in New Zealand. Findings showed the midwives 'Staying involved 'because the need seems so huge''. The midwife's continued involvement throughout the woman's pregnancy, birth, and postnatal period facilitated the woman remaining engaged with care–working towards an optimal pregnancy outcome for both the woman and her new baby.

From the literature presented in this section, it can be seen that increased midwifery support during pregnancy benefits birth outcomes and women's perception of care for those living in socioeconomic deprivation. Models of pregnancy care where women receive continuity from a midwife increase antenatal care attendance, may result in earlier booking with an LMC, and are associated with increased rates of normal birth and a reduction in the perinatal mortality rate. Barriers to accessing early prenatal care include; timing of pregnancy confirmation and subsequent denial and acceptance,

ethnicity, lack of financial resources, poor experiences of the health services, cultural and communication barriers, unwanted pregnancies, lack of knowledge around the importance of early pregnancy care, how or when to access care, or pregnancy signs and symptoms, lack of social support, transport or childcare problems, the cost of health care, stress or depression, having multiple pregnancies, low educational attainment, and not having access to midwife led care. Other barriers reported include; difficulty with English, timing of appointments, being too busy to attend, concerns about potential involvement of government childcare agencies and eligibility for free maternity care, plus some having different health beliefs which impacted on their health care seeking behaviours and choices, such as feeling well so perceiving no need to seek care earlier. All these factors resulted in women booking late in pregnancy or receiving no antenatal care.

Barriers to remaining engaged with pregnancy care include women feeling disconnected from their care, ineffectively communicated with, and not involved in decision making, not being treated respectfully, and feeling stereotyped, judged, and stigmatised in their interactions with staff. For women living in areas of high socioeconomic deprivation, access to, and/or engagement with, maternity services, including midwifery care, which is acceptable to them, appears to impact positively on their pregnancy outcomes. The literature identifies that barriers and enablers to women's ability to access and engage with antenatal care are multifactorial and complex. Women's satisfaction is increased when receiving midwife led care.

2.4 The Effects of High Socioeconomic Deprivation on Birth Outcomes– Specifically Stillbirth and Neonatal Death

The initial literature review demonstrated that the ability to access pregnancy care and form effective relationships with caregivers could make a difference to birth outcome for women living in areas of high socioeconomic deprivation. Therefore, literature on the effects of high socioeconomic deprivation on birth outcomes, specifically stillbirth and neonatal death, was also reviewed.

2.4.1 The association between stillbirth risk and living in areas of high deprivation

Guildea, Fone, Dunstan, Silbert, and Cartlidge (2001) investigated the relationship between social and material deprivation and the causes of stillbirth and infant mortality in Wales over a six year period from 1993-1998. Results showed that the risk of stillbirth and infant mortality was increased in areas of high deprivation. Sudden infant death syndrome was the cause of death most strongly associated with social deprivation.

Unexplained stillbirth, and death caused by infection or a specific condition, was also significantly associated with deprivation. However, there was no evidence of an association between socioeconomic deprivation and deaths caused by placental abruption, intrapartum asphyxia, severe congenital abnormality, or conditions as a result of premature birth. The authors concluded that collaborative public health action within socioeconomically deprived communities, at both local and national levels, was required. Action included the targeting of public health resources aimed at improving nutrition in women and children, reducing smoking in pregnancy, promoting breastfeeding and the social and emotional support of parents, along with improvements in education, housing, employment, and the physical environment of high socioeconomically deprived areas (Guidea et al., 2001).

Identifying there had been no recent research evidence related to the effect of socioeconomic deprivation on the rate of stillbirth, Seaton et al. (2012) explored trends in socioeconomic inequalities in stillbirth in England. Data were used from 20,433 singleton stillbirths that had been reported to a centre responsible for national perinatal mortality surveillance during 2000-2007. Although a study of trends in socioeconomic inequalities in neonatal mortality in England, during an 11 year period from 1997-2007, had shown reductions in singleton neonatal mortality (Smith, Manktelow, Draper, Springett, & Field, 2010), this had not occurred for stillbirths. Instead, stillbirths had become the largest contributor to perinatal mortality in the UK (Seaton et al., 2012). Acknowledging the limitation of not having data on ethnicity, health, lifestyle, and at risk behaviours, Seaton et al.'s results showed that rates of stillbirth were twice as high in the most socioeconomically deprived 10% of areas compared to the least deprived 10% throughout the study. Stillbirth due to antepartum haemorrhage had a rate that was 3.1 times higher in the most socioeconomically deprived areas. The exceptions were issues that occurred during labour, such as cord prolapse or uterine rupture. Half of the stillbirths attributed to deprivation had an unknown cause. Seaton et al. concluded that given the recent reductions in the stillbirth rates in other high-income countries, modifiable risk factors existed. Therefore an improvement in stillbirth rates could be expected by the introduction of interventions targeted at specific geographical areas of high socioeconomic deprivation (Seaton et al., 2012).

In 2011, *The Lancet* published the first of five articles in a series on stillbirths, with the intention of raising international awareness of the stillbirth rates, and gathering data to work towards reducing the rates of preventable stillbirth globally in low, middle, and high-income countries by 2020 (Bhutta et al., 2011; Flenady et al., 2011b; Frøen, et

al., 2011; Goldenberg et al., 2011; Lawn et al., 2011; Pattinson et al., 2011). Globally it is recognised that many stillbirths in high-income countries, such as New Zealand, are linked to avoidable conditions related to quality of care and lifestyle factors (Flenady et al., 2011b; Frøen et al., 2011; Lawn & Kinney, 2011). Obesity and smoking are modifiable risk factors for stillbirth and, increasingly, advanced maternal age is a prevalent risk factor (Flenady et al., 2011b). Flenady et al. (2011a) undertook a systematic review and meta analysis to identify priority areas for stillbirth prevention in high-income countries. The definition of stillbirth varied across the 96 population-based studies, with 54 using a definition that included stillbirth from 20-22 weeks gestation or weighing 500 grams or more. The most important potentially modifiable risk factors identified from the review included maternal weight (defined as being overweight or obese before pregnancy–having a body-mass index of 25 or above), maternal smoking, advanced maternal age (over 35 years old), primiparity, SGA, placental abruption, and pre-existing maternal diabetes or hypertension. Women from socioeconomically disadvantaged backgrounds in high-income countries were shown to have stillbirth rates disproportionate to those living without such disadvantage (Flenady et al., 2011a; Flenady et al., 2011b).

Key foci to reduce the number of stillbirths included reducing the disparities between different ethnic and socioeconomically deprived groups, and reducing the risk factors associated with stillbirth through initiatives such as improved antenatal screening for fetal growth restriction (also known as intra uterine growth restriction (IUGR) or SGA related to placental dysfunction and very preterm birth (Frøen et al., 2011; Lawn & Kinney, 2011). In high-income countries, culturally appropriate preconceptual care, and quality, accessible, antenatal care were identified as having the potential to decrease stillbirth rates (Flenady et al., 2011a; Flenady et al., 2011b). Implementation of national perinatal mortality audit programmes aimed at improving the quality of care, along with thorough investigation of each stillbirth, including placental pathology, and the option of autopsy, were also recommended (Flenadyl et al., 2011b). Longer term initiatives such as improving education and employment opportunities for disadvantaged women remained important (Flenady et al., 2011a, Flenady et al., 2011b).

The literature demonstrated that women living in areas of high socioeconomic deprivation experience more stillbirth and neonatal death than more affluent women. Some of the risk factors for less than optimal birth outcomes are potentially modifiable

through initiatives such as the provision of culturally appropriate antenatal care that is easily accessible to women.

2.4.2 The relationship between reduced antenatal care and risk of late stillbirth for women living in areas of high socioeconomic deprivation

In New Zealand, the Auckland Stillbirth Study (Stacey et al., 2012) assessed the relationship between antenatal care and late stillbirth, defined as 28 weeks gestation or more, over a three year period. Cases were women booked to birth in the study area within the three year timeframe who experienced a singleton late stillbirth without congenital abnormality. Two women with ongoing pregnancies at the same gestation were randomly selected as the controls for each stillbirth that occurred. Consent to take part in the study was obtained from 155 women cases and 310 women controls. The schedule of antenatal visits recommended in the NICE guideline (2008, 2017) was utilised for this study. This schedule recommended 10 antenatal visits for nulliparous women experiencing a normal pregnancy, and seven for multiparous women experiencing a normal pregnancy. Stacey et al. (2012) defined antenatal care as adequate (care initiated in the first trimester and at least 50% of recommended visits attended) or inadequate (care initiated after the first trimester and/or less than 50% of recommended visits attended) using the NICE guideline (2008, 2017). Stacey et al. (2012) reported results that demonstrated a significant relationship between reduced antenatal care attendance and late stillbirth risk, with accessing less than half the recommended number of antenatal visits being associated with an almost threefold increase in late stillbirth risk. This was independent of factors associated with reduced antenatal care episodes such as social deprivation. However, no association between type of maternity care provider or model of maternity care and late stillbirth risk was found, nor was any association between gestational age at booking and increased risk for late stillbirth identified. In Stacey et al.'s study (2012), babies were defined as SGA if they had a birth weight below the 10th centile on a customised growth chart developed for the New Zealand population (McCowan, Stewart, Francis, & Gardosi, 2004). Babies who were identified as SGA prior to birth were at significantly increased risk of stillbirth compared to babies who were identified in the antenatal period. The researchers concluded that in addition to the importance of attending antenatal care regularly, identification of the SGA baby may be one way in which antenatal care could reduce the stillbirth rate (Stacey et al., 2012). While Stacey et al. found no association between accessing less than half the recommended number of antenatal visits being associated with significant increase in late stillbirth risk and social deprivation, as

previously identified in section 2.3.3., the research identified an association between social deprivation and antenatal attendance (Abrahams et al., 2001; Corbett et al., 2013; Corbett et al., 2014; Cubbins et al., 2008; Daniels et al., 2006; Downe et al., 2009; HPCG, 2012; Lindquist et al., 2014; Park et al., 2007; Phillipi, 2009; Ratima & Crengle, 2013; Southwick et al., 2012; Sutherland et al., 2012; Tanuvasa et al., 2013; Wilson et al., 2011). Gardosi et al. (2013), however, did find that living in the most socioeconomically deprived areas increased the risk of stillbirth, with the largest risk factor being unrecognised fetal growth restriction. Recommended strategies focussed on improving antenatal detection of SGA included utilising customised antenatal growth charts (Gardosi et al., 2013; NZCOM, 2012; Stacey et al., 2012).

While Stacey et al. (2012) rationalised using the schedule of antenatal visits recommended in the NICE guidelines (2008, 2017) as it had been "*generally adopted in New Zealand*" (p. 243), it is unknown how many New Zealand midwives undertook additional visits on women experiencing a normal pregnancy above the NICE guideline recommendation. No New Zealand literature on this topic was found. It is possible that knowing this information may have an impact on Stacey et al.'s findings. I queried a Midwifery Advisor at the New Zealand College of Midwives (NZCOM) about whether it would be possible to access this information from the NZCOM research database (A. Eddy, personal communication, December 8, 2017). The database records the national midwifery activities and outcomes of the community LMC members of NZCOM who have joined the Midwifery and Maternity Provider Organisation Limited (MMPO); a national organisation that offers a practice management service (MMPO/NZCOM, 2012). The most recent MMPO report to NZCOM (MMPO/NZCOM, 2012) reported on the 2012 cohort of birthing women from the MMPO registrations. In 2012 there were 62,321 registered births in New Zealand (live and stillbirth), of which 34,313 babies were captured in the MMPO database. This represented 55% of the registered births in New Zealand that year. While data on the number of ante-natal visits per woman were collected in the MMPO dataset, I was advised that it would be hard to define 'normal pregnancy' from the database. Although data on women with antenatal comorbidities are collected, complications which develop during pregnancy are not, and this, along with gestation at birth, would also influence the number of antenatal visits undertaken. While it would be possible to make some assumptions and isolate a cohort of 'low risk' women, then look at their antenatal visit data, the visits would then have to be linked to midwives. Accessing the data would require ethics approval and assessment of the application by the data governance group before approval for access to the data would

be granted. So, while theoretically possible to source this information, it would not be easy (A. Eddy, personal communication, December 8, 2017). I decided not to pursue this further.

For women living in areas of high socioeconomic deprivation, there is an association between reduced antenatal care attendance and risk of late stillbirth. It is important, therefore, to understand how this group of women access and engage in pregnancy care, to optimise their pregnancy outcome.

2.4.3 Reporting socioeconomic deprivation as a contributory factor to potentially avoidable perinatal deaths

Establishing a process to report on contributory factors towards perinatal deaths, to establish whether they were potentially avoidable, was an identified need in New Zealand. In 2006 the PMMRC was established to review the approximately 600 perinatal deaths per year and report on perinatal and maternal mortality aiming to improve outcomes (Masson, Farquhar, & Sadler, 2016). Health professionals began providing demographic and clinical data on perinatal death to a national database in 2007. As this information did not always show how to prevent deaths, from 2009 the PMMRC established a process using a tool they developed for local multidisciplinary case reviews to report contributory factors and whether the perinatal deaths were potentially avoidable. Some perinatal deaths were potentially avoidable, and it was important to identify and address contributory factors to prevent future deaths. The tool had categories for factors associated with the organisation and management of care, provision of care by personnel, access to and/or engagement with care, technology/equipment and environment (Masson et al., 2016). In 2009 the PMMRC sought to validate the use of the tool in this new process by comparing the findings of local review with an independent review using the same methodology using a kappa statistic for agreement. The independent review found 14% more contributory factors than the local review, and almost double the proportion of potentially avoidable deaths. That the independent review identified more potentially avoidable perinatal deaths needs further research (Masson et al., 2016).

At the time of writing the initial literature review, the most recent PMMRC report (2014) reporting mortality in 2012 had identified that Māori, Pasifika, and Indian women, women under 20 or over 40 years of age, and women living in the most socioeconomically deprived areas of New Zealand were more likely to experience stillbirth or neonatal death. Further, 19% of perinatal deaths were reported to be potentially avoidable, with the most common contributing factor being barriers to

access and/or engagement with maternity care; most commonly no antenatal care, and late booking or infrequent access to antenatal care. Significantly, barriers to access and/or engagement with care were reported as the main contributing factor in a potentially avoidable death in approximately 18% of perinatal related deaths in women living in the highest socioeconomically deprived areas; quintile five, compared to less than 5% of perinatal related deaths in quintile one (PMMRC, 2014). Lack of recognition of the complexity or seriousness of the mother's condition by the woman or family was frequently identified as a contributory factor, along with declining treatment or advice. The PMMRC reported that the estimated rate of potentially avoidable perinatal death was highest for Māori and Pasifika women (23% each) compared to 13% for New Zealand European/Pākehā women. As in previous PMMRC reports, other risk factors for perinatal death associated with ethnicity continued to include age, socioeconomic status, obesity, and smoking (PMMRC, 2012, 2013, 2014). Each PMMRC report since (2015, 2016, 2017, 2018) has demonstrated similar results.

The Ministry of Health (2017) and PMMRC (2017) reports showed that 30% of women giving birth in 2015 resided in quintile 5; areas with a NZDep13 score of 9 and 10. A further 23% resided in quintile 4. Less than 15% of women giving birth resided in the least deprived areas–quintile 1. Women under 30, particularly women aged under 20 years, and those aged 20-24, were more likely to live in areas with a high deprivation score. The 2017 PMMRC report, reporting on 2015 data, showed that Māori, Pasifika, and Indian women, women under 25 years old, and women living in the most socioeconomically deprived areas of New Zealand were more likely to experience neonatal death; and Pasifika and Indian women, women under 25 years, and women living in the most deprived areas more likely to experience stillbirth. The 2017 PMMRC report also showed that babies of women living in one of the three North Island cities where this research was taking place experienced a significantly higher stillbirth and neonatal death rate compared to the national rate, and recommended further research. The PMMRC (2017) reported the estimated rate of potentially avoidable perinatal deaths to be highest for Māori and Pasifika women (22% and 24% respectively) compared to 13% for New Zealand European/Pākehā women. Importantly, the same barriers to access, and/or engagement, with maternity care, reported in the 2014 PMMRC report above, continued to be the main contributing factors in a potentially avoidable death in almost 16% of perinatal related deaths in babies of women living in the highest socioeconomically deprived areas–quintile five–compared to 4% of perinatal related deaths in quintile one (PMMRC, 2017). Lack of recognition by the woman or

her family of the complexity or seriousness of her condition continued to be frequently identified as a contributory factor, as was substance abuse. Other risk factors for perinatal death associated with ethnicity continued to include younger age, socioeconomic status, obesity, and smoking. The 2018 report (PMMRC, 2018) again identified barriers to access, and/or engagement, with maternity care, as the main contributing factor in a potentially avoidable perinatal death.

It appeared that living in areas of high socioeconomic deprivation was associated with a number of less than optimal birth outcomes, including stillbirth and neonatal death. Some factors associated with these outcomes were potentially modifiable if there was engagement in appropriate antenatal care that was acceptable to women. The most common causes of neonatal death in New Zealand in 2015 and 2016 were congenital abnormalities, spontaneous preterm labour, and antepartum haemorrhage. However, Māori, Pasifika, and Indian mothers experienced significantly higher rates of neonatal death in babies born without congenital abnormalities, than women of other ethnic groups (PMMRC, 2018). While the most common cause of perinatal related death was congenital abnormality, the most common causes of stillbirth were unexplained antepartum death, antepartum haemorrhage, and specific perinatal conditions (PMMRC, 2017, 2018). As the inequity between Māori and non-Māori perinatal and maternal mortality rates has continued, from 2017 the PMMRC introduced data and discussion related to Māori in their annual report (PMMRC, 2017). The main causes of stillbirth and neonatal death amongst Māori women in 2015 were spontaneous preterm birth, antepartum haemorrhage, maternal conditions (mostly diabetes related), and hypertension. The significant differences in birth outcome between New Zealand's largest ethnic groups need to be taken into account in future policy and planning if equity in service delivery and determinants of health are to be addressed (Craig, Mantell, Ekeroma, Stewart, & Mitchell, 2004).

Women living in areas of high socioeconomic deprivation in New Zealand continue to experience higher rates of stillbirth and neonatal death, and other less than optimal birth outcomes, than those living in more affluent areas. Some of these appear to be avoidable if maternity services, including models of midwifery care, are accessible and acceptable to women, resulting in them engaging with pregnancy care.

2.5 The Benefits to Women and Babies of Continuity of Midwifery Care

Continuity of midwifery care means the provision of care to a woman by one midwife (and her backup midwife) throughout pregnancy, labour and birth, and the postnatal

period (Guilliland & Pairman, 2010). The literature reviewed indicated that continuity of midwifery care enhanced the care received by women living in areas of high socioeconomic deprivation, and supported continuity of midwifery as being beneficial to women and babies. Continuity of midwifery care increased women's satisfaction with the maternity services (Bohren, Hofmeyr, Sakala, Fukuzawa, & Cuthbert, 2017; Hicks, Spurgeon, & Barwell, 2003; Hodnett, Gates, Hofmeyr, Sakala, & Weston, 2012; Howarth, Swain, & Treharne, 2011; McLachlan et al., 2012) and costs were less than standard care; care shared between GP and rostered hospital medical and midwifery staff (Tracy et al., 2011; Tracy et al., 2013). Continuity of midwifery care has been shown to make a significant difference to several pregnancy outcomes. These included shorter labours, less use of epidurals and pharmacological pain relief, more normal births, fewer caesarean sections and instrumental deliveries, and more babies with higher 5 minute Apgar scores (Bohren et al., 2017; Hodnett et al., 2012; Homer, Davis, Brodie, Sheehan, Barclay, Wills, & Chapman, 2001; McLachlan et al., 2012). Tracey et al. (2013) found that continuity of midwifery care resulted in more spontaneous onsets of labour, less use of pharmacological analgesia, and less postpartum blood loss over 500mls, in addition to a significant reduction in length of postnatal hospital stay. Breastfeeding rates at six weeks and six months also seemed to be improved.

A systematic review of 11 trials involving 12,276 women (Hatem, Sandall, Devane, Soltani, & Gates, 2008; Sandall, Hatem, Devane, Soltani, & Gates, 2009) then another of 13 trials involving 16,242 women (Sandall, Soltani, Gates, Shennan, & Devane, 2013) found women receiving midwife-led continuous care experienced less epidural analgesia, less episiotomy and instrumental birth, preterm birth, and fetal loss before 24 weeks gestation. However, no difference in rates of caesarean birth was noted. This review was extended in 2016 to 15 trials involving 17,674 women (Sandall, Soltani, Gates, Shennan, & Devane, 2016). Results concurred with the 2008 and 2013 findings.

A UK study of 2,568 women living in areas of social disadvantage who received continuity of care from a midwifery practice set up in the area they lived, between 1997 and 2009, reported high rates of spontaneous labour and birth, home birth, Apgar scores of 8 or more at 5 minutes, breastfeeding initiation and rates of breastfeeding at 28 days, and low rates of caesarean and preterm birth (Homer, Leap, Edwards, & Sandall, 2017). Findings demonstrated positive outcomes for this midwifery model for women and babies living in areas of high socioeconomic deprivation at that time. Rayment-Jones, Murrells, and Sandall (2015) later compared childbirth processes and outcomes of 194

women with complex social factors who received caseload midwifery care defined as a named midwife as the lead professional in the planning, organisation, and delivery of care from booking to the postnatal period, and standard maternity care. In this UK study, routine antenatal appointments were carried out by midwives and obstetricians at a hospital clinic with intrapartum care from rostered midwives. Results showed that women receiving caseload care were more likely to experience spontaneous vaginal birth, use water for pain relief, have had a first assessment by 10 weeks gestation, have a shorter hospital stay, and 90% knew the midwife who provided their labour care. They were less likely to have a caesarean section, an epidural or spinal for pain relief, and had fewer antenatal or neonatal unit admissions. Additionally, more women were referred to multidisciplinary support services such as psychiatry, translation services, or domestic violence advocacy. Caseload midwifery appeared to increase benefit and reduce harmful outcomes, adding to the body of evidence supporting similar findings. The authors concluded that "*it is unethical to ignore these findings and deprive women of the benefits associated with access to a known midwife, particularly when specific populations are at risk of adverse outcomes*" (Rayment-Jones et al., 2015, p. 416). In an earlier study, Zachariah (2009) researched 111 low income pregnant women in America and found that women who experienced antenatal complications had significantly less social support than women who did not. This also impacted on neonatal complications. Zachariah concluded that social support interventions during early pregnancy are effective in preventing antenatal and neonatal complications.

Outcomes for low risk women receiving care from midwives from pregnancy through to six weeks postnatally in a midwifery group practice in Australia were compared to those receiving standard care from midwives and doctors (Toohill, Turkstra, Gamble, & Scuffham, 2012). Women in the midwifery group practice were less likely to experience labour induction, required fewer antenatal visits, received more postnatal care, and their babies were less likely to be admitted to the special care nursery than those receiving standard care (Toohill et al., 2012).

A cohort of 10 women receiving continuity of care from a midwifery group practice in a high socioeconomically deprived area in London were interviewed about their experiences of preparation and support for pain in labour. Women reported how throughout their pregnancy and labour their midwives had promoted their ability to cope with the challenge of pain in labour (Leap et al., 2010). The women valued being encouraged and supported to labour without using pharmacological pain relief by midwives with whom they had developed a relationship of trust. This, along with

hearing other women's stories during antenatal groups, boosted the women's confidence, resulting in less use of pharmacological pain relief compared to other midwifery group practices. The authors concluded continuity has important implications for promoting a positive pregnancy and childbirth experience for women living in areas of high socioeconomic deprivation.

Continuity of midwifery care enhances the care received by women living in areas of high socioeconomic deprivation, who are at risk of adverse pregnancy outcomes. Continuity improves a number of pregnancy and birth outcomes, and increases women's satisfaction with maternity services. Women receiving continuity of midwifery care are more likely to access midwifery care early and remain engaged with care.

2.6 Conclusion

In this chapter, the place of the literature review in a grounded theory study and the search strategy used for the initial and subsequent literature reviews were presented. The initial literature review identified the benefit of increased midwifery support to women living in areas of high socioeconomic deprivation, and models of midwifery care which may positively affect a range of pregnancy outcomes, including women's continued engagement with pregnancy and reported satisfaction with care.

The wide range of facilitators and barriers contributing to whether or not women in areas of high socioeconomic deprivation access and engage with maternity services were then explored. The literature identified that barriers and enablers to women's ability to access and engage with antenatal care are multifactorial and complex. Women's satisfaction is increased when they receive midwife led care.

For women living in areas of high socioeconomic deprivation, there is an association between reduced antenatal care attendance and risk of late stillbirth. The initial literature review demonstrated that the ability to access pregnancy care and form effective relationships with caregivers could make a difference to birth outcomes for women living in areas of high socioeconomic deprivation; for example, through increased antenatal attendance.

Some perinatal deaths are potentially avoidable, and it is important to identify and address contributory factors to prevent future deaths. Significantly, national monitoring of contributory and potentially avoidable factors into perinatal death has established that barriers to access and/or engagement with care are the main contributing factor in a potentially avoidable death in approximately 18% of perinatal

related deaths in women living in the highest socioeconomically deprived areas.

From this literature review it can be seen that continuity of midwifery care has been shown to benefit women and babies, especially those living in areas of high socioeconomic deprivation, improving a number of birth outcomes. While the association between access and engagement with maternity care and positive birth outcomes has been identified, significantly what is not shown in the literature is how women in areas of high socioeconomic deprivation access and engage with maternity care. The study presented in this thesis focuses on the processes involved for this group of women as they access and engage with midwives.

Chapter 3: Research Methodology

If … we start with the assumption that social reality is multiple, processual, and constructed, then we must take the researcher's position, privileges, perspective, and interactions into account as an inherent part of the research reality. It, too, is a construction. (Charmaz, 2014a, p. 13)

3.1 Introduction

Grounded theory was the chosen methodology for this research study, and was used to answer the research question '*How do women living in areas of high socioeconomic deprivation in New Zealand access and engage with midwives?*' The aim of this research was to develop a substantive theory which would explain how women living in areas of high socioeconomic deprivation in New Zealand access and engage with midwives. The purpose of this chapter is to present the methodology used for the study. After presenting an overview of grounded theory methodology, pragmatism and symbolic interactionism are explained as the two theoretical perspectives underpinning grounded theory, along with consideration of constructionist and constructivist approaches. This is followed by a discussion on the development of grounded theory, and the variant of grounded theory used in this study–Kathy Charmaz's constructivist grounded theory (2000, 2006, 2008a, 2008b, 2009, 2014a, 2014b). How the methodology for this research study was followed and how the theory will be evaluated is then discussed. In this chapter 'grounded theory' refers to grounded theory methodology, rather than the resulting grounded theory.

3.2 Grounded Theory Methodology Overview

A methodology is a set of ideas that inform the design of a research study (Birks & Mills, 2015). The purpose of grounded theory is theory construction (Charmaz & Bryant, 2011) through data analysis. Grounded theory methodology is based on the premise that to make sense of their environment people give meaning to experiences they are exposed to throughout their lives (Glaser & Strauss, 1967); although their world may appear muddled and/or not make sense to observers (Hutchison, 1993). By identifying the processes operating in social and psychological settings, this methodology aims to generate explanatory theory that increases understanding (Charmaz, 2002; Chenitz & Swanson, 1986) of group patterns of behaviour by providing a conceptual explanation (McCallin, Nathaniel, & Andrews, 2011) and placing priority on action (Charmaz, 2008d). Grounded theory is a systematic,

inductive, creative, interactive research approach for the collection, organisation, and analysis of qualitative data. It aims to generate explanatory theory that furthers the understanding of social and psychological phenomena, by identifying the central and subsidiary processes operating within it (Glaser & Strauss, 1967). Grounded theory is an emergent methodology that is indeterminate and open-ended, meaning that the researcher is able to follow unanticipated leads from data analysis in order to generate theories that account for the data (Charmaz, 1990, 2002, 2008c; Holton, 2010). The researcher using grounded theory gathers focused data and stays close to the data while developing concepts that synthesise and conceptualise–make analytic sense of–the collected data (Charmaz, 1990, 2002, 2008a, 2015). "*Grounded theory starts with an inductive logic but moves into abductive reasoning as the researcher seeks to understand emergent empirical findings*" (Charmaz, 2008c, p. 157), such as surprises or anomalies in the data. Theoretical categories are created that are directly 'grounded' in the data (Charmaz, 2008a, 2015).

3.3 Theoretical Assumptions

The research methodology and research method used in a study are supported by ideas about human behaviour. Researchers tend to use a methodology which is in line with their own view of the world–both philosophically and where they position themselves when conducting data collection and analysis. That is, whether they will be an objective instrument collecting data from participants or a subjective active participant generating data with participants (Birks & Mills, 2015). Defining my own position in relation to how I see the nature of reality (ontology) and the nature of justifiable knowledge (epistemology) and how it is acquired, are important steps in deciding which grounded theory methodology to use (Birks & Mills, 2015). This will affect how I collect, generate, and analyse data.

3.3.1 Pragmatism

Pragmatism and symbolic interactionism influenced the grounded theory first developed by Glaser and Strauss in 1967. Constructivist grounded theory developed as a variation of this grounded theory.

Grounded theory has its origins in pragmatist philosophy. Pragmatism is a critical philosophy to enable understanding of ideas. It was originally derived from the work of Charles Sanders Peirce (Crotty, 2010; Lewis, 1976; Nathaniel, 2011; Peirce 1905a, 1905b), and influenced several of Glaser and Strauss' mentors (Lewis, 1976; Nathaniel, 2011). According to Charmaz (2014a), pragmatist theories and beliefs are

measured in value by their effectiveness in practical application. People interpret their experiences prior to taking action. This may lead to them expanding or adjusting meanings and, therefore, entering a process of almost constantly interpreting meaning, practical actions, and making a shift in action. Peirce describes this as "…*recognition of an inseparable connection between rational cognition and rational purpose*" (1905a, p. 163). Through practical actions to solve problems, meanings emerge, and people come to know the world. Facts and values are linked and scientific truth is assessed through what is experienced (Charmaz, 2009, 2014a). Pragmatists believe that reality only becomes that when it is part of the environment in which actors act (Strübing, 2007). Through action, matter is transformed into being and into meaningful objects. If things are not acted upon they are meaningless and cease to exist for us as things (Strübing, 2007). Pragmatism has four tenets: 1) people do not respond to their environment, instead they almost always interpret it; 2) they believe something according to its usefulness in situations they encounter; 3) people are selective in what they notice in each situation, and 4) pragmatists focus on actions, what people are doing within their situation (Charon, 2007).

> *According to pragmatism, humans never see reality as it is: humans learn and remember what is useful to them; humans see and define objects in their environment according to the use they have for those objects; and it is important to focus on human action rather than the person or society to understand the human being.* (Charon, 2007, p. 32)

Pragmatism later became popular through the work of William James, Peirce's patron and friend, and John Dewey (Lewis, 1976; Nathaniel, 2011). Through James and Dewey, pragmatism evolved into viewing the world as a world to be explored and made the most of, rather than one to be subjected to radical criticism (Crotty, 2010). Dewey emphasised human experience, which involved following a systematic approach to the inquiry of interpreting actions and beliefs to describe the nature and concepts of our world (Morgan, 2014). Further, Dewey, for his version of pragmatism, advocated freedom of inquiry in which individuals and communities prioritise the issues that matter most to them and pursue these in ways they consider most meaningful (Morgan, 2014). Peirce, however, was unhappy with James and Dewey's version (Lewis, 1976; Peirce, 1905a), claiming it was less critical than his original version (Peirce, 1905a). Thus, he disowned their version, renaming his own approach 'pragmatacism' (Crotty, 2010; Peirce, 1905a, 1905b).

James and Peirce also influenced George Herbert Mead (Lewis, 1976; Nathaniel, 2011). Dewey's writing was more closely aligned with James, while Mead's work was closer to Peirce's principles (Lewis, 1976). It was through Dewey's association with Mead that pragmatism entered the field of sociology as symbolic interactionism and continues to remain a significant dimension of this approach (Charon, 2007; Clarke & Friese, 2010; Crotty, 2010; Lewis, 1976; Nathaniel, 2011). Pragmatism was one of three main influences on Mead's perspective of symbolic interactionism (Charon, 2007). The other two main influences were the work of Charles Darwin, also influential on Dewey's thinking (Lewis, 1976), and behaviourism. Darwin, a naturalist, believed we must try to understand the world we live in without resorting to a supernatural explanation. To Darwin, evolution of animals was a passive process with changes in the environment and heredity together influencing changes in the animal kingdom. Mead accepted this idea up until when the human was formed. Once speech and the ability to reason arose in nature, the human individual was no longer passive. Instead the individual was able to learn about, understand, and act on its environment. Mead was interested in the human being and society, so through Darwinism Mead came to see everything about the individual as process rather than being stable and fixed. The individual was dynamic, "*never becoming anything but always in a state of becoming*" (Charon, 2007, p. 34). Instead of being socialised, an individual was always in the process of being socialised. Darwin's ideas, the theory of evolution, and the ideas of pragmatism, combined to form the basis of Mead's ideas (Charon, 2007).

Mead agreed that individuals must be understood by what they do rather than who they are. Although this is a behaviourist stance, Mead also believed that without an understanding of mind, symbols, and self, human behaviour could not be understood for what it was. This meant he had a different approach to other behaviourists, which resulted in him calling himself a 'social behaviourist' (Charon, 2007; Lewis, 1976) as he believed that in human social behaviour there was always an interpretation of what we do and how we make sense of what others do. From pragmatism, Darwin, and behaviourism, Mead developed a perspective that regarded the individual to be an active, thinking, creative, self-directing, dynamic being, whose ability to use symbols defined and altered the environment (Charon, 2007).

3.3.2 Symbolic interactionism

Mead (1934) is credited for first laying the foundations of the symbolic interactionalist approach at the Chicago School of Sociology between 1920 and 1950, a school whose focus was on the origin and development of meaning (Crotty, 2010). However it is

Lewis's (1976) view that Charles A. Ellwood, a former student of Dewey and former teacher of Mead at the Chicago School of Sociology, may instead be the founder of symbolic interactionism. It is from Dewey's psychology course that Ellwood developed ideas around social theory containing subjective concepts due to society being unable to be interpreted in objective terms (Lewis, 1976). Mead influenced Herbert Blumer (1969), who later redefined Mead's approach. According to Blumer, symbolic interactionism is based on three assumptions or premises, with the main idea being that human society consists of people engaged in action. The first of these premises is that human beings act toward things on the basis of the meanings that things have for them. Blumer believed that if researchers wished to understand people's actions, they needed to see their objects as they saw them. For example, a health professional may visit a woman in her sparsely furnished home, and make the woman feel inadequate by suggesting that having to sit on a kitchen chair in the lounge because there is no sofa or lounge chairs is unsatisfactory when she visits. Secondly, that the meaning of such things is derived from, or arises out of, the social interaction that an individual has with other people. In the above scenario, the woman, now pregnant, may not be keen on having a community LMC midwife visit her in her home due to the previous negative experience with the health professional, so chooses instead to visit the midwife in her clinic for all her antenatal care. Thirdly, these meanings are handled in and modified through an interpretive process used by the individual in dealing with the things which are encountered (Blumer, 1969). Continuing the scenario, postnatally the woman and her baby do well, but the woman is not home each time the midwife has organised to visit as she is not sure if the midwife will have the same response to her sparsely furnished home as the last health professional who visited. As a consequence of being unable to see the woman and her new baby, the midwife becomes concerned about their welfare. She notifies a child health provider who begins to make unannounced visits to the woman's home to try and make contact with the woman and her baby. The woman does not answer the door to the stranger who keeps arriving unannounced on her doorstep. Feeling harassed and concerned that her baby may be uplifted, the woman moves away. The use of 'meanings', according to Blumer (1969), and as seen through the above scenario, occurs through an ongoing process of interpretation of experiences and action.

Charon (2011) summarised these points; to understand human action we must focus on social interaction, human thinking, interpretation of a situation, the present, and the active nature of person. Mead believed every person was a social construction,

and that "*we come to be persons in and out of interaction with our society*" (Crotty, 2010, p. 62). As the individual and the world around the individual are socially constructed, he/she is ever changing through processes of social interaction. Therefore, individuals and their actions cannot be understood outside of their social context (Hutchison, 1993).

To gain an understanding of what is happening in a situation, the researcher needs to look at the interactions that take place between individuals to discover the basic social and structural processes at both the symbolic and interactional levels (Wuest, 1995). To be able to gain an understanding of a particular group of people, how they think, act, their perceptions, attitudes and values, Crotty (2010) argued, we have to see ourselves as social objects and adopt the standpoint of others. Therefore, symbolic interactionism can be described as the putting of oneself in the place of the other to be able to gain an understanding of a particular group of people (Crotty, 2010). This role taking is both an interaction and a symbolic interaction as it is only possible because of the significant symbols such as language that humans share and through which they communicate (Crotty, 2010), and which, therefore, enables the symbolic interactionist to study behaviour on both an interactional level and a symbolic level. People sharing common circumstances experience shared meanings and behaviours which are not necessarily articulated. This is resolved by identifying the basic social process (Hutchinson, 1993). Symbolic interactionism "*is an approach to understanding and explaining society and the human world*" (Crotty, 2010, p. 3) arising from a constructionist approach to the theory of knowledge. The researcher using grounded theory is interested in social processes to explain or interpret how action and meaning are constructed (Charmaz, 1990, 2002); how reality is constructed or maintained. Grounded theory treats data as the representational material of a reality that is in the process of construction (Strübing, 2007). This is consistent with symbolic interactionism (Bowers, 1988; Charmaz, 2002).

Blumer became a strong influence on Strauss, while Paul Lazarsfeld's work on qualitative analysis using research strategies similar to those used in grounded theory was an early influence on Glaser (Nathaniel, 2011). Lazarsfeld credited James and Dewey who, like himself, were also influenced by Peirce, with pragmatic ideas about the scientific method and behaviour (Nathaniel, 2011). In addition, Peirce may have influenced another mentor of Glaser, Robert Merton. While Peirce wrote about statistics as the study of chance, Merton was interested in the use of statistics as a foundation of social research (Nathaniel, 2011). Peirce believed that using signs or symbols was

necessary to enable understanding of the world and communication between people. Peirce's use of symbols recognised the importance of each person's interpretation. This is consistent with classic grounded theory and, according to Nathaniel (2011), is the small portion of Peirce's philosophy that would lead to the development of symbolic interactionist theories. Nathaniel (2011) surmised therefore that using Peirce's ideas can serve as basic philosophical assumptions of the classic grounded theory method.

Almost 40 years after grounded theory was initially developed, Glaser wrote that symbolic interactionism was being overused, was merely a theoretical code, and was not essential to grounded theory (Stern, 2010). Charmaz (2009) appeared to agree with this, contending that grounded theorists can use various theoretical starting points to open enquiry, just one of which is symbolic interactionism. In her view, although symbolic interactionism and grounded theory work well together, few grounded theorists subscribe strictly to a symbolic interactionist approach, instead drawing on a range of theories including symbolic interactionism to aid analysis. Stern, a maternity nurse (2010), agreed with this stance, stating that while symbolic interactionism cannot be ignored in her profession, it may not be the most important thing happening in the data. It may be just one part of the mix (Stern, 2010).

3.3.3 Constructionist verses constructivist approaches

While symbolic interactionism arises from a constructionist approach to the theory of knowledge (Crotty, 2010), 'constructionism' and 'constructivism' are used interchangeably by some researchers, including Charmaz (2008a, 2008b, 2009). Thus, explicating clear differences between the two approaches can be difficult at times, but there are differences.

3.3.3.1 Constructivist approach

Charmaz (2009) defined a constructivist grounded theory as being a contemporary revision of Glaser and Strauss's (1967) classic grounded theory. The constructivist version of grounded theory encompasses the methodological developments of the last 50 years in qualitative research, taking a different position towards the research process (Charmaz & Bryant, 2011). A constructivist grounded theorist seeks to define statements that interpret how participants construct their realities, aiming to include multiple perspectives of the participants' interpretation of their experience (Charmaz, 2000). When using the constructivist version, research participants and the researcher both construct and interpret their reality, and the resultant theory is based on their interpretation of that reality. Researchers have theoretical perspectives and assumptions

that they bring to the research process (Bryant & Charmaz, 2010; Charmaz, 2008c, 2009; Kim et al., 2015). Charmaz (2014a) believed researchers using a constructivist approach must examine how their preconceptions may shape data analysis and the facts they identify, rather than considering themselves a neutral observer and value-free expert. This approach views data analysis as a construction that locates the data in time, place, culture, context, and reflects the researcher's thinking (Charmaz, 2002). So in constructivist grounded theory the researcher is located within the research rather than remaining a neutral observer sitting outside, separated from the research, as in earlier research using grounded theory (Charmaz, 2011; Charmaz & Bryant, 2011). While understanding is enhanced by taking the role of the other, researchers need to remain aware of the particular lens they bring to the research based on their knowledge and/or experience in the area, and work to keep that lens from drowning out the participants' voices. Charmaz (2009, 2014a) chose the term 'constructivist' to acknowledge the researcher's subjectivity and involvement in the construction and interpretation of the data. In Charmaz's view, researchers and their life experiences cannot be separated from their research, or be objective preconceptions. Scrutiny of life experiences and objective preconceptions was required through reflexivity about their actions and decisions (Charmaz, 2002, 2008b, 2008d, 2011).

At this point in her explanation Charmaz's definition of constructivist grounded theory becomes gray, as she also stated that researchers demonstrating reflexivity–having to think through what they are doing and how and why, including their preconceptions and assumptions–is part of the constructionist research process (Charmaz, 2002, 2008b, 2011). Research findings are co-constructed between the researcher and the participants reflecting their experiences and interactions (Charmaz, 1990, 2002). Findings are also the researcher's construction from where he/she stands, of the participants' constructions (Charmaz, 1990, 2006, 2008b; Higginbottom & Lauridsen, 2014). Birks and Mills (2015) defined reflexivity as an active process researchers undertake of systematically developing insight into their work to guide their further actions, to assure the quality of their work. Researchers constantly subjectively interpret the data based on their "*perspectives, privileges, positions, interactions, and geographical locations*" (Charmaz, 2009, p. 130).

3.3.3.2 Constructionist approach

The constructionist approach is based on the belief that people interpret their world by constructing meaning or truth/understanding of knowledge, through their engagement with their world and interaction with other people and objects in the world. Thus,

different people may construct meaning about the same thing in different ways (Bryant & Charmaz, 2010; Crotty, 2010). "*No object can be adequately described in isolation from the conscious being experiencing it, nor can any experience be adequately described in isolation from its object*" (Crotty, 2010, p. 45). Social constructionism views the participant's actions as constructed, but not the researcher's (Charmaz, 2009). Having stated that her theory is constructivist grounded theory, Charmaz (1990, 2008b) explicated a social constructionist approach as encouraging innovation, and lists the tenets of the form of constructionism she advocates. One tenet includes examining the researcher's constructions in an ongoing reflective process both prior to entering, and during, the study.

Some of Charmaz's work (1990, 2008b) shows her using the term 'constructionism' where in other works she uses 'constructivism' to discuss the same elements. She acknowledges this stating she has used the term 'constructivist' grounded theory in the past to distinguish it from objectivism (Charmaz, 2008b). For example, constructionists assume that the researcher constructs the data, rather than the theory emerging from it, with the participants' views integral to the analysis and how it is presented (Charmaz, 2008b). The constructivist grounded theorist ensures that his/her interpretations of the phenomena under study resonate, and are validated, with participants (McCallin et al., 2011). A constructivist approach necessitates having a relationship with respondents in which they can cast their stories in their terms (Charmaz, 2000). It treats research as a construction which occurs under specific conditions, "*of which we may not be aware and which may not be of our choosing*" (Charmaz, 2014a, p. 13). In this way Charmaz ensured that participant voices were heard.

While being specific to the research participants, so not generalisable, the identified categories of the developed theory can be used to research similar questions in other fields (Charmaz, 2000). While the researcher has a socially constructed reality that influences the research, the research participant too has a socially constructed reality serving as data (Charmaz, 2009). Both researcher and participants contribute to the interaction and give it meaning (Charmaz, 2000, 2009). Lempert (2010) saw their relationship as a conceptual framework of 'give-and-take', where who will give, take, and what will be given and taken, constantly underpin the relationship between the researcher and participants. In responding to emergent questions and ideas for further development, constructionist grounded theorists construct the method of analysis as well as the analysis.

Charmaz (2008b, 2014a) acknowledged that constructivist grounded theory has many commonalities with social constructionism and social constructivism. This, in my view, makes an articulation of the differences between these approaches difficult.

3.3.3.3 Objectivist approach

The constructionist and constructivist approaches are different to other approaches. For example, the objectivist approach is based on the belief that meaning exists outside the need of any conscious thought and is just waiting, needing to be discovered (Crotty, 2010). Objectivists look for generalisations that explain and predict, believing that values and facts are separate (Charmaz, 2008b, 2009, 2011), and data speaks for itself (Charmaz, 2008b). The objectivist approach adheres closely to the positivist or realist approach of traditional science whereby the world can be described, analysed, explained, and predicted by systematically following a series of steps (Charmaz, 2000, 2008b); that experience and fact are separate and there is only one absolute truth (Charmaz, 2008a; Ward, Hoare, & Gott, 2015). "*Data are separate facts from the observer and, in the objectivist view, should be observed without preconception*" (Charmaz, 2009, p. 138). Glaser and Strauss (1967) advised the researcher was not part of the research, but instead should stay detached from it. This meant the researcher should come to the research with no recognition or acknowledgement of his/her prior knowledge or experience in the field under study, and with the ability to not let any of this influence one's interactions with the participants or data analysis. Whereas a constructivist, considers that participants construct their own truths from their own experience, therefore representing multiple realities.

It would seem that the objectivist stance would be almost impossible when researching within a familiar discipline, as remaining impartial means the opportunity for obtaining depth and breadth of rich data may be lost.

3.4 Grounded Theory Development

Sociologists, Glaser and Strauss (1967), were influenced by the philosophy arising from their studies, moving away from the positivist approach of generating knowledge through quantitative research as being the only valid form of inquiry, towards a qualitative approach in which the experiences of participants were the focus. These grounded theory originators were influenced by Glaser's quantitative and middle range theory education at Columbia University working with Paul Lazarsfeld and Robert Merton (Bryant & Charmaz, 2010). There were also strong links to symbolic interactionism, a result of Strauss's University of Chicago education with Herbert

Blumer and Robert Park. This is despite Glaser (1998) stating that grounded theory is aphilosophical. Strauss adopted the pragmatist philosophical tradition and the ethnographic research legacy from the University of Chicago (Bryant & Charmaz, 2010; Charmaz, 2002, 2008a, 2008b, 2008d, 2009, 2015). Glaser and Strauss worked together on their own method of theory generation, arising out of the research they did on death and dying, naming it 'grounded theory' (Bryant & Charmaz, 2010; Charmaz, 2008a, 2009, 2015; Glaser & Strauss, 1967). Grounded theory was a "*discovered, not invented*" (Glaser, 1998, p. 21) method of constant comparative analysis of data, based on the idea that theory can be developed from data obtained systematically in a social setting whereby data collection and theory generation are seen as two parts of the same process (Glaser & Strauss, 1967). Glaser and Strauss (1967) described constant comparative analysis as having four stages: 1) comparing incident with incident in each category, 2) integrating categories and their properties, 3) determining the boundaries of the theory, and 4) writing the theory. Researchers using this methodology were encouraged to remain theoretically sensitive to the data to ensure the resultant theory remained grounded in the participants' experience.

According to Charmaz (2014b), there was growing recognition internationally that research methodologies were developed within specific contexts under particular conditions; social, historical, situational, and disciplinary culture. During the 1950s and early 1960s in North America there was rapid growth in the use of quantitative research methods in the social sciences, resulting in their domination of university departments, journals, and funding agencies (Bryant & Charmaz, 2010; Charmaz, 2014b). This was to the detriment of earlier Chicago School traditions supporting qualitative inquiry through a long tradition of ethnographic fieldwork, interview, and case studies (Charmaz, 2008a, 2015). Positivist quantitative research was used for sociological studies during this time, as the view was that qualitative research could not meet the quantitative standards for validity, reliability, and replication; "*Positivistic beliefs in scientific logic, objectivity and truth supported and legitimised reducing qualities of human experience to quantifiable variables*" (Charmaz, 2008a, p. 83). Positivists assumed there was one scientific method of observation, experimentation, logic and evidence (Charmaz, 2015). Supporters of quantitative methodology in the USA in the 1960s diminished qualitative research considering it to be a preliminary exercise for refining quantitative tools. At the same time, the gap between constructing theory and conducting research grew (Bryant & Charmaz, 2010; Charmaz, 2008a, 2014b, 2015).

Glaser and Strauss' systematic method of qualitative analysis for theory construction built on the analytic procedures and research strategies used by their qualitative predecessors, taught through mentoring students, and immersion field experience, making them explicit from what had previously been an oral tradition (Charmaz, 2008a, 2015). Glaser and Strauss' method integrated research and theory, giving a rationale that legitimised conducting inductive qualitative research, showing that qualitative research proceeded differently, and could not be judged by quantitative research criteria. The theory's emphasis on using systematic techniques to study an external world is consistent with positivism, and its emphasis on how people construct actions, meaning, and intentions is consistent with interpretive traditions (Charmaz, 2008a, 2015). The idea of generating a new theory from data, rather than testing existing theory, saw grounded theory become popular (Birks & Mills, 2015). The blending of Glaser and Strauss's diverse philosophical positions into grounded theory, however, set the method on a course where branching off in different directions in later years was inevitable (Bryant & Charmaz, 2010; Charmaz, 2009; Charmaz & Bryant, 2011).

3.4.1 Variants of grounded theory

Since Glaser and Strauss (1967) wrote their original description of grounded theory, a number of researchers have developed variations of the methodology, including Strauss himself (Bowers & Schatzman, 2009; Charmaz, 2006, 2008d, 2014a, 2015; Charmaz & Bryant, 2011; Clarke, 2009; Corbin & Strauss, 2008; Strauss & Corbin, 1990; 1998). Strauss, since 1960 (Birks & Mills, 2015), had worked in the School of Nursing at the University of California (Birks & Mills, 2015; Bowers & Schatzman, 2009; Stern, 2010) with Schatzman before beginning to work closely with Glaser in the mid-1960s (Birks & Mills, 2015; Bowers & Schatzman, 2009). Glaser and Strauss published their grounded theory text '*The discovery of grounded theory*' in 1967. In 1978 Glaser published '*Theoretical sensitivity*' which presented information about how to use the Glaser and Strauss method emphasising emergence and theory construction. Their methodology highlighted conceptual development as being the result of a process of emergence from the data with the researcher remaining passive throughout (Charmaz & Bryant, 2011). In addition, researchers were encouraged to not engage with the literature (Glaser, 1978, 1998), develop research questions, or be guided by existing theories (Charmaz, 2011; Charmaz & Bryant, 2011).

While supporting the idea of using grounded theory as a method to show others what disciplines such as nursing (Stern, 2009) and other professions (Charmaz, 2008c)

actually did, Stern believed that unless they had studied with Glaser and Strauss and knew the language of sociology, nobody understood how to do grounded theory (Stern, 2010). This view was espoused by Charmaz (1990, 2008c) and McCallin et al. (2011). McCallin et al. expressed concern that methodological rigour with grounded theory had been undermined and unchallenged due to many new researchers not having had mentorship to make the methodology procedures more easily understood. This difficulty in understanding the method resulted in new researchers having to instead learn by trial and error to make the method usable, resulting in "*the associated sloppy scholarship*" (McCallin et al., 2011, p. 80), and variations in methodology.

Clarke and Friese (2010) refuted the view that difficulty understanding the method was resulting in less rigorous scholarship, believing that contemporary versions of grounded theory have enhanced the constructionist tendencies of Strauss. Glaser (1998) also did not support the view of Stern (2010) or McCallin et al (2011), stating how worldwide many researchers were using the grounded theory methodology in isolation, which worked well with the isolation requirements of the methodology. Researchers using grounded theory do have access to support available through their research supervisors experienced in grounded theory, the worldwide web, books, journal articles, seminars, and grounded theory communities, to assist them through the research process. In addition to the knowledge of grounded theory methodology that my research supervisors shared with me, I found attending two Masterclasses on grounded theory and writing qualitative research led by Kathy Charmaz (2017b) in Brisbane, Australia, in September 2017, to be very beneficial in progressing my understanding of constructivist grounded theory, as was attending meetings of the Grounded Theory Group at AUT. Talking together, challenging, and checking perceptions, along with reflective journaling, facilitated knowing the degree to which I, as researcher, had or had not entered the world of the other, in symbolic interactionalist terms, taking the role of the other. I was also able to read comments on the Grounded Theory Australia Facebook page, of which I became a member. Being a distance student, these aspects of working with grounded theory were important for my development.

Glaser and Strauss each developed their separate ideas about grounded theory (Birks & Mills, 2015; Charmaz & Bryant, 2011; Stern, 2009). While Glaser remained a supporter of the objectivist grounded theory approach, believing the researcher was not part of the research, he discarded the search for a basic social process as he saw this as forcing data into a preconceived framework (Charmaz, 2008b, 2008c, 2008d). Charmaz (2008b) agreed with this view, believing the search for a basic social process could

mislead the reasearcher or mask processes in the data. That the discovery of a basic social process was a requirement of grounded theory development was another misunderstanding about this methodology (McCallin et al., 2011). Glaser also dispensed with line-by-line coding as this resulted in disconnected codes, favouring a comparison of incident with incident (Charmaz, 2008d, 2009). Strauss moved towards grounded theory being guided by the tenents of symbolic interactionism and began working with a previous student, Juliet Corbin, on a constructionist approach - significantly revising grounded theory (Charmaz, 2000, 2008b, 2008d, 2015; Corbin & Strauss, 2008; Higginbottom & Lauridsen, 2014; Ward et al., 2015). By the early 1990s established Glaserian and Straussian grounded theory methodologies were being used (Higginbottom & Lauridsen, 2014). Strauss and Corbin added axial coding and use of the causal-conditional matrix as steps in the analytical process to be applied to the data to identify the salient structural conditions of the phenomenon being studied (Charmaz, 2008c, 2008d, 2015; Clarke, 2009; Corbin & Strauss, 2008; Strauss & Corbin, 1990, 1998), rather than steps emerging from data analysis (Charmaz, 2015). These were an alternative to Glaser's theoretical codes which he introduced in 1978 (Charmaz, 2008c).

One criticism of Strauss and Corbin's (1990) work is that the guidelines they offer are prescriptive and instructional rather than emergent and interactive. This risks the researcher forcing the developing theory to fit into the guidelines, rather than the theory being identified from data analysis (Charmaz, 2000; 2008b, 2008d), resulting in a theory leaning towards objectivist rather than the constructionist approach, and not representative of the participant's experience (Charmaz, 2008b). In Glaser's view, the model was too forceful as it pushed the data into preconceived categories, and avoided his families of theoretical codes (Charmaz, 2006, 2008d; Glaser, 1978, 1992, 1998). Additionally, in Charmaz' (1990, 2008b) view, Strauss and Corbin's (1990, 1998; Corbin & Strauss, 2008) method also diluted the social constructionist elements.

Other students of Glaser and Strauss had also started to look at grounded theory through different theoretical lenses. This led to 'second generation' schools of grounded theory, for example, Leonard Schatzman's dimensional analysis (Bowers & Schatzman, 2009; Schatzman, 1991), and Adele Clarke's situational analysis (Clarke, 2009; Clarke & Friese, 2010; Higginbottom & Lauridsen, 2014). Charmaz saw grounded theory as an umbrella covering several different variations and ways to think about data; a constellation of methods, by which each version shares much in common, but differed on foundational assumptions that shape how studies are undertaken (Charmaz, 2008c, 2009, 2014a). The position of the researcher, for example, while not considered in

Glaser and Strauss's grounded theory development (Lempert, 2010) is, as previously discussed, fundamental to Charmaz's constructivist grounded theory.

Consequent to methodological variation of grounded theory, there are now differing viewpoints on how data gathered for grounded theory research should be examined; though all agree with using constant comparative analysis. Stern (2009) has stated that while it is fine to have variations of grounded theory, it is important to understand the original concepts, of which the most vital may be constant comparative analysis. This is supported by Timonen, Foley, and Conlon's (2018) work which outlined the core principles of current grounded theory approaches. While the aim of data analysis in each version remains the same–to discover the core category (or core variable or central process)–the researcher using grounded theory needs to remain congruent with its main elements.

While I was keen to use symbolic interactionism to inform the proposed research, I was more familiar with the methodology of Glaser and Strauss (1967) having used it when undertaking research for a MA (Midwifery) degree. Consideration was also given to utilising the viewpoint of Corbin and Strauss (2008; Strauss & Corbin, 1990, 1998) or Charmaz (2006, 2014a) for data analysis. Both these approaches are situated within the constructionist paradigm and underpinned by symbolic interactionism, which aligned with the topic being explored in this study. Strauss and Corbin's viewpoint was discarded as, after some reading of their method, I interpreted use of the conditional matrix and axial coding as potentially forcing data to fit, rather than allowing data to emerge from analysis. Schatzman (Bowers & Schatzman, 2009, Schatzman, 1991) was also considered briefly. Although Schatzman's students and their students have published well (Clarke, 2009), Schatzman (1991) has not published widely and I did not want to have to rely primarily on secondary interpretations of his methodology, so this variation was discarded. In my reading I came across a chapter Charmaz (2011) had written on using grounded theory in social justice research. In Charmaz's view, while qualitative research attracts many researchers who hope that their studies will matter within their disciplines and the public arena, many of the studies, while addressing interesting populations, have not been taken further to reframe the studied phenomenon as a social justice issue asking questions about inequities and, therefore, advancing social justice enquiry. Social justice enquiry includes research into inequities, and barriers and access, and poverty. Charmaz (2017a) supported grounded theory methodology being used to advance social justice inquiry and to support social change through both practice and policy as it starts from a place of compassion for

participants. Using grounded theory to advance social justice enquiry supported my decision to use this methodology for my study.

The constructivist world view is common in nursing as it is important that nurses understand the subjective experience of each patient (Higginbottom & Lauridsen, 2014). As a consequence, Charmaz's grounded theory has been applied by many nurses in a variety of healthcare settings, often with the goal of understanding experiences and social behaviour and describing processes to enhance care (Higginbottom & Lauridsen, 2014). The same could be said about the constructivist world view being common in midwifery. However, although during my research I came across several midwifery studies using Glaser and Strauss (1967) or variants of grounded theory methodology (Borelli, Spiby, & Walsh, 2016; Brunstad & Hjälmhuit, 2014; Calvert, 2017; Curtis, Ball, & Kirkham, 2006; Griffiths, McAra-Couper, & Nayar, 2013; Lalor, Begley, & Galavan, 2008; Levy, 1999; Licqurish & Seibold, 2011; Meyer, Fran, Muntwyler, Fleming, & Pehlke-Milde, 2017; Parratt, 2004; Way, 2011; Wilkins, 2006), I only came across one midwifery and one nursing article using constructivist grounded theory (Giles, de Lacey, & Muir-Cochrane, 2016; Sheehan et al., 2010). I considered using Charmaz's constructivist grounded theory to identify processes involved in midwifery care, as it is imperative that midwives, as far as possible, understand the subjective experience as well as the context/conditions which impel or shift the actions of each woman to whom they provide care, if they are to enhance the care provided to, and received by, women and their families.

Charmaz (2000) considered that when developing a constructivist grounded theory, questions to participants aim to explore meaning–the meaning for the participant–so are subjective, rather than aiming at getting a truth, as with the objectivist approach. "*Through sharing the worlds of our subjects, we come to conjure an image of their constructions and of our own*" (Charmaz, 2000, p. 529). The interaction that takes place between individuals–in this study how women living in areas of high socioeconomic deprivation in New Zealand access and engage with midwives–is the focus of observation and interview in grounded theory research (Glaser & Strauss, 1967). What processes did they use? Were there common group patterns of behaviour? I wanted the voices of the women and midwife participants to explain to me how this was for them.

While I considered and discussed a choice of methodology (for example critical theory or phenomenology), I decided a grounded theory would provide an explanatory process which had the potential for change. I therefore chose grounded theory instead of

phenomenology or critical theory. I had used grounded theory methodology previously and liked the robustness it gave to research findings. I wanted to reveal the actual processes involved in how women living in areas of high socioeconomic deprivation in New Zealand accessed and engaged with midwives. When a process was identified the findings demonstrated where inequity existed and where the processes did not best meet the requirements of the participants.

Constructivist grounded theory ensures the participants' voices remain prominent in data collection and analysis through the interaction between the researcher and participant as they mutually construct data (Charmaz, 2014a). The theory I developed would be constructed through my interactions with both the woman and midwife participants, and represent their interpretation of their experiences by identifying the group patterns of behaviour exhibited. There were a number of considerations which influenced my decision to use Charmaz. The first was that I could not separate myself from the knowledge and experience I had gained throughout a long career in midwifery and would either openly or subtly bring aspects of this with me to each participant interview. Second, it was important to me that the participant voices in my research were clearly heard through the conceptual explanation that would be developed. I was aiming to explore, then explain, the group patterns of behaviour women living in areas of high socioeconomic deprivation in New Zealand used to access and engage with midwives, which made Charmaz's (2006, 2008a, 2008b, 2009, 2014a, 2014b) constructivist grounded theory an appropriate methodology to use in the study.

3.5 Following the Methodology

In a grounded theory research study, the nature and direction of the study is developed from the data that are collected. Grounded theory starts with an area of interest, with a researcher who is open to following the direction the data take to enable new perspectives on midwifery care to be developed (Roberts, 2008).

3.5.1 Field notes and memo writing

Throughout the research, the researcher writes field notes and memos noting events, actions and interactions, and as an aid to trigger thinking processes (Holloway & Wheeler, 1996; Stern, 2010), exploring ideas and making comparisons between categories, then framing them into a theoretical statement as memo-writing becomes more analytic (Bowers, 1988; Charmaz, 1990, 2002, 2008a, 2015). Writing memos is the process used by researchers to keep track of what they think about the data (Stern,

2010), "*capturing ideas in process and in progress*" (Charmaz, 2008c, p. 166), ensuring the analysis remains grounded (Charmaz, 2008d). The narrative of memo writing conceptualises the data, and is the methodological link, through which data transforms into theory (Lempert, 2010).

Charmaz (2002, 2008c, 2015) offered guidelines for memo writing;

1. Title each memo for easy sorting and storage.
2. Write memos throughout the entire research process.
3. Define the code or category by the analytic properties found in the data.
4. Spell out and detail processes subsumed by the codes or categories.
5. Delineate the conditions under which the code or category emerges, is maintained, and changes.
6. Compare the code or category with other codes and categories noting the relationships.
7. In the memo include the data from which the code or category is derived.
8. Note the consequences of the code or category.
9. Note gaps in the data/emerging analysis and conjectures around these, thus making methodological decisions to check through further research.

While methodological memos are written which capture the direction the researcher plans to take when conducting theoretical sampling, Glaser (1978) saw the writing of theoretical memos as the core stage in the process of generating theory, stating that a researcher is not doing grounded theory if this stage is skipped. I wrote field notes during and immediately after each interview and wrote memos regularly until the final thesis was complete.

3.5.2 Interview guides

Researchers using grounded theory need to decide whether to use interview guides to provide some structure to interviews. Glaser (1992) was not supportive of using methodological tools such as interview guides, believing this may force preconceived ideas onto the data. However Charmaz (2008a, 2015) disagreed, seeing constructing an interview guide with open-ended questions as helpful for those new to using grounded theory methodology, to assist pacing of topics and questions, avoid loaded and leading questions, and give both the researcher and participants direction. A detailed explanation about how interview guides were developed and utilised in this study is presented in Chapter 4.

3.5.3 Transcribing interviews

Likewise, decisions need to be made about whether to transcribe interviews verbatim or alternatively make notes. Charmaz (2015) was very clear about the benefits for the researcher of transcribing his/her own audio recorded interviews and writing their own field notes:

> *From the very start, transcribe your audiotapes yourself or write your own field notes rather than, say, dictating them to someone else. Studying your data prompts you to learn nuances of our research participants' language and meanings. Subsequently, you learn to define the directions where your data can take you. Through studying interview audiotapes, for example, you attend closely to your respondents' feelings and views. They will live in your mind as you listen carefully over and over to what they were saying.* (p. 65)

Glaser (1998) disagreed with transcribing interviews, believing that this wasted time and encouraged researchers to become lost in the data. Stern (2009, 2010), a student of both Glaser and Strauss, believed that data accuracy is overrated. It is her view that as a grounded theory is generated from a variety of study data, the focus should be the meaning of what is happening in the data, rather than word accuracy (Stern, 2009, 2010). Writing field notes while maintaining eye contact with participants, followed by transcribing the interview as soon as possible afterwards, were strategies Stern used, because as she typed she could see and feel the context of the interview. Not recording each exact word did not damage the final study outcome. Stern's concern is that researchers are placing more emphasis on the accuracy of the collected data rather than concentrating on the developing theory, risking developing a rich description rather than a theoretical one (Stern, 2010), an opinion supported by McCallin et al. (2011). Charmaz (2008a) disagreed, believing studying interview transcripts gives new ideas and codes to work with, as well as ensuring the researcher does not miss processes, subtle meanings, or force data into categories prematurely. Transcribing of interviews in this study is discussed in Chapter 4.

3.5.4 Data analysis

In a grounded theory research study, data collection and data analysis are performed concurrently using a method of constant comparative analysis (Charmaz, 2008a, 2008d, 2011, 2015; Glaser & Strauss, 1967; Holton, 2010; Roberts, 2008), so that the nature and direction of the study is developed from the data as they are collected. Data are collected, and the transcribed interviews are analysed line by line, along with the written memos and field notes, searching for patterns, processes, and one or more central themes which would lead to the development of a theory from the data to answer the

question 'what is happening here?' (Charmaz, 2008a, 2015; Glaser & Strauss, 1967; Holton, 2010); 'happening' being the central problem addressed in the research (Charmaz, 2002). Constant comparative analysis continues until the resulting grounded theory is complete (Birks & Mills, 2015).

Coding is the link between collecting the data and developing a theory to explain the data and consists of at least two phases; initial and focused (Charmaz, 2002, 2008a, 2008d). Both initial and focused coding are emerging processes consistent with grounded theory (Charmaz, 2002, 2008c, 2014a). According to Charmaz (2008d), initial codes should be active, specific, and short to aid making comparisons between data and codes. In this way data are separated into categories enabling processes to be seen, to make connections between codes, and the discovery of ideas on which to build (Charmaz, 2008c, 2014a, 2015). Focused codes are more conceptual than initial codes. Polit and Hungler (1995) stated that "*categories elicited from the data are constantly compared with data obtained earlier in the data collection so that commonalities and variations can be determined*" (p. 530). Diversity must be explained and integrated to enrich an emerging theory (Wuest, 1995). Theoretical categories develop as the focused codes are raised from a descriptive to theoretical level, memoing throughout. How coding was carried out for the current study is discussed in Chapter 4.

At times Charmaz (2014a) uses an additional coding method–theoretical coding–to help specify relationships between categories developed through focused coding. Theoretical codes were first introduced by Glaser (1978). These codes aided looking at a variable in an abstract way (Charmaz, 2008c; Stern, 2010). Glaser introduced theoretical coding initially to aid conceptual analysis of data believing that they were emergent. His 18 coding families were a guide for the researcher to use with theoretical sensitivity; to systematically relate categories to generate theory which consider the data, and work with it (Glaser). Glaser advocated using theoretical coding once tentative categories were well advanced. Whether theoretical coding is applied or emergent remains an area requiring further clarity. Birks and Mills (2015) defined theoretical sensitivity as recognising and extracting from data the elements that have relevance to the emerging theory. While Charmaz recommended using theoretical coding when the analysis indicates it, she cautioned against imposing a forced framework upon it. "*If you use theoretical codes, let them breathe through the analysis, not be applied to it*" (Charmaz, 2014a, p. 155).

3.5.5 Recruitment, purposeful and theoretical sampling

Recruitment in a grounded theory study is an ongoing process throughout data analysis. Participant selection (or sampling) is responsive to the data and, therefore, cannot be established before the research begins (Corbin & Strauss, 2008). Hence, not all participants were recruited at the beginning of my study.

Purposeful sampling is used in research to select participants who have the knowledge or experience to inform the study well (McNeill, 2011). Theoretical sampling is then used for collecting more data to develop the theoretical categories (Birks & Mills, 2015; Charmaz, 2002, 2008a, 2008c, 2015; Holton, 2010; Stern, 2010). Theory construction is the objective of theoretical sampling (Charmaz, 2011). As the study progressed, theoretical sampling was used to aid decision making on where to go next to develop a theoretical category in order to advance the emerging theory (Birks & Mills, 2015; Charmaz, 2002, 2008a, 2008c, 2015; Holton, 2010; Stern, 2010). Theoretical sampling is used to refine properties of tentative categories in the research, as opposed to ensuring participant representativeness; an erroneous interpretation of grounded theory (Charmaz, 1990, 2002, 2011; Charmaz & Bryant, 2011). Charmaz stated (1990, 2002, 2008a) that theoretical sampling should not happen until later in the research when significant data has emerged, relevant issues are defined, so not until after the initial data collection and analysis (Charmaz, 2011) when the researcher has emergent tentative categories to develop or refine (Charmaz, 2008c, 2011). Memo writing is an important part of this process as the researcher makes decisions on who will provide a rich source of data to fill analytical requirements, and provides the researcher with an audit trail of decision making used during theory development (Birks & Mills, 2015). Categories are defined, their properties noted, variation discovered, and gaps between categories identified, and ways to fill the gaps found (Charmaz, 2008a, 2015). How recruitment and purposeful and theoretical sampling occurred in this study is addressed in Chapter 4.

3.5.6 Theoretical sensitivity

Once categories have been identified from data analysis, literature is reviewed to access other material which may support these categories (Charmaz, 1990, 2008a, 2011) to develop theoretical sensitivity (Charmaz, 2014), to place the research findings into the context of current knowledge, and to complete and enrich the research (Stern, 2010). How the subsequent literature review was carried out was discussed in Chapter 2.

3.5.7 Theoretical saturation

Normally the criteria for judging when to stop theoretical sampling the participant groups relevant to a category, is the category's theoretical saturation (Glaser & Strauss, 1967). This is when no new ideas on the properties of a theoretical category emerge from analysis of the data; when it can be stated that theoretical saturation of categories has occurred (Charmaz, 2008a, 2008c, 2008d, 2015; Charmaz & Bryant, 2011; Holton, 2010; Stern, 2010). "*Saturation means that no additional data are being found whereby the [researcher] can develop properties of the category*" (Glaser & Strauss, 1967, p. 61). Glaser (1978) further stated that "*when one is in the field and feels he has saturated a category in one situation, he probably has*" (p. 53). Corbin and Strauss (2008) cautioned researchers against concluding a study too soon saying they have saturated their categories when what they mean instead "*is that 'they' are saturated with the data collection process*" (p. 149). As can be seen there is some debate about the meaning of saturation amongst researchers with some assuming that categories are saturated when they may not be. According to Stern (2010) the sample of a grounded theory study needs to be representative. If huge amounts of data are collected researchers risk either becoming overwhelmed with the amount of data and lose sight of the processes that are occurring, or do not analyse it. In Stern's view, 20 to 30 participant interviews is generally sufficient to saturate emerging categories (Charmaz, 2011). Charmaz (2008b, 2008c) contended that claims about reaching data saturation are proportional to the thoroughness of the data collection and, while often claimed, is scarcely practiced. In her view saturation tends to be an elastic category that gets bigger or smaller to suit the researcher's definition rather than any consensus (Charmaz, 2002). In this study recruitment of participants continued until no new ideas emerged from data analysis.

3.5.8 The debate over identification of a core category

The aim of data analysis in Glaser and Strauss' original grounded theory was to discover the core category (or core variable or central process); the major category linking all others. The core category was the basic social-psychological process involved in the research and demonstrated the ideas that were most significant to the participants (Glaser, 1978). The core category is what, in the participant's view, was the major concern or problem in the setting; what summed up the pattern of behaviour. In other words, the substance of 'what is going on' in the data; what it was that brought about process and change (Glaser, 1978). The basic social-psychological process is one type of core category which may or may not be present. It is processual, having two or more clear emergent stages which involve change and occur over time (Glaser, 1978).

The stages should differentiate and account for variations (Glaser, 1978) in how participants encountering challenges or problems interpret and select strategies which they consider to seem the most effective for them. Charmaz, however, did not agree that identification of a core category is a necessary requirement of a constructivist grounded theory. While a core category may occasionally be identified, she questioned whether it should be considered the only important one in the coded data (Charmaz, 2014a). Holton (2010) refuted Charmaz's claim, stating that if a researcher is undertaking classic grounded theory research, then the emergence of a core category is a necessary requirement.

3.5.9 Substantive or formal theory

Glaser and Strauss (1967) stated that two types of theory could be produced–substantive or formal. Substantive theory is specific to the substantive area upon which the research is based (Lempert, 2010); whereas formal theory is not specific to group or place, instead applying to a wide range of concerns and problems across situational contexts (Strauss & Corbin 1998). The aim of the present study was to develop a substantive theory which described how women living in areas of high socioeconomic deprivation in New Zealand accessed and engaged with midwives.

While following the above guidelines for data collection and theory generation, Charmaz (2014a) emphasised using these flexibly, rather than as a set of strict methodological rules to be followed. Unlike Glaser and Strauss (1967), who talked about discovering theory as emerging from the data, Charmaz's view is that we are part of the world we are researching, the data collected, and the resulting analysis. Our grounded theories are, therefore, constructed through our past and present perspectives, research experience, and interactions with people, so are an interpretive portrayal of the world we are researching, not an exact picture of it. They are a construction of reality (Charmaz, 2014a).

3.6 Evaluating the Grounded Theory

Study rigor is important to ensure that clinical practice, in this case, midwifery practice, is safe, effective, and based on the best available research evidence (Giles, de Lacey, & Mure-Cochrane, 2016). Rigor and transferability of findings is strengthened when core grounded theory methods and procedures are systematically applied. This chapter has discussed how grounded theory methodology was followed for the study, demonstrating the rigor utilised. Chapter 4 details the research method. Being explicit about how the methodology was employed to construct my theory strengthens the claims I can make of

the knowledge generated from this research (Giles, de Lacey, & Mure-Cochrane, 2016). The substantive theory, 'Working through complexity' was identified through data analysis as the major process women living in areas of high socioeconomic deprivation in New Zealand undertook as they accessed and engaged with midwives. To be credible, the developed theory "*must make sense*" and "*it must be clear that the developed theory comes from data rather than being forced to fit an existing theoretical framework*" (Stern, 2010, p. 114). The theory must also have explanatory power, linkages between categories, and specificity (Holloway & Wheeler, 1996), meaning the categories must be shown to be grounded in the data. Demonstrating links between categories provide the developed theory with explanatory power; meaning the theory should explain variations in the data and identify changes in the process being studied. The theoretical ideas that emerge from the theory should be significant if they are to help in understanding the phenomenon under study (Holloway & Wheeler, 1996). The four findings chapters (5-8) will demonstrate the care taken to ensure the initial codes, focused codes, and theoretical categories were all grounded in the data. Discussion of the linkages between categories are threaded throughout these chapters, as are the conditions and consequences of the processes taking place.

Glaser and Strauss (1967) stated that to be credible the theory that is developed should have fit (validity), understanding, generality (transferability), and control. A theory has validity when the categories have a close fit with the data and the theory is acknowledged as representing the reality of all those involved in the study area; the theory is understood by them and, because of its relevance to them, has credibility (Cluett & Bluff, 2000). As will be discussed in Chapter 4, as the theoretical categories emerged from the data and became increasingly dense, member checking was undertaken. This meant the theoretical categories were returned to several women and midwife participants, as well as discussed with other midwives and a group of student midwives, to see if they fitted their reality. Member checking confirmed the theory represented the reality of those who lived or worked in the study areas.

The theory should have generality, meaning it should be able to be applied in other situations where the studied phenomenon can be found. When study results were discussed with participants, colleagues, and presented at public fora, there was agreement that the processes presented with these findings were transferrable.

The theory should also offer control, meaning "*it must allow the user partial control over the structure and process of daily situations as they change through time*" (Glaser & Strauss, 1967, p. 237). Cluett and Bluff (2000) explained control further as

meaning that, in the case of this research, midwives should be able to use the theory, adjusting it to the current circumstances or in response to the effects or consequences it has on mothers and babies. An example of having control is the theory identifying the benefit to midwives working with women living in areas of high socioeconomic deprivation of working in or being associated with an integrated health service where clear pathways of referral, from the initial contact with the first primary health provider to confirm pregnancy, to accessing a midwife, are in place for women.

In addition to having 'fit', in '*Theoretical sensitivity*' Glaser (1978, 1998) espoused the need for the theory to have workability, relevance, and modifiability. 'Workability' means the concepts and the way they are related sufficiently account for how the matter of concern for the participants is resolved; 'relevance' because it deals with the main concerns of the participants makes the research important; and 'modifiability' means the theory being able to be modified when compared to new data (Glaser, 1998). My theory demonstrates how working through complexity was the major process undertaken as this group of women accessed and engaged with midwives. The theory has workability, as the three theoretical categories explain the processes undertaken, and relevance, as these categories were identified from data analysis, so are firmly grounded in it. Depending on the conditions operating at the time, women modified the process they undertook, for example, when prioritising competing demands around attending for antenatal care or a child's school function.

According to Charmaz (2009), "*Constructivists aim for an interpretive understanding of the empirical phenomena in a theory that has credibility, originality, resonance, usefulness, related to its historical moment*" (p. 139). Codes and categories were constantly compared with each other during coding (Charmaz, 2014a; Glaser & Strauss, 1967), demonstrating credibility. Recruitment of participants continued until theoretical saturation of the data occurred, when no new ideas emerged from data analysis, again demonstrating credibility. Member checking confirmed the developed theory represented the processes involved when working with this group of women, resonating with them, so had credibility and resonance. Prior to this study taking place little was known about how women living in areas of high socioeconomic deprivation accessed and engaged with midwives. This theory is my own work and was developed out of analysis of the study participants' words, so is original. It offers new insights into the area under study through identifying the processes involved. The recommendations for practice, research, education, and maternity system development, discussed in Chapter 9, developed from the data obtained from this research study, demonstrating its

application, so therefore its usefulness to midwives and others involved in providing pregnancy care to women living in these areas.

3.7 Conclusion

This chapter has presented the methodology used for the current study. Following on from an overview of grounded theory methodology, pragmatism and symbolic interactionism have been explained as the two theoretical perspectives underpinning grounded theory, along with consideration of constructionist and constructivist approaches. This was followed by a discussion on the development of grounded theory, and the variant of grounded theory used in this study–Kathy Charmaz's constructivist grounded theory (2000, 2006, 2008a, 2008b, 2009, 2014a, 2014b). How the methodology for this research study was followed and the criteria against which the theory will be evaluated was discussed. Chapter 4 discusses the research method.

Chapter 4: Research Methods

4.1 Introduction

Methods are the practical procedures used to generate and analyse data (Birks & Mills, 2015). This chapter explains the research methods used in the study and builds on Chapter 3 showing how the grounded theory methodology utilised for this research was put into practice for data collection and data analysis. Ethical considerations are introduced first, followed by the positioning of myself as researcher. Data collection methods are then presented, including participant recruitment, and purposeful and theoretical sampling, and data analysis. Throughout this chapter I use the first person for myself, as researcher, to acknowledge my active participation rather than being a neutral observer in the research study (Charmaz, 2014a).

Throughout the remainder of this thesis, when a woman participant is quoted the quote is in italics, followed by the woman's name, then 'W' e.g. *quote* (name W). When a midwife participant is quoted the same format is used, but 'MW' follows the midwife's name e.g. *quote* (name MW).

4.2 Ethical Considerations

Once the full research proposal was accepted by the Auckland University of Technology (AUT) Faculty of Health and Environmental Sciences Board in December 2013, and approved by the AUT University Postgraduate Board on 18 February 2014, ethics approval was sought from the Health and Disability Ethics Committee (HDEC) and the AUT Ethics Committee (AUTEC). I completed the HDEC form up until the initial assessment stated that the proposed study 'did not require HDEC review'. I then contacted the HDEC administrator by phone, who confirmed that as I would not be accessing women participants' health information to identify potential women participants, nor approaching women directly myself, and as participants could consent or not to participating in the study, HDEC review was not required. The Ethics Application was approved by the AUTEC on 5 September 2014 (Appendix A). At this point recruitment of midwife participants began.

The next step was presenting study information to local research contacts of the locality committees in the DHBs in each of the three areas the research was taking place, and requesting approval for recruitment advertisements in their facilities. While this was not an AUTEC requirement, and women would not be approached to be

participants on DHB premises nor be interviewed there, my supervisors and I considered it prudent that the DHBs were aware the research was taking place in their areas, and that it involved women who may birth in their facilities. We decided to await approval from the local DHBs research contacts before beginning to recruit women participants. The process required in each area differed slightly and took some time. During October and November 2014 approval was received from each of the three DHBs (Appendices B, C, & D). At this point recruitment for women participants began.

This study involved interviewing women participants who lived in vulnerable situations (i.e., areas of high socioeconomic deprivation), and midwives who worked with women in these areas. While ethical considerations are an important part of any research, from the beginning, when discussions about this potential study began to take place, my research supervisors and I took great care to ensure that all participants, particularly the women participants who live in vulnerable situations, were kept safe. Respect for the vulnerability of the participants was reflected in the design of the research study and how it was carried out. My two supervisors and I were therefore pleased to receive a commendation for the quality of the application and, in particular, for the amount of consultation undertaken.

4.2.1 Ethical considerations of perceived power imbalances

For this study, possible power imbalances in the professional, social, financial, or cultural relationship between the participants and I were considered. Some ethnic groups are over represented in the areas this study took place, specifically Māori and Pasifika people, as are people with English as a second language. I was aware of potential perceived power imbalances in the relationship between the women and midwife participants and myself due to my ethnicity, particularly if I was from a different ethnic group to participants, my role as a midwife and researcher, and the socioeconomic realities of the women participants' lives. To manage the potential for power imbalances between the participants and myself, and to mitigate any adverse effects that may arise from them, all participants were informed that they could bring a support person to their individual interviews if they wished. Each participant chose or was given a pseudonym to maintain confidentiality.

Throughout the study I ensured participant interviews were always at a time and place that was mutually convenient. Transcribed interviews were returned to participants to review and did not become data until returned to me. Procedures for storage of data ensured confidentiality. I considered participants' safety during the interviews, and had a plan in place should they experience any discomfort or

disturbance during or from them. Possible coercive influences in participant recruitment were also considered for this study. No potential participants were approached directly by me to take part.

4.2.2 Honouring Te Tiriti o Waitangi principles of partnership, participation, and protection

I had a responsibility to respect, support, and honour Te Tiriti principles of participation, protection, and partnership during all interactions with all participants. These principles guided all interactions between participants and myself throughout the duration of the research.

4.2.3 Consultation

As part of the ethics application preparation for this study, I had consulted with the AUT University Kawa Whakaruruhau Komiti (Cultural Safety Committee), Nga Mai (representing Māori midwives in New Zealand), and had planned to consult with the NZCOM Pasifika Midwives Group (representing Pasifika midwives in New Zealand). I had informed these groups about the study, inviting their advice about any features of the study they felt required addressing regarding the specific population they represented. Feedback following consultation with a representative from Nga Maia was positive about the topic with assistance offered and no alterations requested (Appendix E).

Feedback following consultation with a representative of the Pasifika Midwives Group indicated the group was, at that point, in a state of flux, and feedback was not possible. Thus, it was decided to arrange to meet formally with representatives of the group once the ethics application was approved. Although this did not occur, one of the thesis supervisors met with one of the leaders of the Pasifika Midwives Group to discuss the study. No alterations were requested. I also had a local Pasifika midwife who was a member of the Pasifika Midwives Group acting in an advisory role available to provide me with on-going cultural advice and support. This was also an attempt to address the gap in being unable to consult directly with the Pasifika Midwives Group. I discussed the study with her, and she was very encouraging and keen that the voices of Pasifika women were represented. As I had no involvement in which women would be approached by midwives to take part in the study, and therefore their ethnicity, this was not something I could control; however, I was hopeful that Pasifika women would be represented in the participant group. Feedback following consultation with the AUT University Kawa Whakaruruhau Komiti resulted in two requests for me to consider related to the design and practice of this research (Appendix F):

1. Initially the research question when preparing the proposal for this study was 'How do midwives access and engage with women living in areas of high socioeconomic deprivation in New Zealand?' The Komiti was concerned that this implied that the focus of the research question was on midwives, and that women were insufficiently represented. They requested that the voice of women participants be highlighted in the research question. Reflection and discussion with my two supervisors resulted in the decision to alter the research question to 'How do women living in areas of high socioeconomic deprivation in New Zealand access and engage with midwives?' The working title was altered to 'Women accessing and engaging with midwives in areas of high socioeconomic deprivation in New Zealand.' These alterations more accurately reflected the focus of the study.

2. The Komiti wanted me, as researcher, to emphasise purposefully recruiting Māori women as equal bicultural partners, and wished to ensure that at least 50% of participants were Māori in recognition of Te Tiriti o Waitangi and Māori women as equal bicultural partners.

This research targeted women living in areas of high socioeconomic deprivation in New Zealand, rather than of specific ethnicities, and midwives who worked with women living in these areas. It was unclear whether meeting the Komiti recommendation would be possible as, again, I had no involvement in which women midwives would approach to take part in the study and, therefore, their ethnicity. It was not something I could control. It was anticipated that the historical reticence of people from some ethnic groups to come forward as study participants may also have an impact, perhaps resulting in less Māori and Pasifika participants. Anecdotally I was told by several midwives that populations in specific metropolitan areas were over-researched, so was unsure if this would have an impact on participant recruitment. However, given that Māori and Pasifika people are overrepresented in these areas, I was hopeful that a proportion of women participants would be from Māori and Pasifika ethnic groups.

4.2.3.1 Ethnicity of women participants

At interview, when women participants were asked which ethnicity they identified as, three women participants stated Māori, another identified her first ethnicity as Māori with her second being Chinese. Another woman stated Māori as her first, Tongan as second, and Chinese as third. One woman identified her first ethnicity as New Zealand European and her second as Māori. Five women identified as Pasifika; including, three being Tongan, one being Samoan/Niuen, and one wishing to be recorded as a Pacific

Islander. With six of the 11 women identifying their first or second ethnicity as Māori, the Komiti recommendation was achieved.

One of the midwives identified as Māori, one as New Zealand European and Māori, seven as New Zealand European, and one as European Other. At the time of consultation the 2012 Midwifery Workforce Survey (MCNZ, 2012b) showed 8.1% of the midwifery workforce identified as Māori for their first, second, or third ethnicity; and 2.4% identified their first, second, or third ethnicity as Pasifika. At the time of writing this thesis, the latest Midwifery Workforce Survey (MCNZ, 2016) showed an increase to 9.4% of the midwifery workforce identifying as Māori for their first, second, or third ethnicity; and a decrease to 2.1% identifying their first, second, or third ethnicity as Pasifika. This is well below the representation of Māori and Pasifika in the general population at the 2013 census at 14.9% and 7.4% respectively (Statistics New Zealand, 2017). Recognition of this discrepancy and the need to increase the indigenous midwifery workforce is recognised in Australia (Sweet, 2010). Results for the latest census (2018) will not be available until March 2019 (Statistics New Zealand, 2018).

Having 20% of the midwife participants identifying their first or second ethnicity as Māori was above the MCNZ workforce statistics results. Sadly no Pasifika midwives were recruited. The ethnicity of study participants and how many women and midwife participants this applied to is summarised in Table 2.

Table 2: Ethnicity of study participants

Ethnicity	Woman participants	Midwife participants	Total
Māori (1st or 2nd ethnicity)	6 (54.5%)	2 (20%)	8 (38.1%)
Pasifika	5 (45.5%)	-	5 (23.8)
NZ European	-	7 (70%)	7 (33.3%)
European Other	-	1 (10%)	1 (4.8%)
Total	11 (100%)	10 (100%)	21 (100)

4.2.4 Cultural advice and support

I had a local Māori and a local Pasifika midwife available to act in advisory roles to provide me with ongoing cultural advice and support given that I was hopeful that

Māori and Pasifika women may be recruited to the study. There was also a local named midwife in each area the study was taking place to be my contact person for any research or communication issues. These midwives were well known and established in their local communities. In one area the Pasifika consultant was also the named midwife for the area.

In the three areas in which the study was taking place, the named midwife attempted to recruit woman participants through midwives working in midwifery group practices. In one city the named midwife arranged mutually convenient interviews times with women, and transported me to six women's homes for interviews. The named midwives displayed Advertisement for Midwives notices (Appendix G) in midwifery clinics, birthing units, and hospitals in their DHB areas to support recruitment of midwives into the study. They also acted as intermediaries, approaching women and community LMC midwives asking if they would consider participating in the study and offering them a Participant Information Sheet (Appendices H & I). One named midwife discussed the content of the Participant Information Sheet herself with women who were interested in taking part in the study, as she was concerned the written information would be too complex for women for whom English was not a first language. More details of these processes are given in section 4.4.1.

4.2.5 Keeping participants safe

Every effort was made to optimise each participant's relaxation prior to and during the interviews. However it could not be anticipated in advance whether participants would address distressing events. It was also possible that I may ask a question which caused them some level of discomfort or embarrassment. Interviewer skills such as informing the participant that she could decline to answer the question, offering to take a short break, or to stop the dictaphone recording, would enable this to be dealt with in a safe and appropriate way, facilitating safe passage for the participant.

In the event of any woman or midwife participant experiencing any discomfort or disturbance from the interview they could be referred to counselling support from the AUT Counselling Team (Appendix J). This service provided up to three free sessions in person or via phone. Alternatively women could be offered the contact details of the local NZCOM Resolutions Committee. Each committee consists of a consumer and a midwife member. Resolutions Committees are available in each NZCOM region of New Zealand. This is a free, low level resolutions service where women have an opportunity to resolve concerns or questions they have about midwifery care received

from a NZCOM member in a neutral, accessible, confidential, and supportive environment (NZCOM, 2017).

Midwives could also be offered the contact details of the NZCOM to access the Employee Assistance Programme (EAP). The EAP is an anonymous service offered by many employers to their employees primarily to assist them with strategies to address personal and/or work issue that may be impacting their job performance, and/or their mental and emotional wellbeing (EAP Services Limited, 2018). NZCOM offers EAP services to its community LMC midwife members. No participant required the offer of any of these services.

4.2.6 Conflicts of interest

Conflicts of interest likely to arise as a consequence of my professional, social, financial, or cultural relationships were considered as part of ethical considerations. I had no conflict of interest to declare.

For the duration of the study I was employed in the School of Midwifery at Otago Polytechnic. This study was separate from my roles within the School of Midwifery. I have not worked as a midwife in two of the cities where this study took place. For the first year of the study I worked as a community LMC midwife maintaining a very small caseload of women, some of whom lived in a suburb of the third city in the study. However, none of the women lived in the specific study areas of high socioeconomic deprivation, and they birthed at the neighbouring DHB. I was not working in any midwifery groups with potential women or midwifery participants. Additionally, I had never worked in the primary birthing unit in the third city, nor had an agreement to access the DHB maternity facilities there. During the last three months of interviewing for the study, I worked the occasional casual shift as a midwife in the maternity unit in a different DHB to the study areas. None of the midwives interviewed from May to July 2016 were accessing this DHB during this time, and women interviewed during this time were from another city. No potential woman participant who had received midwifery care from me, as either a community LMC or core midwife, volunteered to be part of the study. If they had they would have been excluded. I did not come across any of the woman participants while working casual shifts.

4.2.7 Storage of data

Electronic data were pass-worded on computer. All recordings, transcribed interviews, and notes and memos relating to the research are being kept in a locked cupboard in my

alarmed garage for 10 years post completion of data analysis. They will then be destroyed by deleting or shredding. As I live at distance from AUT University, the consent forms were securely stored in a locked cupboard in an alarmed garage at my home and given to the primary supervisor when I visited Auckland. The consent forms are being kept by the primary supervisor in a locked cabinet in her office at AUT University for 10 years, after which they will be destroyed by shredding.

The two supervisors and I have had access to the data during the data collection and analysis stages. All data were anonymised from interview using pseudonyms. I transcribed all the interviews myself.

4.2.8 Who will have access to the data after the findings have been produced?

After the study completion, my two supervisors and I will have access to the data for auditing purposes. A summary of study findings will be offered to all participants at completion of the study. The written thesis will be available through the AUT University library. It is anticipated that national and international conference presentations and articles in peer reviewed midwifery journals will be generated from the research findings. The contribution of the women and midwife participants will be acknowledged in all published papers and conference presentations arising from this study.

It is anticipated that the findings of this study may be of particular interest to the social and cultural groups the study participants represent. This could include, but may not be limited to, Māori, Pasifika, Asian, and European cultural groups; as well as social groups with an interest in people, specifically childbearing women who live in areas of high socioeconomic deprivation, and midwives working with women living in these areas. A summary of research findings will, therefore, be sent to the groups consulted during the preparation of the research proposal, and I will be happy to present the findings at any related meetings, if invited. It is hoped that this will address reported complaints from Māori about not receiving the results of research they have been involved in, leaving them uninformed and unable to judge if they have been represented well (Cram, 2009). There are no plans for future use of the data beyond those already described.

4.3 Positioning of the Researcher

Although stating "*the researcher does not approach reality as a tabula rasa*" (Glaser & Strauss, 1967, p. 3), and must have a perspective that will aid data analysis, Glaser and Strauss did not consider the positioning of the researcher in their grounded theory

development (Lempert, 2010). As discussed in Chapter 3, it is Charmaz's view that no researcher comes to a study as a blank slate without preconceived ideas or predetermined goals. Charmaz (2002, 2008b, 2008d, 2011), instead, recognised the researcher's preconceptions and prior knowledge, requiring scrutiny of these through reflexivity throughout the research process. I remained acutely aware of the requirement for reflexivity throughout my study. From time to time, when interviewing participants, I realised mid sentence that I may be leading the participant in a specific direction that was based on my own view. I would stop speaking, refocus, and carry on. I read each interview transcript carefully to ensure I was not leading the participant down a perspective that was a presumption of mine. I carefully considered my experiences in my own community LMC midwifery practice when I had previously worked with women living in areas of high socioeconomic deprivation, and the results of my MA study, determined not to let these affect my actions or decisions. I remained open to what was identified in the data, trying to ensure my own views were not given unwarrented strength over those of the participants' voices. Additionally, writing reflective memos, being a member of the grounded theory group at AUT, and sessions with my study supervisors, provided opportunities for ensuring data remained as close to the participants as possible.

4.4 Data Collection

Dealing with the complexity of interviewing both women and midwives was considered at length as this study was being designed. While the study was focused on how women accessed and engaged with midwives, I felt it was important to get midwives' perspectives of how they accessed and engaged pregnant women if I was to be able to gain enough rich and detailed data to explain the processes taking place.

4.4.1 Participant recruitment

Participants in a grounded theory research study are those who have experience of the phenomenon under study. For this study, participants were women living in areas of high socioeconomic deprivation in New Zealand who had experience of accessing and engaging with midwives, and midwives working in these areas. Inclusion criteria were women living in one or more areas of high socioeconomic deprivation in three cities in the North Island of New Zealand, who had experienced maternity services, were conversant in English, and had never received midwifery care from me; and community LMC midwives for whom at least 50% of the women they provided care to lived in the high socioeconomically deprived areas of the cities in the North Island.

4.4.1.1 Recruitment of women participants

Potential women participants were recruited through a named midwife in each of the three study areas. The named midwife was my contact person in the area for any resource or communication issues, and each was well known and established in their local communities. In each of the three cities the named midwife attempted to recruit woman participants through midwives within midwifery group practices who were not study participants themselves. It was hoped that midwives in the midwifery group practices would be happy to act as intermediaries, and approach potential women participants from their individual caseloads who met the inclusion criteria. The named midwives also approached women they knew who met the inclusion criteria, but for whom they themselves had not been midwife. If a woman was interested, the named midwife or the intermediary gave the woman a Participant Information Sheet. The Participant Information Sheet provided a full explanation about the research including that participation in the research was voluntary, a consent form would need to be completed prior to participating, participants would have the opportunity to ask questions about the study prior to signing the consent form, a pseudonym would be chosen by or given to each participant and that each participant would be identified by the pseudonym in the final report, and all responses would be treated confidentially to protect the privacy of participants. Information regarding data transcription, storage, access, and dissemination was on the Participant Information Sheet.

If, after reading the Participant Information Sheet, the woman was interested in becoming a study participant, the midwife asked if she could pass the woman's contact details to me. I then contacted the woman to talk about the study and to arrange an interview, or alternatively the woman could contact me directly. In one of the cities, where this research was taking place, all the women elected for the named midwife or the intermediary to pass on their contact details directly to me. In a second city, with consent, contact details of interested potential participants were passed on to the named midwife who then contacted the women who had agreed to be interviewed, organising interview times based on my availability. In this way women were successfully recruited in two of the study areas. In the third area midwives being approached by the named midwife did not result in any interested women participants. It was decided to persist and try and recruit one or two women from this area, so the named midwife then approached a woman known to her who met the study criteria to gauge her interest in becoming a participant in the study. This resulted in the woman contacting me directly and becoming a study participant. Although known to me she was not a personal friend.

Although the women participants, bar the one mentioned above, were all unknown to me, they all met the inclusion criteria and I accepted the named midwives' word that they would all be suitable participants for the study. The first three women were purposefully sampled for interview through meeting the inclusion criteria. The women were easily contacted by phone, and interview dates and times arranged.

While recruiting women in the area where she worked, the named midwife advised me early in the study that the Participant Information Sheet for women was too long and wordy, and that she felt women, particularly Pasifika women with English as a second language, would never read through it. She instead discussed the information in the Participant Information Sheet with each woman and, if they were interested in taking part in the study, gained consent to pass their contact information on to me. In these circumstances, such actions were seen as an appropriate way to deal with the named midwife's concern.

The following is a summary of which cities the 11 women participants were recruited from;

- City 1: Three women were recruited by the named midwife.
- City 2: One woman was recruited by the named midwife.
- City 3: The named midwife was very active in approaching midwives to talk to women in their caseload about participating in the study. The four midwives she approached agreed to act as intermediaries and approached a total of 17 women in their caseloads. The named midwife also approached two women in her own caseload. How this was managed is discussed in the section on 'interviews' later in this chapter. Of the 19 women approached, seven agreed to be interviewed.

4.4.1.2 Recruitment of midwife participants

Once AUTEC approval was gained, potential midwife participants were notified of the study through the named midwife in each of the three North Island cities placing Advertisement for Midwives notices in midwifery clinics, birthing units, and hospitals in their DHB areas. The notices included named areas of high deprivation in each of these cities from the Atlas of socioeconomic deprivation in New Zealand NZDep2006 (White, Gunston, Salmond, Atkinson, & Crampton, 2008). Advertisement for Midwives notices were also emailed to community LMC midwives in all three cities utilising the region or sub region's NZCOM newsletter, and NZCOM email lists in two of the regions. The researcher was rung by an advisor at NZCOM for more information prior to agreeing to the local NZCOM person in one of the regions using their email list for this purpose. Once reassured that I was not wanting to access the local NZCOM

midwifery email database myself, the NZCOM advisor gave approval for the study notice to be emailed out to the regional community LMC midwives as planned. Potential midwifery participants then contacted me directly and were sent a Participant Information Sheet. This gave information covering the same areas as the woman's Participant Information Sheet. Midwives I knew who had experience of working with women in the named areas of high socioeconomic deprivation were also approached by an intermediary to see if they were interested in participating. This was to encourage them to consider taking part. If they were interested the intermediary either emailed them or gave them a hard copy of the Participant Information Sheet. Potential midwifery participants approached by an intermediary then contacted me directly if they wished to participate in the study.

There were 11 women participants and 10 midwife participants recruited to the study. An additional 10 midwives across the three cities showed initial interest in the study, and each received a Participant Information Sheet. I did not hear back from five of the midwives following this; however, the other five midwives responded that they were happy to be interviewed. An intermediary informed me that one additional woman was happy to be interviewed. I responded via text to the woman and emailed each of the five midwives who were happy to be interviewed, explaining that as grounded theory methodology was being used for the study, data collection (through interviewing) and data analysis were occurring concurrently, so they would not be interviewed immediately but would be interviewed within the next few months. When contacted again nine months later via email or phone, the woman and four of these midwives did not respond. The other midwife was unable to participate at that time. Fortunately other women and midwives had been recruited to the study during this time, so were interviewed. Recruitment of women and midwife participants continued until the last participant was interviewed in July 2016.

4.4.1.2.1 Description of midwifery participants' practice contexts

Two of the midwife participants were employed by a health centre and ran midwifery clinics from there. Two had midwifery clinics co-located within health centres. Two were employed by DHBs. One of these midwives worked as part of a high risk obstetric team based at a satellite secondary facility that also ran outreach clinics situated in areas of high socioeconomic deprivation. This midwife carried a caseload of women whom she saw in clinic and visited at home ante and postnatally. The second DHB employed midwife ran a clinic out of the local primary unit as well as home visiting women

antenatally. The remaining four midwife participants practiced from stand-alone midwifery clinics.

4.4.2 Support person

When I contacted potential participants to arrange an interview I informed each midwife participant and four of the women participants that they may bring a support person with them. The named midwife in one area arranged interview times with seven of the women for days I was available, and these times were then passed on to me. While this named midwife knew to inform each woman she may bring a support person to the interview, I could not be sure this had definitely taken place. Prior to being asked to sign the consent form at the interview, all seven women confirmed they were aware they could bring a support person.

Many of the women, and some of the midwives, had their own children or grandchildren present during their interviews. These children ranged in age from 15 years to a two day old baby. Although some women and midwife participants had friends or family come into the room, or call in to visit during the time their interviews were taking place, none elected to bring a support person to their interview, and none elected to stop the interview due to family/friends being present for short periods of time or in rooms close by. The family/friends did not take part in any of the interviews, but were either occupied elsewhere in the house, or sat in a nearby room usually playing with the children present. When this was apparent I asked the participant if she was happy to continue with the interview, and each time participants were keen to continue.

4.4.3 Researcher safety

It was anticipated that some individual interviews would take place in participants' homes, which raised the issue of researcher safety. While midwives and other health professionals, such as WellChild Tamariki Ora personnal (child health providers), visit women and their families in their own homes every day in New Zealand, and there are very few reports of incidents when the health professional has felt unsafe, there is always the potential for this to occur. With this in mind, a Researcher Safety Protocol was developed (Appendix K), with the intention it be actioned for all the interviews. A midwifery colleague agreed to be my contact person for the protocol throughout the study. Midwife participants chose to be interviewed in a variety of places; one midwife chose to be interviewed via Skype, and another at a primary unit. One midwife was interviewed twice in my home and once at hers. Three more interviews with midwives occurred in their own homes, and four interviews took place over the telephone. As it

transpired, I knew, to varying degrees, the midwife who chose to be interviewed in my home, the three midwives who were interviewed in their own homes, plus the midwife interviewed at the primary unit. I therefore did not feel the need to implement the Researcher Safety Protocol with midwife participants. However, I did not know the three women in one city who were interviewed in their own homes, so the Researcher Safety Protocol was utilised. Though not in the protocol, I texted my midwifery colleague when I left each of these homes.

In another city, where seven women were interviewed in their own homes in an area unfamiliar to me, I was fortunate to have the named midwife transport me to and from six of the interviews. She was, therefore, aware of where I was and after she introduced me to each woman she left when I entered the house. If she was not already waiting in her car outside the house once the interview was over, I texted her once I left each home and we met at a predetermined location shortly after. I caught a taxi from the seventh participant's home, as planned, ringing the named midwife to inform her that I had left the house. The named midwife had done preliminary drive bys to all the participants' houses in this area introducing herself to women who were home, and to check whether there were any dogs wandering free on any of the properties. If so, when she contacted each of the women to arrange interviews she also ensured the dogs would be tied up/contained before I arrived. The woman from the third city chose to be interviewed via a phonecall so, again, the Researcher Safety Protocol was not utilised.

There were no safety concerns at any point in the interview process, although I did stay on the footpath outside a fenced property for a time while one large dog was eventually caught and secured by a woman's family members. Fortunately the named midwife had remained outside the house in her car monitoring the situation until the dog was safely contained.

4.4.4 Addressing confidentiality and gaining consent

To maintain participant confidentiality, immediately prior to each interview and once I had ensured the participant had either read the Participant Information Sheet about the study, or alternatively had gone through the Participant Information Sheet with her ensuring she understood the information, I briefly talked about the purpose of the study, and explained what participating in the study would involve. After ensuring that any questions had been answered to her satisfaction, each participant was asked to read the Participants' rights (on the consent form) and asked if they had any questions about those. The participant was then asked to sign the Consent Form in my presence

(Appendices L & M). Each participant signed two identical consent forms. The participant and I each kept one copy of the consent form.

Participants were reminded that they could decline to answer any question, take a short break, or ask for the dictaphone recording to be stopped at any time. Prior to commencing the interview each participant was asked to choose or be given a pseudonym to maintain confidentiality. Nine of the participants–seven women and two midwives–chose to use their real name. This was unexpected. On discussion with my supervisors we decided that this may be due to the participants' desire to ensure their voices were identifiable in the resulting thesis, and any publications and presentations arising from the study.

4.4.5 Interviews

Once the dictaphone (and the iPad recording App from interview eight onwards) was turned on, I started by collecting demographic information to ease the interviewee into the interview. Next, women participants were asked to tell me whether they knew anything about midwifery or midwifery care before they were pregnant for the first time/most recent time. Midwife participants were asked to tell me how they went about accessing pregnant women living in areas of high socioeconomic deprivation. I had prepared Interview Guides (Appendices N & O) for the women and midwives as part of the ethics application. These contained some questions and prompts.

From the end of September 2014 until the end of July 2016, 24 semi-structured interviews were undertaken with the 21 participants.

4.4.5.1 The initial interviews with midwife and women participants

The named midwife in one area very much wanted to be interviewed for the study herself. After discussion with my two thesis supervisors it was agreed this could happen early in the study. This first midwife participant was interviewed at the end of September 2014 via Skype, using the Interview Guide. In line with grounded theory, this midwife was deliberately chosen out of those who had shown an interest in the study using purposeful sampling. This was important as I felt she had good knowledge and experience of working with women living in areas of high socioeconomic deprivation and would be able to confidently talk about this topic. As in all interviews that did not take place face to face, prior to the interview the midwife was emailed a Consent Form and had responded via email that she had read the form and consented to participating in the study. Prior to the first interview commencing the participant had read the Participant Information Sheet and had no questions to ask me. The midwife

was then asked how she went about accessing pregnant women living in areas of high socioeconomic deprivation.

The first interview took 1 hour 40 minutes and resulted in 21 pages of transcribed data. As the participant talked, I was aware that elements of the categories of my MA thesis were being captured (Griffiths, 2002; Griffiths, McAra-Couper, & Nayar, 2013). This was interesting given the time that had passed since the MA research had been undertaken. Data analysis commenced as described in section 4.5 below. As the named midwife in one of the study areas, the midwife then assisted with recruitment of women.

In collaboration with my supervisors it was decided to go ahead and interview a second midwife participant. This interview occurred a month after the first, also purposefully choosing the midwife from those who were interested in being study participants. This midwife worked in a different context from the first and had a lot of experience in working with women living in areas of high socioeconomic deprivation. The participant needed to answer her pager 16 minutes into the interview as she was on call for her caseload of women. The dictaphone was turned off and turned back on at the conclusion of the midwife responding to the pager text. The interview then continued for 45 minutes. It was not until I began transcribing the interview that I realised this 45 minutes had, for some unknown reason, not recorded. Fortunately, during this interview, as with all the interviews undertaken, I had written field notes noting words, key phrases, and actions such as gestures and displays of emotion. These were able to be used as a prompt for the subsequent re-interview the midwife was happy to do six days later. At the second interview she repeated much of what she had said during the lost recording. This participant also mentioned many topics the first midwife had reported.

The first three women participants were interviewed next over the 2014-2015 summer holiday season. They presented interesting perspectives on accessing and engaging with midwifery care.

4.4.5.2 Subsequent interviews with midwife and women participants

Following the initial data collection phase, I immersed myself in data analysis constantly comparing the identified initial codes and focused codes with each other, identifying ideas participants had raised, and gaps in the data which gave me direction for further interviews, leading me to commence theoretical sampling. Four further interviews with three midwives were held throughout 2015, followed by another period of data analysis.

The third phase of data collection occurred throughout 2016, when 14 interviews with six midwives and eight women were held. One midwife participant was interviewed a third time as she was shifting her practice context, and after discussion with my supervisors it was considered that capturing her shift at the time it was occurring may benefit the study in some way.

Almost two years after the first midwife was interviewed, two women in her caseload wanted to participate in the study. The named midwife had approached them even though women were supposed to be recruited through midwives who were not study participants themselves. The midwife felt that both these women were articulate, strong women, and would have some valuable perspectives to add to the research. By this time it was 21 months since the midwife herself had been interviewed, and both women had babies under a month old, so were not in the midwife's caseload when she herself was initially interviewed. The women had read the Participant Information Sheet and both wished to be interviewed. After considering the time lapse since the named midwife was interviewed, that the two women were not in her caseload at the time of her own interview, and both women's wish to take part, and following discussion with my supervisors, they were recruited into the study.

Early in the study I had been approached by a midwife known to me who was very experienced in remote rural midwifery and was very keen to be interviewed. She did not strictly meet the study criteria as although the women she worked with lived in a remote rural area of high socioeconomic deprivation, the area was not one of the identified study areas. However women in the area she worked did access the maternity unit in one of the three cities where the research was taking place. I felt her perspective in accessing and engaging with women in the areas she worked would be valuable, and discussed accepting her as a participant with my supervisors. They agreed this would be worthwhile towards the end of the study, so I deliberately saved interviewing her until later as I felt her interview would be a rounding up or a closure of outlying thoughts I was having about the tentative categories that had been identified.

Both women and midwives portrayed a variety of emotions during their interviews including chuckling, laughing, voices raising or becoming much quieter, or swearing. Some of the midwives became teary or had a 'wobbly' voice for a short period. "*At the end of the day something had to give, because otherwise I was just giving it so [pause], a lot of myself. It was, to protect myself. And [pause, becoming tearful], and I feel bad about that [crying]"* (Steph MW).

Some participants paused leaving an impacting sentence unfinished, particularly when relating an individual woman's story. "*She was like this beautiful untouchable person you know, who had the money, the car, and here was me, and I felt [silence]*" (Grace W).

One midwife requested the dictaphone be turned off while she told me about an event that she did not want recorded. Several midwives and women continued to talk on once the interview was over, and twice I asked participants for their consent to turn the dictaphone on again and for them to repeat what they had just said, as it was relevant to the study. Both readily agreed. No participant declined to answer a question or requested a break from the interview. If a midwife participant received a telepager message to which she needed to respond, the dictaphone was turned off to ensure the details of the ensuing phone call were not recorded. Apart from the events relayed above, the dictaphone was kept on throughout all the interviews.

While no participant chose to bring a support person to any interview, people's lives carried on. Apart from quick interactions with various friends or family members wandering in and out of the room during interviews, phonecalls, text messages, and telepagers needed to be monitored, and some responded to. Participants also needed to deal with their children's needs or the needs of theirs or others' pets for short periods during the interviews. In several homes televisions blared to keep the children of all ages entertained while the interviews took place. I sometimes wondered whether the interview recording would be audible above the din when transcribing. However, it was all fine and I really enjoyed being amongst the reality of the women's and the midwives' day to day lives. I ensured I brought each interview back to normal day to day conversation prior to it concluding and that it finished on a positive note (Charmaz, 2002).

Interviews were anticipated to take 60-90 minutes each. In addition, time was required for some participants travelling to the agreed venue. Interviews with most women took between 30 and 60 minutes with the shortest lasting 16 minutes. This was with a young, primiparous woman who was very happy with the midwifery care she had received but whom I was unable to draw into more conversation. Interviews with midwife participants took between 60-100 minutes. All participants were offered either a $20 petrol or supermarket voucher at the end of their interview to thank them for their time. Participants reported not expecting to be offered any koha (gift) and all were pleasantly surprised. Some participants–both women and midwives–declined the koha, requesting that it was given to another person 'who really needed it' instead. Two

women participants commented on how delighted they were to receive the koha, stating that as it was the school holidays the voucher was the 'icing on the cake' and would be used for buying sweets when they took their children to the movies for a special holiday treat.

In addition to the field notes taken during the interview, I wrote a memo of any thoughts, commonalities identified, or further questions that I had as a result of the interview, shortly after each. These too became data.

4.4.6 Transcribing interviews

All the participants in my study consented to their interviews being audiorecorded, and I transcribed all the interviews myself. Although this took time, I felt it would be an additional way to engage with the data. Transcribing interviews enabled reflection on the nonverbal interaction that occurred during each interview and on the questions I asked. Whether I interrupted or let the participant follow the direction of a story they were telling, whether either of us changed the direction of the conversation, or whether I put my own interpretation on what a participant meant or checked with them for clarification, were all skills I refined as the interviews progressed. This was important when considering the co-construction of the data. I gained so much more from analysing the interview transcripts than I would have by just relying on my memory and field notes alone. Maybe this will change with more exposure to using this methodology, and I will be able to trust that the essential information will rise to the top–the 'cream'–of the interview (Stern, 2010). Once transcribed, each transcript was returned to the participant to review to ensure the transcript reflected the interview, and to make any changes or additions that she wished.

Most women and midwives returned their transcripts within the first two weeks. Women and midwives who had not returned their transcripts were sent a reminder email or text from me at two weeks, which resulted in most women and midwives either giving consent for their transcripts to be used as is, or the return of the transcript with minor changes via email. Two women participants consented at the end of their interviews for their interview transcripts to be used without being returned by them as they were both sure they would not get around to sending them back to me once reviewed. One midwife took two and a half months to return her transcript. She reviewed half the transcript and sent minor changes back to me within three weeks and had always been committed to completing the review of the remainder. She responded to reminder texts, and eventually returned minor changes for the remainder of her transcript. One woman and six of the midwives made adjustments to their transcripts.

These were minor, clarifying points made, deleting some words to ensure they or their colleagues were not identifiable or, in the case of one woman, writing additional information. Once the transcript was returned, data analysis began.

4.5 Data Analysis

As described in Chapter 3, in a grounded theory research study data are analysed using a method of constant comparative analysis whereby data collection (interviews) and data analysis occur concurrently (Glaser & Strauss, 1967; Roberts, 2008). Data included the field notes and memos. Data collection and theory generation are seen as two parts of the same process (Glaser & Strauss, 1967).

I had long considered how I was going to approach analysing data from the women and midwife transcripts. I was not sure how this would work if I did not keep the women and midwife data separate, and had some concern I could perhaps end up with two separate substantive theories. Would it be better to meld their data together from the beginning, or not? Because I was unsure whether analysis would identify processes that were similar or different for the women and midwives I decided to initially keep the data analysis separate. This meant that women's transcripts were constantly compared with data from other women, and the same for the midwives. There came a point around half way into the interviewing when I realised that data from women and the midwives were crossing over and that there was no longer a clear delineation between them. So data identified that what women and midwives were relaying were similar, though experienced through their different contexts. At that point data from both women and midwife participants began to meld and analysis of the combined data continued.

4.5.1 Initial coding

To do the initial coding I printed each transcript and used a pencil coding methodically in the right hand margin looking at what was happening in the data. Using Charmaz's (2002, 2008c, 2011, 2014a) constructivist grounded theory methodology, initial coding of each initial interview transcript began with line by line coding for actions, processes, and meaning. At times I used gerunds; verb forms of nouns, words that reflected the actions. In the example of initial coding in Table 3 below (p. 101) 'labelling' is a gerund.

Table 3: Example of initial coding using gerunds:

Interview transcript	Initial coding
…and they get labelled as being non compliant and not wanting to look after their health. (Janice MW)	Labelling

Line-by-line coding using gerunds helps to capture, make clear, and connect pieces of data, and therefore see processes, assumptions, and consequences (Charmaz, 1990, 2002, 2011; Charmaz & Bryant, 2011). Charmaz recommended using gerunds "*but if they don't work, use what you find*" (personal communication, September 26, 2017).

Single words or small phrases are called initial codes or properties. As suggested by Charmaz (2008a, 2014a), I searched for what was going on, what people were doing and saying, what the actions and statements took for granted, and how these actions and statements were served, maintained, impeded or changed, while trying to keep the initial codes close to the data. An example of initial codes/properties is below in Table 4.

Table 4: Example of initial codes/properties

Interview transcript	Initial codes/properties
They do want to look after themselves. They do want to do well. They want to actually go to these appointments. But you've just got to empower them that it's actually ok for them to have some choice. They need to feel empowered in making these very simple decisions that you and I take for granted. … and … when I have got the receptionist on the phone for the appointment for the GTT or the scan, I'll then say 'they can give you a Tuesday morning at eight o'clock, or eight thirty or nine or nine thirty. You've got to get the kids to school, so tell me which of those times is going to suit you with the kids'? And so again, I am empowering them before we make the decision. But do you see how five minutes could pass? (Janice MW)	Wanting to look after themselves Wanting to do well Wanting to attend appointments Empowering by having choice Empowering woman to make decisions Offering choice Negotiating with the woman Taking time

Initial coding also gave me ideas to pursue with subsequent participants. At times I used *in vivo* codes, using important words or groups of words of the participants to capture special characteristics of a term which needed to be explored further to understand its meaning or action for the participant, or of a definition of what was happening in the data (Birks & Mills, 2015; Charmaz, 2015). For example, Mary, the first woman participant, related the midwifery care a previously unknown community LMC midwife provided during her third pregnancy that was important to her and nurtured the building of an effective relationship between them. I explored whether the features Mary talked about as supporting the development of an effective relationship were similar or different for other women participants, and added a question to the Interview Guide: '*When you think about the midwife's midwifery care, what other things stand out in your mind?*' The data obtained from asking this question in subsequent interviews eventually identified 'building effective relationships' as a theoretical category.

4.5.2 Identifying focused codes

By constantly reading and rereading the participants' transcripts, the most frequent initial codes were then amalgamated into focused codes (also called sub categories) to explain larger pieces of data (Charmaz, 2002, 2008d; Charmaz & Bryant, 2011) and thus build the theory. Again this involved me sitting with the hard copy of the interview transcript with my pencil, this time writing focused codes in the left margin of the page. Throughout the initial and focused coding process I was frequently writing memos to explore ideas that were emerging from the data. Theoretical sensitivity was demonstrated as I made decisions about which of the focused codes explained how women living in areas of high socioeconomic deprivation in New Zealand accessed and engaged with midwives. I drew many cluster diagrams following focused coding to help visualise the relationships between the tentative categories developed; however, I did not use Glaser's (1978) coding families to generate theory. Rather, as I was using constructivist grounded theory I was wanting to identify tentative categories from the data analysis, and not be influenced by whether they fitted a specific framework such as Glaser's coding families.

Table 5 (p. 103) shows a portion of Grace's transcript. Grace was the fourth woman participant interviewed. As data from this interview was compared with data from the previous participant interviews, initial codes identified many aspects of accessing midwifery care. Various complexities surrounding this process were also identified, such as not having the resources to contact a midwife, and being assisted to

access midwifery care. Analysis of subsequent interviews, along with those before, identified 'the complexity of accessing midwifery care' as being a focused code.

Table 5: Example of focused code

Focused codes/subcategories	Interview transcript	Initial codes/properties
The complexity of accessing midwifery care	*When I was pregnant how I found my midwife? I had no way of like getting a midwife. I went to the Accident and Medical [clinic] and they gave me a sheet [of names], but I had no phone so I couldn't ring a midwife. And then I went to WINZ because I was running out of money, and the WINZ lady said 'oh I had a midwife. She was amazing,' and rung the midwife and organised for her to come out to my house and see me.*	Having no way to access a midwife Being given a list of midwives Having no means to contact a midwife Accessing WINZ Running out of money Being assisted to access a midwife Having midwife home visit organised
	Ok. And so how did you find that? *... I didn't know anything about midwives. ... I didn't really know why I needed one, and I was about 14 weeks pregnant. So she just said 'oh this is a good one,' and I was like 'well, she's coming to my house. That's a good thing' .... Yes, so it was the lady herself who she'd been her midwife, and she rang her cos she had her number, and said to her 'can you take this person? She needs a midwife,' and they arranged a meeting and then she came out and booked me basically.* (Grace W)	Not knowing anything about midwives Being in second trimester Having midwife recommended Being happy to take recommendation Using recommendation of other Having assistance accessing midwife Having meeting arranged Being seen by midwife and booked in for care

I documented initial codes while analysing data, grouped these under focused codes, and documented when I moved them to other focused codes. Figure 2 (below) is an example of a portion of one focused code 'having clear pathways to midwifery care' from analysis of the first five midwife transcripts. The initial codes hyperlinked to the relevant data taken from each transcript.

Having clear pathways to midwifery care (formally 'Getting referrals') (4.2.16 maybe change this to 'getting women', 'receiving referrals', being referred to'?? 'HAVING CLEAR PATHWAYS TO MIDWIFERY CARE' maybe…yes I think so! A-ha!)

- Getting referrals through clinic mostly (P6I1L53-64, 352) (P7I2L95-104) (P2I1L48-81) (P2I2L170-179, 756-762 –also under 'prison visiting/dealing with the challenges) (P1I1L1163-165, 172) (P8I1L62-72, 87-88, 92-108, 1005-1008, 1013-1016, 1019-1029)
- Through the DHB phone service (P6I1L53-94) (P7I2L95-104) 4.2.16. Already included in 'getting referrals through clinic mostly' directly above.

Figure 2. Example of focused coding

I was aware of the difficulty some researchers experienced when attempting to raise their analysis from descriptive to conceptual, and I certainly struggled with this initially as I explored and developed possible tentative categories. Over many months I thought, walked, woke in the middle of the night thinking, wrote memos, and drew pictures and cluster diagrams, as I worked to make sense of the data and develop my model. This time was slow, at times disheartening, and interspersed with moments of brilliance when I 'saw' something in the analysis which provided linkages. As I raised the focused codes from a descriptive to a conceptual level, theoretical categories developed. Initially six tentative categories were identified. Memo writing continued as I worked to explain the properties of each theoretical category; the conditions under which it occurred, was maintained, and changed; its consequences; and its relationship with the other categories (Charmaz, 1990, 2008a, 2015). This is demonstrated in Figure 3 (p. 105), which is a portion of a memo about the complexity of accessing midwifery care, a theoretical category that had been identified from data analysis.

- 6.1 The complexity of accessing midwifery care: These women–more transient, less education and health literacy than more affluent women, mainly Māori and Pasifika, many have English as second language, if employed in low paid/unskilled jobs, no transport, sharing mobiles and homes, resources fluctuate, history of unsatisfactory experience with other health professionals. In these circumstances accessing a midwife could be challenging.

6.1.1 Finding a midwife was a smooth, protracted, or delayed pathway. This influenced when the woman found a midwife and began accessing midwifery care. Conditional on women's expectation, knowledge of maternity system (may not access care til later if no knowledge), knowledge of midwives and midwifery, negotiations between various health personnel, access to databases/lists of midwives, referral, midwife availability, advice/recommendations from family/friends, woman's personal context (not being able to contact a known midwife so needing to seek an alternative, being unaware of the potential for pregnancy), previous experience (if had accessed a midwife late previously and all gone well may plan on doing same again), willingness or reluctance to work with a known midwife again and whether this is during a current or subsequent pregnancy (seeking another midwife taking time = delay in receiving midwifery care), taking time to accept an unexpected pregnancy. Going to health centre most often first entry point into maternity system – if pregnancy confirmed given advice how to access midwifery care/offered choice of care/resources/list of midwives/data bases. Accessing resources conditional on having access to the Internet, phone, money. Women registered at a health centre with employed or co-located midwives had a straight forward path to access midwifery care resulting in early engagement. Being the family midwife. Family referrals having a range of outcomes. Some pregnant women picked up by midwives through other means – taken on as midwives aware women had limited resources to access another midwife and wanted them to receive midwifery care being aware of effect on pregnancy outcome. Accessing a midwife easier if midwives located clinics in areas women frequent with good public transport = no extra travel required therefore women more likely to remain engaged with midwifery care. Midwives being contacted earlier in recent years especially if women happy with previous care, as women realise midwives thinner on the ground so making early contact = potential improvement in pregnancy outcome.

Figure 3. Memo about the complexity of accessing midwifery care

Over time, with more analysis, the number of theoretical categories were conceptually developed and reduced to three with several name changes. Eventually, the memos became integrated into the writing up of the study and influenced other data sought, e.g. literature. 'Negotiating through complexity' was identified as the major category linking the theoretical categories from around midway through data analysis.

However, with time and ongoing analysis, it became apparent that not all processes were negotiating. Eventually 'working through complexity' was identified as the major process explaining what was going on in the data and linking all three theoretical categories. While taking a lot of time, each part of the process was vital for the development of a theory that fit the underlying data and remained congruent with constructivist grounded theory.

4.5.3 Purposeful and theoretical sampling

In my study, women and midwives were recruited as the data analysis identified a need for their experiences to be explored to aid the development of the theory. Purposeful (purposive) sampling was used to obtain as varied a participant population as possible, and theoretical sampling was used to aid theory development.

Purposeful sampling was used initially to access midwife participants who had worked with women living in areas of high socioeconomic deprivation for some time, and whom I perceived could confidently talk about the focus of the study. Two midwives, who I knew met these criteria, were the first midwives interviewed. Further sampling occurred as I collected the initial data, analysed them, and then used the results of the analysis to decide on the next area of data collection.

Theoretical sampling was used as data analysis revealed the need to clarify ideas or concepts emerging from the data to develop the theoretical categories. Multiple and diverse perspectives were sought to illuminate the theoretical properties of emerging concepts in the theory (Glaser, 1978). As the research progressed and focused codes were identified from the data and conceptualised into tentative categories, questions were added to the Interview Guide to see if what participants were saying represented the reality for other women and midwife participants, to develop the elements of a conceptual category. For example, after interviewing the first four woman participants and hearing about midwives not turning up for planned appointments and not ringing to say they were delayed or were not able to come, and women having to wait some time for a response from the midwife when they tried contacting her, I was interested in whether subsequent women interviewed felt the midwife responded in a timely manner when contacted. Also, what 'timely manner' meant to the women, and how they felt about the response time. A question about this was added to the woman's Interview Guide. I also became aware, after the first four interviews with women that while they had all started looking for a midwife on confirmation of pregnancy, for a variety of reasons it had taken some much longer than others to finally be connected with a midwife to provide their care. Some women were then classified as 'late bookers'

despite beginning to search for a midwife much earlier. For example, despite seeking care early in pregnancy, due to a variety of reasons Terina was not registered with a midwife until she was around six months pregnant. A question was added to the woman's Interview Guide asking when they first began looking for a midwife, and their stage of pregnancy when they accessed a midwife. Asking this question of subsequent women participants developed the focused code 'accessing a midwife', which was an element of a conceptual category at that time named 'varied connecting'. Following further data collection and analysis, this focus code was eventually renamed 'the complexity of accessing midwifery care'.

Data analysis of midwife transcripts three and four revealed they were providing care for women with complex medical or obstetric conditions in collaboration with the hospital secondary clinic obstetric team. These were women whose care would formerly have been transferred to the hospital obstetric and core midwifery staff. A pattern was identifiable around this being related to resource issues, such as staffing and funding, rather than the care that community LMC midwives could necessarily provide. "*Yes. Yes. We're pretty much keeping everything. I'd still refer them and they say 'that's nice', send me a letter, and send them back*" (Molly MW).

> *I'm happy doing secondary care. There's one or two I've handed over at delivery like a complicated twins and another woman with this really bizarre qst syndrome thingy who just needed all this extra cardiac stuff at the delivery ... so I just handed that over. Otherwise I don't mind. I learn, and yes, I just provide the primary diabetes [care], everything, yes. I don't mind doing that.* (Elizabeth MW)

Therefore, a question was added to the Interview Guide for midwives asking about this to identify similar experiences. "*No, most of the time they try and take them off you*" (Liga MW). "*I do think that I'm expected to do a lot of secondary care and I don't know where it stems from. Maybe it's a misunderstanding of what the midwife's role is*" (Catherine MW).

> *I have often been put in the position in the tertiary unit where it's completely outside my scope. And it used to worry me about my [indemnity] insurance for example. And quite blatantly in Section 88 when it's recommending handover, well you will get 'well you can't hand over, cos we've got no one for you to hand over [to]', and you can't desert your woman, so you get this whole emotional blackmail. It will depend who the [shift coordinator] is, but this whole 'well why aren't you here for your woman,' and you might have been up [a long time]. It's unsafe.* (Joanne MW)

Theoretical sampling became more specific over time as I sought to saturate categories by asking more specific questions (Corbin & Strauss, 2008). For example, I

added questions to the Interview Guide for women after woman participant three's interview asking if it was easy or difficult finding a midwife. Another question was added asking how they got around structures like the midwife perhaps wanting to see them more often, or wanting them to have more blood tests, or recommending they need to be seen at the secondary care clinic. After the sixth midwife participant was interviewed a question was added to the midwife Interview Guide as data analysis identified that an ability to deal with dilemmas was a quality required when working with women living in areas of high socioeconomic deprivation. Midwives were asked what sort of dilemmas they had come across in their midwifery practice while working with this group of women. During the interview with midwife participant 10, I asked her about the ideas identified by earlier participants to see if she had another perspective to add to the data already obtained. Questions added included what she did when women did not turn up or were not home for planned visits, and whether she felt protected or vulnerable when taking responsibility for women who may not be receiving the amount of midwifery care she would like to provide.

I also had a telephone conversation with an experienced rural midwife colleague and, during this conversation, the topic of who was the second health practitioner present with the midwife for a home or primary birth in remote rural areas arose. While being aware that in some areas of New Zealand GPs backed up the midwife in these instances, I had not known that other health professionals, such as District Nurses who had undergone specific neonatal resuscitation education, may also perform this role at births. A question about this was added to the Interview Guide for the last interview with the midwife who was highly experienced in rural practice.

Not all the questions on the Interview Guide were asked in order, nor all asked as the interviews progressed (Charmaz, 2014a). As the number of interviews progressed and I became more adept I was able to recognise repeating patterns that were raised in previous interviews and ask questions 'thinking on my feet.' The scope of the questions narrowed as data were sought to develop the emerging theory.

4.5.4 Constant comparative analysis

While coding, I used constant comparative analysis to compare data to find similarities or differences, comparing codes with categories, categories with other categories, and categories with concepts (Charmaz, 2014a; Glaser & Strauss, 1967). An example of using constant comparative analysis is when an aspect of midwifery care emerged from the data which required further enquiry, the perspectives of midwives who could share their experiences were sought. I had interviewed four midwives co-located at, and/or

employed by, health centres. One of the advantages highlighted by midwife participants of working this way was ready access to other health professionals; for example, a GP, community worker, or social worker, should the woman or her accompanying children require it. I then wanted to compare this with the perspectives of midwives who were based at stand-alone midwifery clinics to see how they negotiated the extra services women may require that were readily available if attending a midwife located at a health centre. The next four midwives I chose to interview because they were based at stand-alone midwifery clinics.

4.5.5 Theoretical saturation of categories

Recruitment of participants continued until no new ideas emerged from analysis of the data (Stern, 2010). As no new initial codes or focused codes were identified after the eighth woman and tenth midwife participants were interviewed, at this point theoretical saturation of categories had occurred.

4.5.6 Identification of a core category

While I was not using classic grounded theory as developed by Glaser and Strauss (1967), I began by keeping an open mind about whether a core category would be identified from the study data. In the substantive theory developed from the data in this study 'working through complexity' was identified as the major category linking all the others demonstrating the process that was going on in the data. Once categories had been identified, I searched the literature to place the research findings into the context of current knowledge and to demonstrate how this study has added to existing understandings (Charmaz, 2014a; Glaser & Strauss, 1967), to access other literature which may support these categories (Charmaz, 1990, 2008a, 2011), and to complete and enrich my research (Stern, 2010).

4.5.7 Member checking

To be credible, the theory that is developed must fit the phenomena being studied (Glaser & Strauss, 1967); so, for this study, provide an explanation of how women living in areas of high socioeconomic deprivation in New Zealand access and engage with midwives. When planning this grounded theory research I expected to return to some of the women and midwife participants to test the emerging theory to establish the validity of my interpretation of the data to ensure it represented their reality of how women accessed and engaged with midwifery care (Birks & Mills, 2015; Cluett & Bluff, 2000; Glaser & Strauss, 1967; Sandelowski, 1993), and that the participants had access to what had been made of their experiences (Sandelowski, 1993). This is known

as member checking. Member checking generally means taking ideas back to research participants for confirmation (Charmaz, 2014a), though it can also involve people who were not participants.

Women and midwives were informed on the Participant Information Sheet that I may contact them again during the data collection and analysis stages of the research to clarify some ideas emerging from the data. Involving participants in analysing the information they provide in this way allows more perspectives to be taken into account, and also offers the researcher protection against her own preconceived ideas (Dick, 2010). Birks and Mills (2015) cautioned grounded theorists against an overreliance on member checking, agreeing with Sandelowski's (1993) claim that "*research participants often change their stories from one telling to the next as new experiences and the very act of telling itself cause them to see the nature and connection of the events in their lives differently*" (p. 4). Researchers using grounded theory are aiming for a high level conceptualisation of process in the particular area of enquiry with the aim of increasing knowledge and influencing practice rather than providing an accurate representation of an individual participant's experience (Berk & Mills, 2015). Therefore, it is important to consider which level of data to discuss with participants, as they may not recognise their own experiences in the data conceptualisation. While techniques such as member checking are an attempt to make research practice more visible and acceptable, it is possible they may also cause as many problems as they resolve (Sandelowski, 1993).

4.5.7.1 Member checking with midwife participants, other midwives, and midwifery students

I planned to return to some of the midwife participants to test the emerging theory to ensure it represented their reality of working with women living in areas of high socioeconomic deprivation. Between April 2016 and mid-February 2017 six member checking discussions with midwives and a seventh with a group of third year student midwives were held.

I discussed the tentative categories identified with two midwife participants. The first time was towards the end of the interviews when, during an unrelated conversation with the midwife who had been the first participant interviewed, the conversation moved to me sharing some of the tentative categories identified from the data and asking her the extent that these categories fitted her practice experience (Charmaz, 2014a). Likewise, tentative categories were discussed with the last midwife participant several months after her interview had taken place.

I also had the opportunity to discuss the progression of the research study with three groups of midwives and one group of student midwives in their final year of the midwifery programme. The first was following a presentation on my PhD progress to a group of around 12 midwives enrolled in a postgraduate Complex Care course at Victoria University of Wellington (VUW). The midwives were a mixture of community LMC and core midwives. By then, 10 interviews with eight participants had been undertaken (three women and five midwives–two midwives had been interviewed twice).

One of the midwives present at this member checking session asked me if rural midwives were to be represented amongst my participants. This was because she was aware of the high socioeconomic deprivation in which many families were living in different rural areas of New Zealand, and she felt it important that the view of a midwife working in these areas was included. This supported my decision to include the rural midwife in my study for constant comparative analysis, and I interviewed her as the final participant.

One member checking session followed a PhD progress presentation to postgraduate midwives enrolled in a Complex Care course at AUT, and another following a similar presentation to Year Three midwifery students at AUT enrolled in a complications in childbirth course. Another was after presenting progress to Masters and Doctoral students at an AUT Research Symposium. The responses from these six member checking conversations were memoed and became data. Following a presentation at a NZCOM conference about my research I also had several midwives come up to me and tell me how much my findings had resonated with their experiences in working with women living in areas of high socioeconomic deprivation–giving me examples from their own practice experiences. All seven member checking discussions confirmed the focused codes the data analysis was identifying resonated with the experiences they too had had/were having. As well as recognising fit with the midwifery profession, member checking can also check transferability i.e. does this process occur in other health disciplines? Attending the Grounded Theory group at AUT was a useful example of a context where I was able to member check whether the focused codes resonated with other health disciplines.

By the time I presented the progression of my study to midwives on the postgraduate course at VUW I was interested in what the women and midwife participants felt good care was, and how long good will around care lasted, as these issues had been identified from analysis of the women's interviews. A question on this

was about to be added to both the woman and midwife Interview Guides. After my presentation I told the group that some participants had talked about what good care was, and how long they felt good will around care lasted. I was interested in their views around these two questions;

- What is good care?
- How long does good will around care last?

Good care was defined by midwives present as working in partnership with women, 'working within scope', individualised, safe for both the woman and midwife, good communication, individual, feeling valued, advocating, and requiring self-responsibility on the woman's part. This feedback was similar to results of the data analysis and was, therefore, reassuring.

4.5.7.2 Member checking with women participants

I was concerned that requesting women participants to have a member checking discussion of the findings may not be welcomed, as it would be just another thing for them to fit into their already complex lives. However, after consideration and discussion with my supervisors, I decided that it was up to the women to decide for themselves if their lives were too complex to accommodate the request, not me. Hence, I returned to some of the women participants for member checking discussions about the study findings. In December 2017 I texted the four women participants who lived in the two cities closest to me asking if I would be able to come and discuss my findings with them. I planned to talk through what I had found, using the cluster diagram of the model I had prepared three months previously. With consent I would make notes and audio record the discussion. It had been up to three years since I had interviewed the women so I did not know if the mobile numbers I had for them all were current.

I immediately heard back from one woman participant and arranged to meet with her over the phone (at her request) three days later. A second woman rang me an hour later, happy to speak with me. Due to her busyness in the lead up to Christmas, she preferred I discussed my findings with her on the phone then if possible, which I did, taking the opportunity while she was available. With consent the discussion was recorded and I jotted down words and phrases throughout. I started by discussing the initial and focused codes I had identified from the data and asking for feedback. We then moved on to talking about their conceptualisation into theoretical categories, from which the major category/process had become evident. At the end of the discussion

once the audio recorders had been turned off I again thanked the woman for responding to my text. She responded;

> *No, thank <u>you</u> for getting in touch with me. It's really good. It warms my heart. Hope you can feel the warm fuzzies coming on [chuckling]. It makes me feel good that it's a continued effort; that you have returned to talk about the findings with me, and [it was] not just a one off survey [interview].* (Mary W)

I felt moved and humbled by her response. She then requested that I not leave my finished thesis 'on a shelf' but instead publish from it so I 'get the word out there'. I assured her that this was my plan and told her I had already presented my progress at several conferences while doing the research. She was really happy to hear that. The recorded discussion lasted 33 minutes. I then listened to the recording making notes on what had transpired.

I rang the second woman at the agreed time and repeated the same process. She too felt the codes identified from the data and the subsequent conceptualisation into theoretical categories related strongly with her own experience. The responses from the two women also became data.

4.5.8 Meeting with supervisors

I met with my two supervisors regularly right from the beginning when I first had some ideas to explore for a research study. This continued while the research proposal and then ethics application were being prepared, incorporated a change of second supervisor after my research proposal was written, through concurrent data collection and data analysis, conceptualisation, and the writing up of the thesis. Apart from a handful of meetings over this time we always met together, initially via Skype, then on Zoom and, if I was in Auckland, in person. Between these times I was also able to have a quick catch up with my midwifery supervisor if we were both attending a midwifery event. To date (at 25.3.19) I have had 66 supervision sessions. These sessions were an opportunity to discuss progress and feedback, debrief, decide strategies, and to plan ahead. In between, my supervisors have co-authored a journal article with me (Griffiths, McAra-Couper, & Nayar, 2013), reviewed many chapter drafts, and several conference presentations. I have benefitted from them sharing their vast knowledge about midwifery and grounded theory methodology. Throughout they have remained positive, encouraging, and supportive. They were integral to me getting to the point I have with my study, and I am very grateful to them.

4.6 Conclusion

This chapter has explained the research methods used in the study showing how the grounded theory methodology utilised for this research was put into practice for data collection and data analysis. Ethical considerations were introduced, followed by the positioning of myself as researcher. Data collection methods were then presented, including participant recruitment, and purposeful and theoretical sampling. How data was analysed was described.

In Chapter 5, the theory of **working through complexity**, the first of four chapters presenting the findings from this research study, is introduced. In Chapter 5 the major category is presented in bold in the introductory paragraphs, e.g. **working through complexity**. The same format is followed for the theoretical categories in each of the three following findings chapters; 6-8, e.g. **navigating a shifting landscape**.

Chapter 5: The Theory of Working Through Complexity

This chapter introduces the theory of **working through complexity**, the first of four chapters presenting the findings from this research study. The theory of **working through complexity** is introduced, along with a diagrammatic representation (Figure 4, p. 116) and explanation of the theory. This is followed by an overview of each of the three theoretical categories and their subcategories summarised in Table 6 (pp. 117-118). The theoretical categories and their subcategories will be discussed in greater detail in the following three findings chapters.

5.1 Introducing the Theory of Working Through Complexity

Working through complexity arose from data analysis as being the major category linking all categories. The findings of this study showed that women participants were constantly **working through complexity** as they accessed and engaged with midwives. Entering the maternity system exposed women to complexity additional to the personal, relational, and situational complexity already present within the context of their daily lives. The way the health system was organised meant that while many maternity care requirements could be met for this group of women, those needs arising out of the complexity of the women's context were more challenging to address. Navigating the maternity system was complex, requiring constant negotiation between women, community LMC midwives, and the maternity system, if women were to remain engaged with midwifery care. As they accessed and engaged with midwives, women moved backwards and forwards between the three theoretical categories of *'navigating a shifting landscape', 'building effective relationships'*, and '*negotiating a pathway*' working together with the midwife, or not. The process of **working through complexity** was in constant movement and an ever changing process for both women and midwife participants. Midwives encouraged women to remain engaged in midwifery care, as receiving midwifery care optimised pregnancy outcomes for women and their babies. In this way, midwifery care was identified as the vehicle through which **working through complexity** occurred.
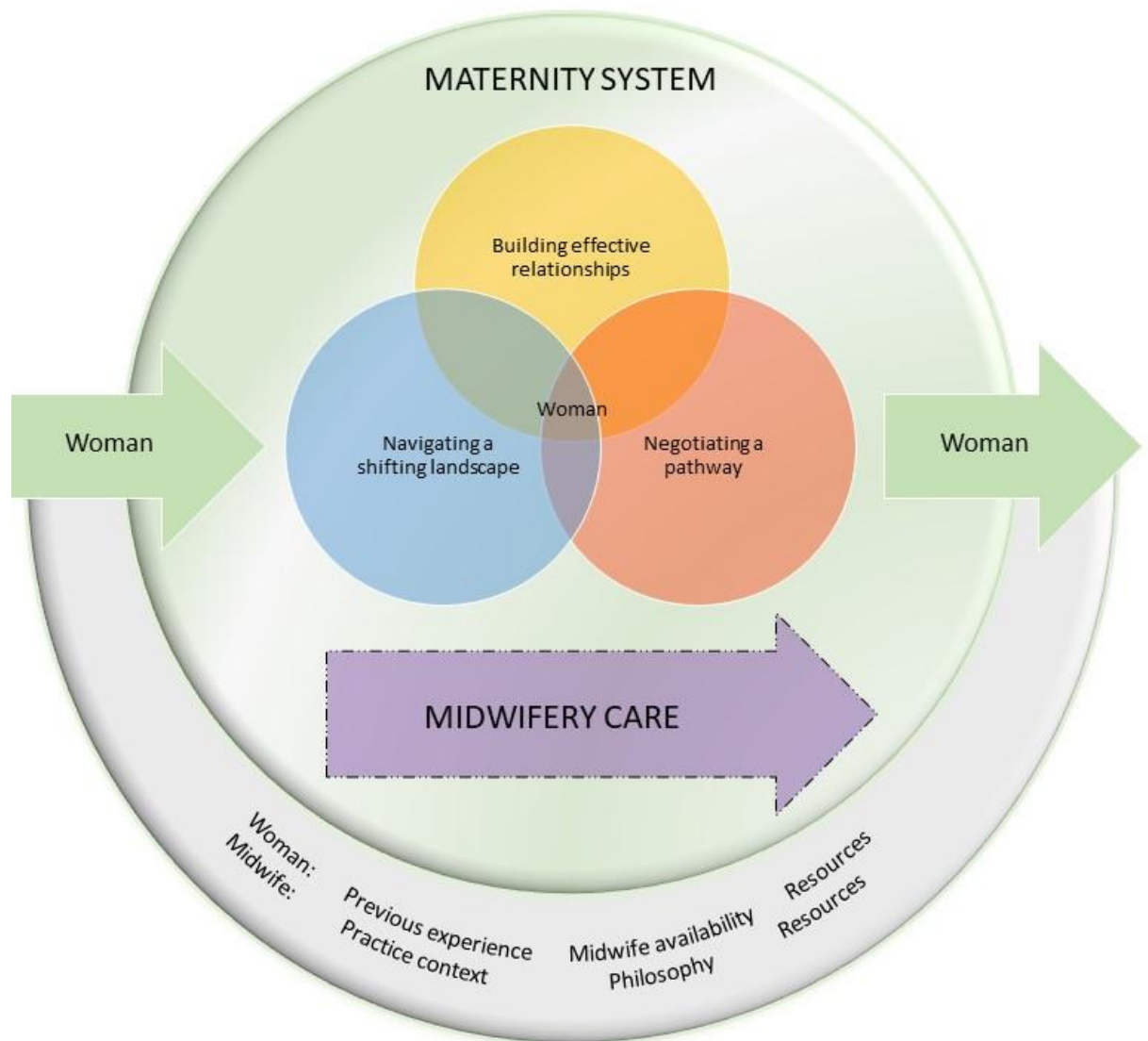
Figure 4. Diagrammatic representation of the theory of Working through complexity

5.1.1 Explanation of the diagrammatic representation

Figure 4 is a diagrammatic representation of the theory of **working through complexity**. The process of **working through complexity** begins within the woman's already complex life with its personal, situational, and relational complexity. When a woman first enters the maternity system, depicted by the 'woman' arrow on the left, she brings these complexities with her. Midwifery care is only accessed within the maternity system; hence being represented within the circle. A woman may not access a midwife as soon as she enters the maternity system. A delay in accessing a midwife is represented by the left 'woman' arrow not being flush with any of the three interlocking circles. Women may experience a delay in receiving midwifery care for a variety of reasons. The perforated arrow line surrounding 'midwifery care' depicts times when the

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women may not be receiving episodes of care, through it being delayed or missed. The woman moves back and forwards through the three processes of *navigating a shifting landscape*, *building effective relationships*, and *negotiating a pathway*, sometimes moving with the midwife and sometimes not. At some point, usually at the end of her pregnancy care, the woman leaves the maternity system, depicted as the 'woman' arrow on the right. The complexities she brought with her into the maternity system generally travel with her as she leaves the maternity system, whereas the midwife and midwifery care remain behind within the maternity system. The area where the three circles intersect represents the woman **working through complexity**.

The theoretical concept **working through complexity** linked the many strategies women used to access and engage with midwives. Salient conditions influencing **working through complexity** for women included their previous experience of midwifery care, midwife availability, as well as resource availability, including time, finances, transport, and satisfactory childcare. Midwives working with women living in areas of high socioeconomic deprivation were influenced by the salient conditions of their practice context and personal philosophy, influencing how they worked to enable the women to access and remain engaged with midwifery care. Strategies midwives used were also conditional on resource availability, including time, funding, and the need to sustain themselves.

5.2 Overview of the Theoretical Categories and Their Subcategories

The table below outlines the findings chapters, including the category and subcategories.

Table 6: Outline of the findings chapters

Chapter	Topic
Chapter 5	Major category: **Working through complexity**
	Introducing the theory of **working through complexity**.
	Overview of the three theoretical categories and their subcategories.
Chapter 6	Theoretical category: **Navigating a shifting landscape**
	Subcategories: the complexity of accessing midwifery care, midwives being responsive to a maternity system not working for women

5.3 Navigating a Shifting Landscape

The lives of women living in areas of high socioeconomic deprivation were complex. They navigated a shifting landscape of complexity around having adequate resources to buy food and pay for rent and utility services, accessing reliable transport, ensuring satisfactory childcare or accommodation, and dealing with family dynamics. These resources were in a constant state of change so could not be relied upon to be available at any time. On confirmation of pregnancy, women entered a maternity system which was not set up to respond to the complexity of their needs, within which they were required to find a midwife to provide their midwifery care. Accessing midwifery care required women navigating a shifting landscape to find a midwife. Coupled with which, women were entering a maternity system where midwife availability and location varied. The depleting resources of time and funding impacted midwives as they worked within the complexities of the maternity system. These, along with needing to sustain themselves for the complexities of working with this group of women, affected what midwives could offer women during their pregnancy experience to keep them engaged with midwifery care. Women reported the complexity of accessing midwifery care, with the process ranging from being easy to difficult. Finding a midwife was conditional on a woman's previous experience of midwifery care, availability of midwives, and having access to resources, such as money and transport. While accessing a midwife was straight forward for some women, various conditions led to delays in accessing a midwife for others. These included lacking information on the maternity system, the timing of the pregnancy being confirmed, and not having access to resources such as a phone or the money to phone a midwife. These conditions resulted in women booking late with a midwife and consequent delays in receiving midwifery care. The complexity of their lives required women to constantly balance competing priorities as they navigated an often shifting landscape. At times this resulted in women prioritising other activities and commitments over attending midwifery care.

Midwives were not always provided with the resources they required from the maternity system to respond to the women's complex requirements. Recognising this, and not wanting women to fall through the gaps in the maternity system, resulted in midwives employing various strategies to encourage this group of women to remain engaged with midwifery care.

5.4 Building Effective Relationships

Women participants in this study were living in vulnerable situations due to the complexity of their daily lives. Entering a maternity system not set up to meet what they required risked them deciding not to engage with midwifery care and, therefore, miss receiving this care, potentially impacting their pregnancy outcomes. Findings revealed that building an effective relationship between women and midwives was pivotal to women remaining engaged with midwifery care. Women and midwives worked at building effective relationships with each other acknowledging the knowledge and experience that each brought to the relationship. Perceiving the reality of these women's lives such as having limited resources, differing world views, and often a history of receiving poor treatment from previous health providers, resulted in midwives employing deliberate strategies to foster relationship building. Once developed, an effective relationship enabled women and midwives to create a partnership, working together to optimise pregnancy outcomes. Working in partnership meant women were more likely to receive services which were appropriate to meet their specific need requirements; and therefore were more likely to decide to access and remain engaged with them. Being part of the partnership–being heard, feeling safe, and trusting the midwife–meant women felt comfortable expressing what they required, or contacting the midwife to ask for help. Acknowledging the close involvement of family in the woman's daily life by including them in the woman's care was an important aspect of building an effective relationship.

Midwives spent time educating women about the various processes and progress of pregnancy ensuring women understood, so they could be supported with making informed decisions about their care. Working in partnership meant women were part of the conversations taking place during information sharing and decision making.

However, not all women and midwives built relationships that developed into partnerships. When women did not feel they had built an effective relationship with midwives some chose to miss midwifery appointments, thereby missing midwifery care.

Others sought out a different midwife to provide their care, sometimes resulting in a delay in receiving care, or changing midwives for a subsequent pregnancy.

Women reported trying to stay connected with midwives who did not arrive for their midwifery appointment or inform women they were delayed or unable to come. Midwives used many strategies to stay connected with women who missed an appointment perceiving it was important to ensure they continued to receive midwifery care, especially as this group of women were known historically to fall through the gaps in the maternity system. While midwives used different strategies, including their knowledge of the woman's community connections to stay connected to women, there were limits around their time and effort. Most midwives kept the door open for the woman should she return for care.

5.5 Negotiating a Pathway

Once they had accessed a midwife, women participants relied on midwives to negotiate a pathway through the maternity services with them wherever that pathway led during pregnancy. This was able to happen through the effective relationships they had built with their midwives. Continuity of midwifery care enabled negotiating a pathway to occur.

Women reported being caught between family members/others and their midwives over recommended care. Women were also caught between dealing with the competing demands of their daily lives and those of the health system, needing to make decisions about priorities. Wanting their known midwives to continue providing continuity of midwifery care when women's pregnancy requirements moved from primary to secondary, resulted in women being caught in the middle between the midwifery model of care which supported continuity and women centred care, and the health system which divided women's care into primary and secondary care episodes. Throughout the change, the midwife negotiated remaining involved. When women developed obstetric complexity, midwives reported the tension of being caught between the woman and the secondary care obstetric team when needing to make decisions around continuing to provide midwifery care. If the woman developed medical complexity such as diabetes, the midwife experienced the additional tension of being caught between the woman, the secondary care obstetric team, and the medical specialist team. In these situations, women relied on the support and advocacy of their midwives to facilitate acceptable solutions and negotiate a pathway through.

There were many influences on the midwives' decision making as they either successfully negotiated continued care or transferred the woman's midwifery care to their core midwifery colleagues, thus ending the primary relationship. The required negotiation and outcome could be dependent on facility financial and staffing resources.

The complexities which arose when working with this group of women led midwives to develop strategies to sustain themselves professionally and personally, enabling them to continue to gain satisfaction from their work. Midwives then continued providing care which met the individual requirements of women. This resulted in women remaining engaged, optimising their pregnancy outcomes. When they did not have sustaining strategies in place, midwives struggled with the complexity they were continually negotiating. In response, some midwives changed how they worked or chose to leave midwifery practice.

5.6 Conclusion

This chapter has introduced the theory of **working through complexity**, the first of four chapters presenting the findings from this research study. Women living in areas of high socioeconomic deprivation in New Zealand were constantly **working through complexity** moving backwards and forwards between the three theoretical categories of '*navigating a shifting landscape*', '*building effective relationships*', and '*negotiating a pathway*', as they accessed and engaged with midwives, working together with the midwife, or not.

Women reported the complexity of accessing midwifery care. They brought the complexities they navigated daily with them as they entered a maternity system which was not always set up to provide the resources required to respond to their complex needs. Various conditions led to delays in accessing a midwife, which for some women resulted in booking late with a midwife and consequent delays in receiving midwifery care, potentially impacting their pregnancy outcomes. Midwives employed various strategies to encourage this group of women to remain engaged with midwifery care.

Findings revealed that building an effective relationship between women and midwives was pivotal to women remaining engaged with midwifery care. Once developed, an effective relationship enabled women and midwives to create a partnership, working together to optimise pregnancy outcomes. When women did not feel they had built an effective relationship with midwives, some chose to miss midwifery appointments or seek out a different midwife to provide their care, sometimes resulting in a delay in receiving care. Midwives used many strategies to stay

connected with women who missed an appointment to ensure they received midwifery care.

Women participants reported being caught variously between family members/others and their midwives over recommended care, between the competing demands of their daily lives and those of the health system, and between the midwife and the health system in negotiations around care responsibility. In these situations, women relied on the support and advocacy of their midwives to facilitate acceptable solutions negotiating a pathway forward. To avoid struggling with the complexities which arose when working with this group of women, midwives put strategies in place to sustain themselves professionally and personally.

The theory of **working through complexity** was introduced diagrammatically, and an explanation of the diagram given. This was followed by an overview of each of the three theoretical categories and their subcategories. The theoretical categories and their subcategories will be discussed in greater detail in the following three findings chapters.

Chapter 6: Navigating a Shifting Landscape

The first time around I had no way of getting a midwife. There was just no way. … I was even trying to save up money that I'd get out of the bottom of the washing machine–out of his clothes–so I could use the payphone. So I could never get enough. It was just I couldn't. I would never have had a midwife. (Grace W)

This chapter presents **navigating a shifting landscape** to explain the process women living in areas of high socioeconomic deprivation in New Zealand undertook as they entered a 'one size fits all' maternity system. Women entered the maternity system bringing with them the various complexities that they constantly navigated through their daily lives. Resources available to feed and house their families, for transport, and relationship dynamics were some of the many complexities they faced. These were changeable and could not be relied upon to be available when required. Navigating this shifting landscape was complex and affected all decisions women made, including accessing a midwife for midwifery care.

Women **navigated a shifting landscape** within the maternity system to find a midwife, where midwife location and availability were inconsistent. How women accessed midwifery care was complex and varied. The process was reported to be variously smooth, protracted, or delayed. A delay resulted in women 'booking late' with a LMC within a maternity system which wanted them to be booked for pregnancy care by 10 weeks gestation. The complexity of the women participants' lives meant they were many times prioritising their needs in a range of changing conditions, such as when competing concerns in their personal circumstances required their attention. Prioritising needs could mean the woman chose to use transport money for food rather than attending midwifery clinic appointments, thus the complexity of the decisions she was making meant competing demands such as attending appointments with her midwife fell off the priority list. Consequently, there was the risk of missing midwifery care.

A number of conditions contributed to why this group of women **navigated a shifting landscape** as they entered the maternity system. These included the women's constantly changing resources and context, their health needs, together with their previous experience of the health system. In addition, the degree and nature of the support available through the maternity system to meet the complexity requirements of these women was limited and shifted, depending on contexts such as funding, midwife and specialist availability. Midwives responded in a number of ways to a maternity

system which was not working for women, aiming towards keeping women engaged with care, working towards an optimal pregnancy outcome. Figure 5 (below) highlights the theoretical category of **navigating a shifting landscape**. Figure 6 (p. 125) is a diagrammatic representation of the subcategories of this theoretical category.
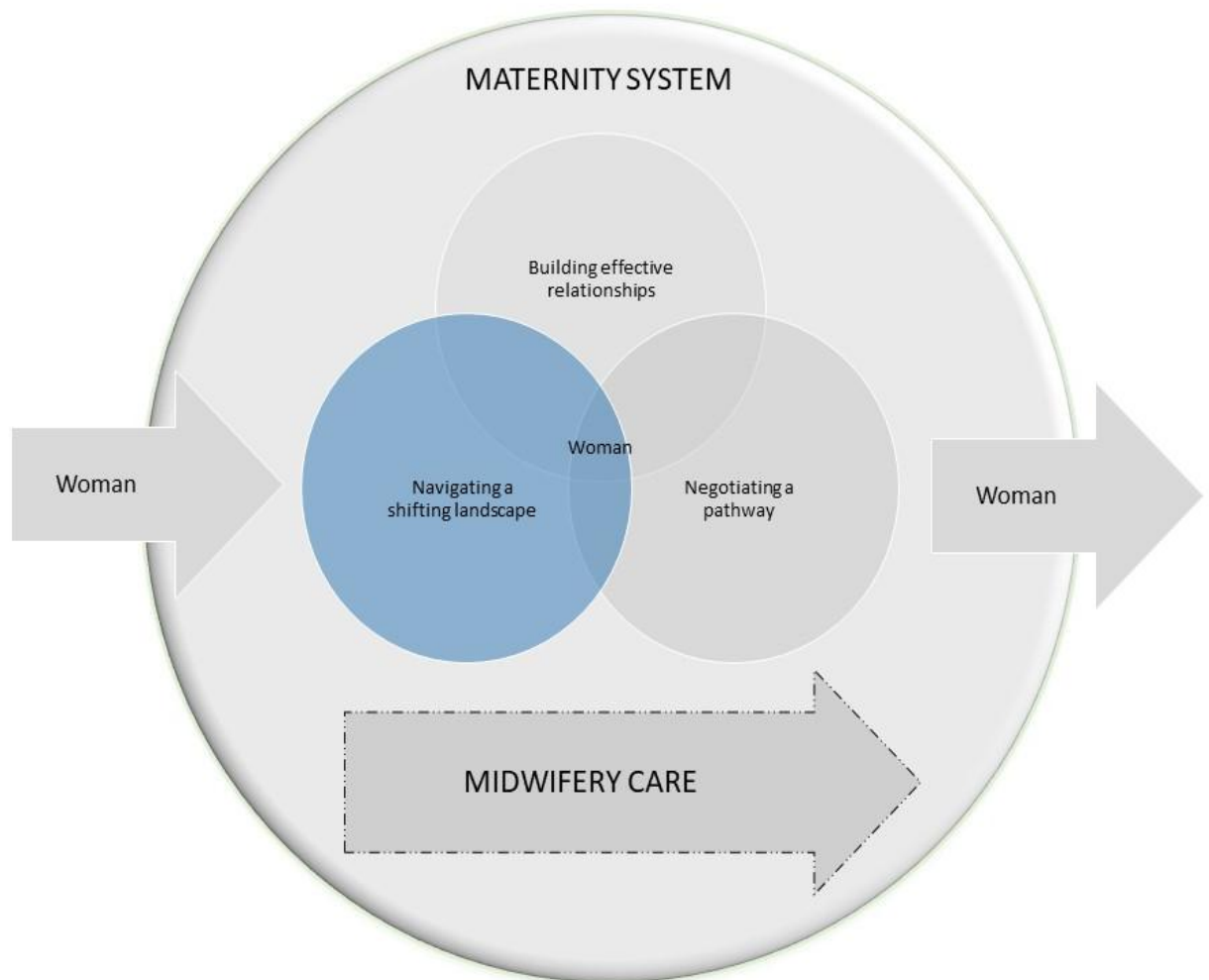
Figure 5. Theoretical category 'Navigating a shifting landscape'
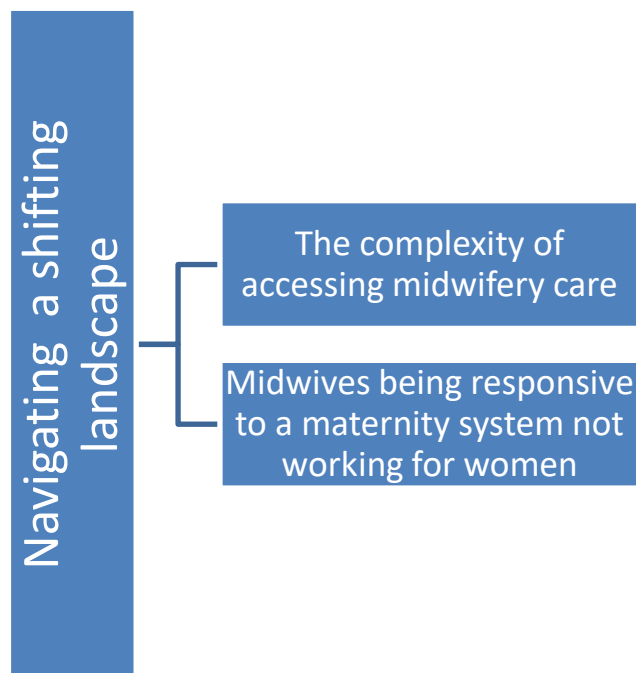
Figure 6. Subcategories of 'navigating a shifting landscape'

6.1 The Complexity of Accessing Midwifery Care

All the women in this study demonstrated wanting pregnancy care, as was seen when on confirmation of pregnancy they began searching for midwives through varied pathways. However, the complexities of their lives meant women were often prioritising their needs around concerns they lived with on a daily basis, and this included attending midwifery care. Trying to access midwifery care while navigating the constantly changing landscape of their day to day lives was challenging.

Midwife participants noted that women living in areas of high socioeconomic deprivation were generally more transient and had limited education and health literacy knowledge than more affluent groups of women. They also noted a high proportion were of Māori and Pacific ethnicity, and more likely to have English as a second language and operate out of differing cultural world views. If employed, this was usually in low paid jobs whether or not they were skilled at their work. They may not have had access to their own transport so relied on public transport for the supermarket and local shopping. They may have shared a mobile phone between family members. They may have shared a house with extended family members and not have access to the internet. Their resources (financial, social, transport) for accessing midwifery care were in a state of flux and unreliable due to regular changes, so the women were reliant on a range of conditions to be met in order to attend midwifery appointments. For example, depending on whether this was a pay/benefit week women may have money to

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access public transport for the midwifery appointment and add phone credit. This was weighed against their need to pay bills and get food onto the table for their families. However, their childcare may be unreliable. Additionally, a number of these women reported previous unsatisfactory experiences of interactions with health providers. They had been treated poorly, not listened to, and felt powerless in those relationships. Accessing a midwife when surrounded by, and coping with, this complexity could be challenging.

6.1.1 Finding a midwife

The pathway to accessing midwifery care for the pregnant women in the study began with finding a midwife. This process was reported to be easy or difficult and could take time. Finding a midwife was conditional on when the pregnancy was confirmed. However, as reported by both women and the midwives, finding a midwife was also conditional on women's expectation, knowledge of the maternity system, negotiations between various health personnel, referral, midwife availability, advice from family and friends, as well as the woman's personal context. When women were unsure of the health system, finding a midwife could be a hap hazard process. Women who had previously had their maternity care led by a GP, a hospital primary midwifery team, or a secondary care obstetric team, while having had exposure to core midwives, were not necessarily familiar with the role of a community LMC midwife. Women new to pregnancy held varied knowledge about midwives and midwifery. Some had been involved with family members during pregnancies and births so knew what a midwife was and something about midwifery care. Others had no knowledge about midwives or midwifery. "*I didn't know anything about midwives…so I really didn't know why I needed one*" (Grace W). "*…but to be honest, I was a little bit scared. A little bit scared. And it was like 'midwife,' that's a big word you know. I was like 'oh'*" (Renée W). When a woman knew a midwife from a previous pregnancy, whether she was willing or reluctant to work with that midwife again influenced her accessing midwifery care. Finding midwifery care was also dependent on whether the woman experienced difficulty contacting a known midwife. A resulting time delay led to women booking late with a consequent delay in accessing midwifery care. When women reported dissatisfaction with their experience of midwifery care they chose an alternative midwife during the current pregnancy or for the next pregnancy.

Seven women reported booking with a midwife after 10 weeks gestation for one or more pregnancies. This represented 10 of their combined 22 reported pregnancies. Of these, five women were booked before 20 weeks gestation, and a further five before six

and a half months; about 26 weeks gestation. Two women had always booked before 10 weeks gestation (four pregnancies in total). This information was not sought from the first two women interviewed about their five reported pregnancies.

6.1.1.1 Accessing midwifery care easily

Some women were able to access midwifery care easily. Belonging to a health centre which was easy to get to and had midwives on site, having previous experience of accessing midwives, and being able to utilise other resources, aided this process. The majority of participants first began finding a midwife through their registered health centre, where those with a confirmed pregnancy were advised how to access midwifery care.

6.1.1.1.1 Having a straight forward path

Women registered with a health centre, which employed midwives or had co-located midwives, had a straight forward path to access midwifery care, whereby they confirmed their pregnancy at the health centre and were referred to a midwife who would then make contact. This generally resulted in early engagement with care, with women usually being under 10 weeks pregnant when first referred to a midwife. Early engagement enabled registration with a midwife, full history taking, an opportunity for discussion and decision making around screening tests, advice about nutrition and exercise, and identification of any medical or obstetric complexity when early referral to other providers would be recommended. Early engagement also influenced the development of a relationship between the woman and the midwife, giving it a longer timeframe to develop.

Alternatively, women were offered a midwife working within a hospital based primary midwifery team. Midwives reported that occasionally women were also offered care from a private obstetrician; however, this option was rarely taken by this group of women.

6.1.1.1.2 Utilising resources

Women with no experience of finding a midwife accessed resources such as recommendations from family/friends or used databases, for example findyourmidwife (NZCOM, 2018e). In some instances the Practice Nurse or GP provided the woman with a contact list of midwives.

Finding a midwife could be easy when the participants had community support through friends/family, or where there was a community history of previous effective relationships with midwives. Through family referrals, women brought their sisters,

aunties, cousins, and others to midwives for midwifery care. In this way many of the midwife participants had provided midwifery care to several members of the same family. In these circumstances the midwife became well known within the family and held a special place within it. "*She said that I'm the family midwife now, and if any of her sisters and things have a baby, apparently I'm going to look after them*" (Catherine MW). Being considered the family midwife through the previously established connections was a privileged position valued by midwives, especially as the midwives were aware of how these women had often been treated by health professionals in the past. "*...it's a sense of belonging to the community for the midwife; being accepted as community*" (Marion MW). Becoming a trusted family midwife took time. Midwives related being told by women that they were considered part of the family and that they looked forward to their visits–this was a really enjoyable part of working with this group of women. Family referrals had a range of outcomes however, with the woman either being happy with the care received so returning for subsequent pregnancies, or seeking another midwife when she perceived the care to be unsatisfactory. "*...at times I did feel just like 'case number 54'*" (Mary W). Seeking another midwife could take time, resulting in a delay in receiving midwifery care

6.1.1.1.3 Relying on previous experience

Accessing a midwife was also conditional on previous experience. Midwives reported that if women had not accessed a midwife until later in a previous pregnancy and everything had turned out normally, they may plan on doing the same again. Molly gave the example of one woman who had recently turned up at her midwifery clinic when 36 weeks pregnant to register for midwifery care having had her previous baby in one of the Pacific Islands. The woman told Molly "*you don't really get [antenatal] care there. You just turn up when you're having baby and that's kind of it. So I thought you'd be the same.*" Assuming maternity services in New Zealand were similar to those experienced previously meant the woman may not have discussed accessing services with anyone.

6.1.1.1.4 Midwifery clinics being easily accessible

To provide a service that was easily accessible to women, midwives located their clinics in areas women regularly accessed which had good public transport, for example, near a shopping centre or supermarket.

> *I said 'look I need to be down in the [shopping] centre. I can't be up in that place' [in another part of the city] because it's too far away for a lot of my*

clients [women] [from] where they were going, because a lot ... can't get up there. They don't have the transport. ... And they need to have access to the bus, and they walk down the centre for other things, so they will come in to [the shopping centre]. Whereas up there [in another part of the city] is out of their league. ... So we decided to go into there. (Liga MW)

Having a clinic that was easily accessible and could be accommodated within a trip to, for example, the supermarket, meant women were more likely to remain engaged with midwifery care.

6.1.1.1.5 Contacting midwives early

Women who found it took time to access a midwife in their previous pregnancy often contacted the midwife early for subsequent pregnancies. This was especially clear when they had been happy with their midwifery care. "*By then I knew you had to get a midwife as soon as possible [chuckling] because they can get booked up very fast. Again she was very nice. She's lovely*" (Trish W).

Some midwives reported noticing a change in when women were first contacting them. Previously those midwives who were employed by or co-located with a health centre had experienced many women arriving at the health centre later in pregnancy, and therefore defined by the maternity system as booking late. They reported that in recent years women were increasingly recognising midwives were a limited resource, with some areas experiencing a shortage of community LMC midwives, and were contacting a midwife early to register for pregnancy care.

This was resulting in women booking and engaging in midwifery care earlier, with the potential improvement this had on pregnancy outcome. As noted above, nine women reported booking with a midwife before 10 weeks gestation for 16 of their 26 reported pregnancies, with two of these women always being booked by this time.

6.1.1.2 Accessing midwifery care with difficulty

Not knowing the maternity system, lacking the information or resources about how to contact a midwife, seeking an alternative midwife, adjusting to news of the pregnancy, along with working with the complexity of her daily life, could result in a woman experiencing a delay in accessing a midwife. Midwife availability varied in each area, and this could also lead to delays. If women did not access midwifery care or were not provided with a service until after 10 weeks gestation they were classified a 'late booker' by a maternity system that wanted all women to commence antenatal care by this gestation to optimise their pregnancy outcome (NICE, 2008, 2017; PMMRC, 2013,

2014, 2015, 2016, 2017, 2018). While women were trying to access pregnancy care, they found the landscapes they were working to access kept shifting.

6.1.1.2.1 Being unable to use resources

Having details of a website, a contact list of midwives, or recommendations from family/friends did not always enable a woman to access midwifery care. Utilising these resources was conditional on whether the woman had access to the Internet, a mobile or home phone, or money to use a phone box. When Grace had her pregnancy confirmed at her health centre she was given a list of midwives to contact. Grace had never heard of midwives. She knew nothing about them so was unsure why she needed one. At the time Grace was in an abusive relationship, had no phone and no money, and was unable to contact midwives on the list. As a result Grace did not book with a midwife until after 14 weeks gestation.

6.1.1.2.2 Experiencing a time delay

Women may have been delayed in early access to midwifery care, but this did not mean they had not been seeking midwifery care. Sometimes not being able to contact a known midwife resulted in a woman realising she then needed to seek out an alternative midwife. This took time, sometimes resulting in the woman only being able to book with a midwife later in pregnancy. For example, with her second pregnancy Lily tried to find the midwife she had had previously but was unable to. Time was passing so Lily rang a number to find a midwife and took the first midwife she could get.

Recognising during a phone conversation that she was not going to be happy with the midwife she had been referred to following confirmation of her third pregnancy, Terina contacted the midwife and told her that she did not want her to provide her midwifery care. Terina then began searching for her previous midwife. She tried many times to catch her midwife at her clinic but was unsuccessful and was aware that time was moving on. "*I was kind of stressed cos I was really needing a midwife*" (Terina W). Terina then contacted the hospital who sent a midwife to her home. Despite wanting pregnancy care and actively seeking care from early in pregnancy, Terina did not register with a midwife until she was around six months pregnant, being now classified by the maternity system as a late booker.

In some areas women who had their pregnancies confirmed early found the first midwife they contacted was fully booked, and the midwife she recommended was also booked. After ringing several more midwives, leaving messages, then waiting to hear back and many times not hearing back, by the time a woman eventually got in contact

with a midwife who could take her, several weeks had passed. "*I rang the midwife. She was fully booked, so she recommended another midwife. Yes. … she was fully booked, and she recommended the third, another midwife who was free, and then I think I was second [trimester]*" (Trish W).

6.1.1.2.3 Searching for an alternative midwife

When women felt they were not being well cared for by their midwife they reported feeling less able to voice concerns or ask for more information to add to what they had already been told. In these circumstances not feeling connected to the midwife yet having to trust the midwife knew what she was doing, was difficult. Some women made the decision to either pull away, perhaps by not attending midwifery appointments, or to seek out another midwife, potentially resulting in a delay in accessing care or booking late. In a subsequent pregnancy if the relationship with the midwife was not optimal, due to their previous experience, women sometimes felt more confident and aware of what they wanted so felt more able to change midwives either during the pregnancy or for the next pregnancy. This may be to an alternative midwife or to one known previously.

> *It was ok, but it was kind of new for me, and I kind of missed a few appointments because I didn't really feel comfortable, and sometimes I'd forget my appointment, but she'll never ring me to like [reschedule], so that's why I decided to hunt back for my old midwife.* (Nia W)

> *Word of mouth hadn't given me the experiences that I had hoped for. … So for the third time around … I [knew] that if I wanted a better experience I should really I think cast my net wide for a midwife. So I did that.* (Mary W)

Choosing to have a different midwife was conditional upon midwife availability and could result in late engagement with care, which may impact the pregnancy outcome.

6.1.1.2.4 Staying with a known midwife

For those experiencing midwifery care for the first time, usually with a first pregnancy, not knowing what to expect from midwifery care, thinking the care they were receiving was normal, and not wanting to rock the boat or cause a fuss, meant some women were more inclined to settle for the midwife they had even if they were unhappy with their care. In a subsequent pregnancy because of the difficulty some women experienced trying to seek an alternative midwife they decided to return to a known midwife if they were happy overall with their experience of care. Not wishing to share their health information with a different person was another factor influencing this decision. "*I*

didn't feel like I could go to anyone else cos I didn't want anyone else to know my business kind of thing" (Grace W).

6.1.1.2.5 Being referred for midwifery care

Not being able to find a midwife with spare capacity sometimes meant women were referred to the hospital primary midwifery team instead. As a result, women again ended up booking late despite seeking midwifery care early in pregnancy. In addition, receiving hospital primary midwifery team care meant receiving fragmented care, with antenatal and postnatal care undertaken by several primary team midwives, and labour and birth care being received from core hospital midwives. "*My sister…had to go to one of those shared midwives. …every time she goes into her appointments it's a different midwife. … She said that she didn't really like that kind of midwife"* (Nia W). Importantly for this group of women, it meant again being in a maternity system that was not resourced to take into account their individual situational complexity or meet their individual requirements.

6.1.1.2.6 Late confirmation of pregnancy

Managing day to day through lives that held many challenges meant women were not always aware of the potential for pregnancy. This impacted when they accessed midwifery care. Terina did not find out she was pregnant with her second baby for five months.

> *It was a shock. I didn't realise myself. I found out from, my cousin was actually meant to have a pregnancy test but she was nervous, so I kind of did one with her, and then hers came out negative and mine was positive*. (Terina W)

Terina then visited her GP who chose a midwife for her.

If a woman had a late pregnancy confirmed she sometimes needed time to get used to the idea before accessing a midwife, resulting in a further delay accessing midwifery care. Lynette was 18 weeks pregnant when she accessed a midwife for her first pregnancy. In her current pregnancy with her sixth baby Lynette was six months pregnant before she found out, by chance, she was pregnant. She reported needing time to adjust to the news. Consequently, it took another month before she contacted the same midwife she had had for her previous five children. This resulted in Lynette booking in with a midwife when seven months pregnant.

Having difficulty finding an available community LMC midwife when booking later in pregnancy showed a lack of midwife availability and was a resourcing issue. When a woman booked late with a midwife there was less opportunity to develop a

relationship with her, and less opportunity for sharing information to enable informed decision making. The woman also missed out on some of the screening tests offered earlier in pregnancy. All these conditions may impact the pregnancy outcome.

6.1.1.2.7 Prioritising competing concerns

Women participants' pregnancies were one part of lives which were taken over with multiple concerns, such as social disruption, children, childcare, housing, benefits, transport, and money issues; hence, attending for antenatal care did not always take priority. The pregnancy was competing with other priorities such as attending school activities or church events, an appointment with a Government department such as WINZ (Work and Income New Zealand) or Housing New Zealand, or an unexpected family event such as a tangi (funeral). Other women considered there were just too many appointments with what else was demanding their attention.

Women participants sometimes made decisions about more urgent or competing concerns. This meant that some concerns became lower priority than others, were simply overlooked, or forgotten. Within the complexity of the various decisions the woman made, an appointment with her midwife sometimes did not happen. It could seem like women were not prioritising their pregnancy care when they did not turn up to planned midwifery appointments due to the many social issues they had. "*It's just that it's not high on their priority list. ... They've other things to do*" (Molly MW).

6.2 Midwives Being Responsive to a Maternity System Not Working for Women

The community LMC midwife participants providing midwifery care to this group of women were working within a maternity system with limited support for the women's additional complexity requirements. An example is the assumption that a woman would have access to transport, money, childcare, and phone credit to access a maternity service, in this case, midwives. Recognising the complexity of accessing midwifery care within a maternity system which was not necessarily set up to consider women navigating a shifting landscape of complexity in their daily lives, and competing with their needs as a pregnant woman, midwives responded by stepping in to fill gaps they saw in these communities of complexity and limited resources.

6.2.1 Working around differing world views informing accessing care

Some midwives perceived that when everything was progressing well a few women felt it inconvenient to visit the midwife in the clinic so often, did not see midwifery care as an essential part of their pregnancy care when they felt well, or that there were too many

pregnancy appointments. These situations demonstrated a mismatch between different philosophies with a maternity system based on risk and the potential for something to go wrong, and a woman's world view of a normally progressing pregnancy.

Midwives found trying to get some women to participate in their care and come to appointments was one of the challenging aspects of working with this group of women, as the women did not think they needed the care, or if they had come from other countries their experience of pregnancy in their country of origin may have been quite different, again demonstrating differing world views. Midwives relayed experiences of some women not prioritising pregnancy care if they had booked late in a previous pregnancy and all had gone well, or had come from countries where they were just expected to turn up to the hospital when they were in labour. "*They think 'oh why is this person getting involved in my life? This is just normal. I can have a baby'*" (Liga MW). These women perceived they knew what was happening and when to call the midwife as they had already had several babies–so in their own world views this was not required. It also demonstrated a maternity system where consistent information encouraging early engagement with pregnancy care to optimise pregnancy and birth outcomes was not being shared appropriately with, or accessed by, each woman. "*I could see where she was coming from, and that it was her sixth baby and she just felt that everything was going to be ok 'I've done it so many times before'*" (Catherine MW). In these situations women and midwives negotiated an agreed arrangement to keep the woman engaged with care.

Midwives negotiated with women to keep them engaged with care especially when there were risk factors and frequent appointments were required. Midwives recognised that missing appointments meant women risked being labelled as non-compliant by the maternity system, with the implication they were not invested in looking after their own health. Whereas "*the majority of the women who are persistent non-attenders have already got children, and there's outside issues influencing what they prioritise and what is important to them*" (Steph MW).

Dispelling myths was sometimes necessary and having an understanding of important concepts for different cultures was advantageous. For example, some Pasifika believed that exercise, or riding in a bus or a car, was associated with causing trauma or abnormality, and were reasons babies died. Knowing that shared responsibility was an important concept for Pasifika, a strategy Janice used to undo these myths was taking some responsibility off the woman and giving the partner some responsibility for those activities.

You need to be brisk walking 30 minutes–half an hour–six days a week. You can have church day off. And you need to be doing this cos it keeps all the muscles strong, and that means your wife will be stronger for birthing your baby, and riding in the car or the bus is not going to cause damage because she's going to be sitting there quite safely, and the seatbelt keeps mum and baby safe. (Janice MW)

In this way the woman's health while she was pregnant became a shared responsibility. When the responsibility for the wellbeing of the woman in pregnancy was shared by the family during pregnancy, she was more likely to receive the care and support she required to be in optimal health.

6.2.2 Serendipitous access

Serendipitous refers to discovering something beneficial by chance. For example, a pregnant woman attends a midwife organised meetup for women and babies, and when the midwives enquire and find she is not yet booked with a midwife, they add her to their caseload. This ensures she receives pregnancy care which is beneficial to the pregnancy outcomes of her and her baby.

In response to a need for women in the area to have a regular social activity with associated opportunities for education, Joanne, a midwife, and her midwifery partner, ran a coffee morning playgroup for women and babies who had received their care. Having heard about it in the community, other women would also attend. Sometimes women would bring along a pregnant friend. Joanne and her midwifery partner would enquire about her midwife and, if she did not have one, they would take her on whatever gestation she was, to ensure she received midwifery care. At other times, a woman would arrive at their midwifery clinic in early labour unsure of her due date asking for a midwife. Joanne and her colleague would arrange to book the woman and add her to their midwifery caseload. They did this because they were aware this group of women may have limited resources to access another midwife, and they wanted to ensure she received midwifery care, while knowing that booking late or receiving no care potentially affected the pregnancy and/or birth outcome. Serendipitous access enabled women who, due to various complexities in their lives, had not been able to access a midwife, to do so.

6.2.3 The amount of antenatal visits

Despite midwives perceiving some women felt there were too many pregnancy appointments when they felt well (see Section 6.2.1), women participants were happy with the amount of antenatal appointments offered. They reported results were

reassuring that all was well with their babies and themselves. "*Cos the more the merrier [chuckling]! ...I'm happy because I know you know, every time I go there's some news about the baby and myself. Yes, just to make sure things are good. I like it*" (Lucy W). Negotiating fewer antenatal visits with midwives was mentioned by women as a possibility for multiparous women who felt well. This was seen as dependent on having developed an effective continuous relationship with known midwives. These women felt that the woman and the midwife knowing each other well would contribute to them being able to trust each other's expertise. In the following quote Trish shows her reasoning as well as her ability to prioritise her own needs within her relationship with her midwife.

> *I think, with my first pregnancy, I liked the frequency, but it was different with my third. I did have that sense of feeling like 'oh, I feel good today' or 'this week. I don't really need to. Can we stretch it out?' I guess ... maybe it can be stretched out with women who've had more than two children and they feel confident in themselves and there's no problems? And the midwife; I guess it depends on the relationship with the midwife - if they have confidence in their client [the woman] as well. Hence it's quite good with that continuity of care. Like having the same midwife for subsequent pregnancies would benefit cos it would work both ways for both the client and the midwife spreading out those intervals, because by then they've got this trust relationship; that they can depend on each other, or rely on each other's expertise. Yes. It's harder though if you have a different midwife each pregnancy.* (Trish W)

Only Lynette mentioned having had her midwife negotiate the number of antenatal visits with her in case she felt there were too many. Lynette was having her sixth baby with the same midwife so had developed an effective relationship with her midwife over a number of years. The known midwife negotiating the number of antenatal visits with Lynette, whose pregnancy was progressing normally, was one strategy for working towards keeping her engaged in midwifery care, particularly when she was aware of the complexity of limited resources and support that Lynette was constantly navigating in her day to day life.

6.2.4 Considering spaces for delivering midwifery care

Efforts to provide a service to women with limited resources led midwives to consider the spaces in which to deliver midwifery care. While all the midwives visited the women postnatally at home, depending how the midwives worked women were offered antenatal care in different locations, usually in their own home or through attending midwives' clinics. Believing that taking some responsibility for their own health and care was beneficial for women long term led to some midwives maintaining the expectation of women attending their clinic. "*You've just got to actually own this*

yourself. This is your pregnancy and you're worth it, like your care and your baby's worth it…. So come along and let me check you and everything" (Elizabeth MW).

The decision to not offer home visits antenatally was sometimes a result of midwives' previous experiences; for example, picking women up to take them to a hospital secondary care appointment when there appeared to be issues with transport and discovering later that this was not necessarily true. Some reported that offering home visits was not a good business model due to the unpaid travelling time required in addition to the length of the antenatal visit itself. Other midwives had a different view, believing that the extra time and petrol it took to visit this group of women at home was part of providing care. "*Some midwives won't do any home visits. They don't think that's economical. But these women can't put food on their table every day of the week and I can, so that's where I come from"* (Janice MW).

Midwives reported that when offered home antenatal visits they had experienced women recognising they were busy and declining; instead committing to including clinic visits as a priority where possible. Women who had chosen home antenatal visits were happy to travel to the midwives' clinics for antenatal appointments if the midwives were unable to home visit for any reason. This demonstrated the woman working with the midwife to optimise her pregnancy care within a shifting landscape–navigating the change in the location of her appointment. The location of antenatal visits varied amongst midwife participants, as did their reasons for the locations offered.

6.2.5 Incentivising attendance

At times there were women who did not attend appointments despite encouragement. In these situations midwives may decide to use incentives or 'tricks of the trade' to encourage attendance. Some midwives had access to taxi chits for transporting women to and from secondary care clinic appointments. Offering a scan such as the 20 week anatomy scan generally resulted in women attending a midwifery appointment to get the required form. Offering a midwifery appointment when contacted by a woman wanting a medical certificate or a letter signed at 27 weeks so she could apply for the sickness benefit, usually resulted in attendance. After the initial booking, trying to get women to come for the 20 week appointment, have the anatomy scan done so the midwife knew where the placenta was, and get routinely offered early pregnancy blood tests done by that time so her blood group was identified, was the minimum information the midwife required if she was to continue to provide care for the woman who did not attend regularly for midwifery care. Incentivising care was used when alternatives had failed,

as the midwives knew that walking away from providing midwifery care would possibly result in the woman receiving no midwifery care.

6.3 Conclusion

In this chapter '**navigating a shifting landscape**' was presented to explain the process women living in areas of high socioeconomic deprivation in New Zealand undertook as they entered a 'one size fits all' maternity system which was not always resourced to meet their or the midwives' needs. Accessing midwifery care was complex, with women reporting finding a midwife as easy or difficult. It could take time and was dependent on several conditions. **Navigating a shifting landscape** where resources required for meeting day to day needs were under constant change and unreliable for a range of reasons, including those for accessing midwifery care, resulted in women relying on a range of conditions to be met if they were to attend midwifery care. The complexity of women's lives meant women were constantly balancing competing priorities when prioritising their needs, which sometimes resulted in missing appointments with midwives. Midwives responded to a maternity system which was not always working for women using several strategies to keep them engaged with midwifery care working towards an optimal pregnancy outcome.

Chapter 7 presents '**building effective relationships**' which findings revealed was pivotal to women remaining engaged with midwifery care. At times, women's social situations interrupted the relationships that had been developed with midwives.

Chapter 7: Building Effective Relationships

> *"So I think the most important thing is building that relationship and having confidence in the midwife, and the midwife listening to the woman carefully"* (Trish W).

For women living in areas of high socioeconomic deprivation, having a maternity system which was not always resourced to address the complexity requirements arising from the context of their daily lives risked women deciding to not engage and, therefore, miss receiving care, potentially affecting their pregnancy outcome. However, through **building effective relationships** with midwives, as they navigated the maternity system, women were encouraged to remain engaged with pregnancy care. **Building effective relationships** resulted in the creation of a partnership between the woman and the midwife. Creating partnership enabled women and midwives to work together to effectively address the woman's care requirements within a maternity system that did not readily meet their needs. Working in partnership meant sustaining the relationship. Consequently, women were more likely to remain engaged with midwifery care by turning up for subsequent appointments, enabling continued monitoring of the wellbeing of their baby and themselves. They felt reassured by their midwives about their progress throughout the pregnancy and postnatal period. This was often the women's first experience of being treated as an equal partner by a health professional, and was valued by women, who reported a satisfactory experience.

One aspect of building an effective relationship was ensuring women understood the processes and progress of pregnancy so they could make informed decisions about their care. If women missed an appointment with their midwife, following them up to try and ensure they stayed connected was crucial, as midwives knew this was a group of women who traditionally fell through the gaps in the maternity system. Due to the woman's complex living situations staying connected was dependent on the midwife's knowledge of the woman's community connections. Staying connected took time, energy, and sometimes family or community negotiations.

When social circumstances were such that a woman did not develop an effective relationship with her midwife, the development of a partnership was interrupted. In these circumstances while midwives went to some lengths to remain connected to ensure she remained engaged with midwifery care, there were limits to their resources. There were also limits around how much time, effort and negotiation were appropriate when trying to ensure women stayed connected. Figure 7 (p.140) highlights the

theoretical category of **building effective relationships**. Figure 8 (p. 141) is a diagrammatic representation of the subcategories of this theoretical category.
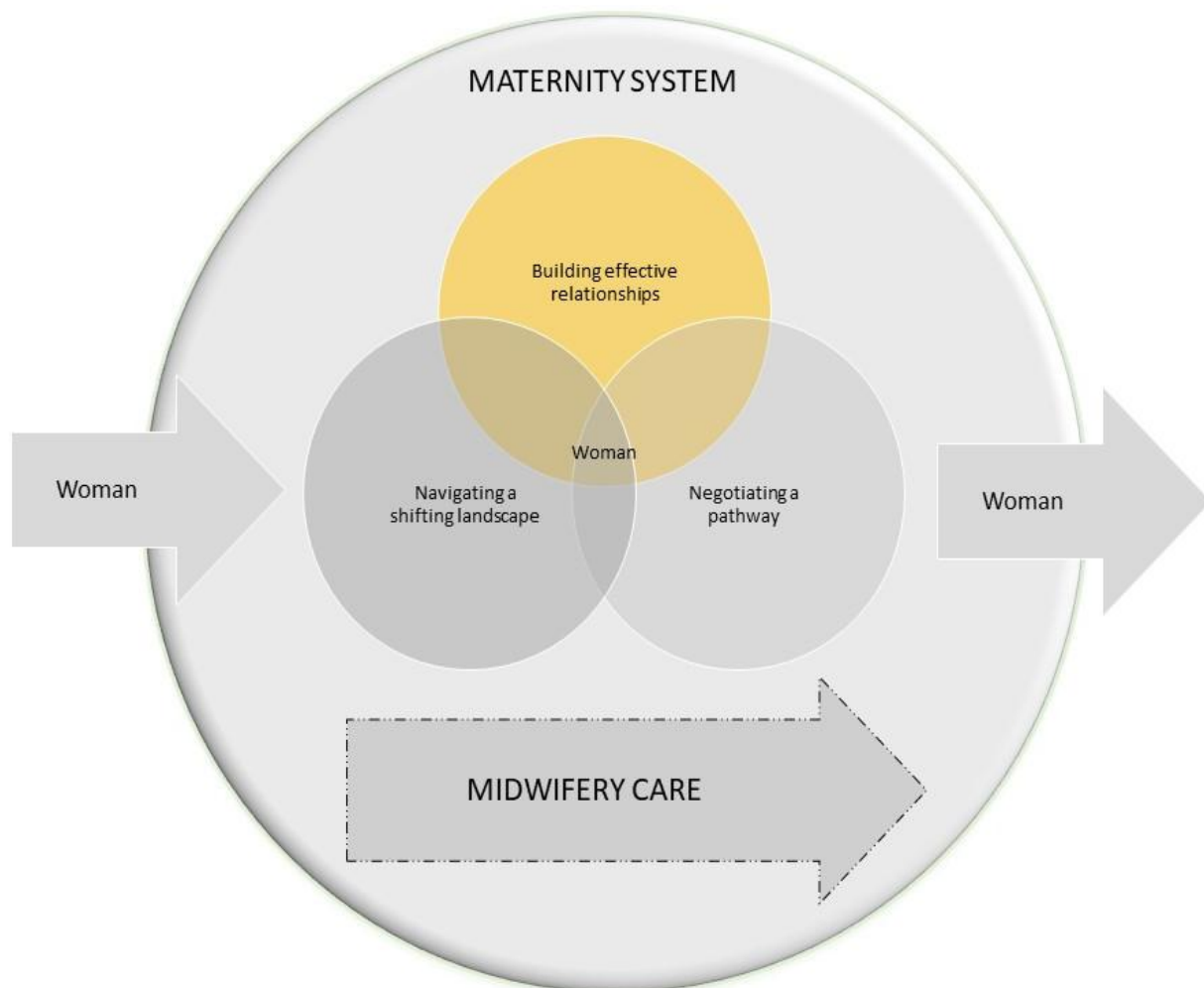
Figure 7. Theoretical category 'Building effective relationships'
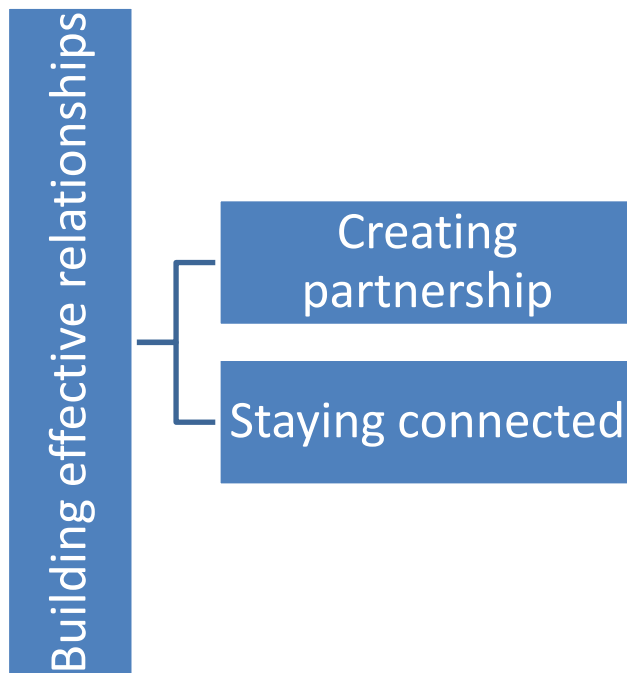
Figure 8. Subcategories of 'building effective relationships'

7.1 Creating Partnership

Once the woman had registered with a midwife, building an effective relationship was key to working together to optimise the woman's pregnancy care. An effective relationship was also necessary for women and midwives to share information in a way that ensured understanding for both. Midwives used strategies such as getting to know the woman, finding common ground, taking time, explaining, negotiating, and understanding the women's context and world view, to build relationships with this group of women. *"She explained everything and made me understand"* (Lute W).

> *...and I just felt safe with her. Yes. ...just the way that she explained herself from the beginning right to the end. It was very helpful. It just made me feel, oh I don't know .... We just had a great, growing a bond.* (Renée W)

Having limited resources, coupled with the complexity of their daily lives, contributed to women participants with a first pregnancy often coming to midwives with little knowledge of the maternity system, what midwifery care entailed, or what midwives offered to promote the wellbeing of themselves and/or their babies. Some women experienced with pregnancy also exhibited a lack of understanding and appreciation of the impact managing their own health may have on the outcome of their pregnancy. Additionally, women's previous interactions with other health professionals may have resulted in them being passive partakers in a system. Working with women and their previous experiences required midwives to build an effective relationship

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using deliberate strategies which, at times, extended beyond usual effective midwifery care due to the women's contexts of having limited resources, differing world views, and previous negative experiences of health professionals. Woman reported trust in the midwife enabling them to work together to optimise the pregnancy outcome. "*...it was a partnership between her and I, as opposed to feeling like I had [with previous midwife]. I suppose I, I just felt included. I felt very, yes, included*" (Mary W). Through working in partnership the various complexities of the daily context of the women's lives were addressed, resulting in women remaining engaged with care. Being informed was identified by women and midwives as important to women participants.

The woman's family had an important role in her care as the majority of the women were from cultures in which extended family were closely involved in their day to day lives. Family provided ongoing support throughout the pregnancy and birth and, importantly, once midwifery involvement had ceased. Working with the woman's family was therefore an important aspect of creating a partnership with the woman herself.

7.1.1 Establishing rapport

How women perceived they had previously been treated by midwives had a major influence on the nature of how that relationship developed. Women participants identified the traits and supportive behaviours they wanted from the midwives. These included taking the time to get to know them, giving information about what to expect during the pregnancy, being easily contactable, responsive to concerns, and explaining information so they clearly understood. Women wanted to be listened to, involved in decision making, have their questions answered, and to not feel rushed at midwifery visits. "*It was like she took her time to make sure that I was able to tell her everything that I was feeling and going through, so she could make sure that she was helping me as well*" (Terina W). When these attributes were present within the women-midwife relationship, rapport was established easily and women reported feeling comfortable sharing information. They developed confidence and trust in their midwife and the birth process, felt cared for, and safe. This was often the first health professional with whom they had been able to build a trusting relationship. Women then chose to return to the same midwife for subsequent pregnancies. "*So yes, that's how good our relationship is that I went back to her with this baby*" (Nia W). Midwives spent time using different strategies to establish rapport.

7.1.1.1 Taking the time

The first appointment with a woman took time due to the volume of information and documentation required. This first appointment was an opportunity to assess women's health literacy knowledge and understanding around pregnancy and childbirth, and to identify any social, medical, or obstetric complexity. It was also the beginning step of the woman and midwife developing an effective relationship. The midwife making sure she could pronounce the woman's name correctly and identifying the correct place the woman was from or where her family roots were, encouraged women to contribute, thus opening the door to the development of an effective relationship. Finding something in common to connect each other helped get the relationship off to a good start. For example, finding that sport was an interest she had in common with her midwife enabled Tina to feel connected to her through the conversation that resulted. Tina lost her initial shyness and felt she and her midwife could be open to one another, and she got along well with her.

Being mindful of body language was useful, for example, the midwife seeming interested in the woman and her family by ensuring she looked at the woman instead of turning away to face her computer or write notes during appointments.

> *So like if I'm sitting there you know, instead of turning to my computer, and again, I've found it's really different when you've been asking all the questions, you know all the history questions, and you've been asking them for so many years you know them off the top of your head. ... turning around and looking at them and not looking at my screen and not writing anything, I think helps.* (Molly MW)

The importance of taking time for small talk in building the relationship with women was recognised by midwives. Asking the woman about her family in a conversational, rather than enquiring way through having a chat, rather than interrogating, gleaned much information. "*She had an openness and an ease about her which maybe was easier for me to connect with*" (Mary W).

Midwives took the time to discuss some of the many topics related to pregnancy and the maternity system during the initial and subsequent visits with each woman, in addition to monitoring the woman and baby's physical wellbeing. Topics included ensuring women understood midwifery care, what to expect during pregnancy, and the different options they had up until postnatal discharge from midwifery care. Women often had not had this information discussed with them before. While time consuming, women appreciated the time midwives took to give them this information. Taking time

in this way was more likely to result in the development of an effective relationship between the woman and the midwife.

7.1.1.2 Developing a bond

Conversations aided women and midwives getting to know each other, and developed relationships. Finding midwives friendly, open, and honest, made women feel relaxed and able to build a good rapport. This led to a trust relationship where the woman and midwife could depend on each other and rely on each other's expertise. Showing that midwives listened and cared were attributes women sought. "*I felt like she wanted to be there, and [she] was very professional in all of her dealings with me*" (Lily W).

Midwives recognised that if they lost the relationship with the women, for any reason, the women could decide to not have them back. For this group of women who were already at risk of not accessing care, this was more likely to result in receiving no care.

> *If they won't see you for the remaining four weeks of the postnatal period, unlike other more affluent women who will be ringing around different midwives saying 'look, I've just sacked my midwife. I'm looking for another one. Can you do the four weeks remaining of my care?' this group of women won't do that.* (Sophia MW)

Midwives found having empathy was useful in getting to know women. Being able to refer to their own experiences around pregnancy and birth created a bond with the woman, especially if their children were of a similar age or the same sex.

> *Before I had a baby they'd say 'I'm feeling really tired,' and I would say 'oh, try and have a nap.' But now I know! I can see that you would lie down in the supermarket and go to sleep if you could.* (Molly MW)

Midwives found some women more difficult to connect with than others, with women sometimes appearing very 'closed off' to them. The reasons midwives reported for some women being more difficult to connect with included the woman's previous interactions with health professionals or other health services. Women needed to trust the midwives were there to help them, and that their information was not going to get forwarded to another agency. However, by continuing to be respectful, open, showing women kindness, and making sure she felt she was important, most women learnt to trust and feel safe, and eventually accepted their midwife. "*And it can take several births without the back up of someone [family or friends] knowing you to gain that trust in that relationship with you where they'll accept you*" (Sophia MW).

When the women reported a negative response while accessing the midwife or a negative relationship during a previous pregnancy, they recounted experiences of not being heard, feeling diminished, dismissed, and even receiving rude responses. Under these conditions, the women decided to either take charge of the situation and change their midwife during the pregnancy or choose not to return for future pregnancies. However, when women felt midwives had spent time getting to know them they were more likely to feel positive about them, remain engaged with midwifery care, and return for subsequent pregnancies. Women felt that choosing to return to a known midwife for care made everything easier. "*I really felt she had my interests at heart; not just my, my care and my welfare, but my interests*" (Mary W). Knowing the midwife meant women felt comfortable and more able to express their concerns. "*It just feels like 'oh, it's back; that feeling.' Like 'oh, she's here. She's going to look after me with my pregnancy and the baby.' Yes. It just feels good*" (Lucy W). Women then perceived the midwives as responsive, providing great support, and felt confident and reassured by their care. When women experienced additional challenges associated with pregnancy, for example postnatal depression, they considered their midwife had provided care that went above and beyond what they expected of midwives. Feeling encouraged by their midwife was valued especially when experiencing difficulty with, for example, breastfeeding.

> *She knew how much I wanted to breastfeed. Yes. She just knew. And she would always –she didn't push me–she always said 'we can do this [chuckling]!' You know, so I was like 'I so can! Yes I can!' You know, so yes. During those times it was good. It was just good encouragement. ...and to have her there was a good feeling.* (Renée W)

When Lynette developed postnatal depression she was surprised at the amount of support her midwife provided.

> *When I went through it she was really great. She came over every day even when she was only supposed to be coming over once a week. Yes. She tried to help me as best as she could while I went through it. ... And I think that's why I feel myself so attached to her; cos she didn't just come for the baby, she came for me too. That's why.... Having that other support from somebody else; it feels crazy.* (Lynette W)

When women found midwives approachable, caring, and responsive, they were more likely to sustain their relationship and, therefore, remain engaged with midwifery care.

She was like this beautiful untouchable person you know, who had the money, the car, and here was me, and I felt [silence]. But she didn't treat me any different from anyone else. Yes. So she was really nice. (Grace W)

Developing a bond was an important aspect of establishing rapport.

7.1.1.3 Being proficient in other languages

Some of the midwives were proficient in other languages and women deliberately sought them out to provide their midwifery care. The ability to communicate with women and families using their unique language skills assisted the midwives to develop an effective relationship. It also meant women could communicate with the midwife in their first language throughout their whole labour, rather than relying on intermittent contact with Language Line, or using another interpreter. When dealing with other ethnic groups it became apparent to midwives how much the women and families potentially missed out on due to the midwives not speaking their first language.

> *…it was a real insight to me from what I could give to the [people from country A] what the [people from country B] weren't getting.*
> **[Researcher] Do you mean about the language**
> *Yes, the language, because they could have a next to, an experience close to what they could get where they came from almost, just for the language, not for the culture and how it was done, but the [people from country B] couldn't get that.* (Sophia MW)

7.1.2 Sharing information

Sharing of information between the woman and the midwife supported the development of an effective relationship and the creation of partnership. Midwives in this study identified several features which made the role of educating women living in areas of high socioeconomic deprivation different and more time consuming than with other groups of women. Giving information to this group of women was challenging as every woman came with different education and health literacy knowledge arising out of their culture of origin. "*…so trying to meet them where they're at for them to understand the processes and progress and decisions in their pregnancy*" (Elizabeth MW). The midwives worked to ensure women had a good understanding of information to enable informed choice and decision making around their pregnancy care and the maternity system. It was particularly important knowing this group of women had usually had previously unsatisfactory experiences of other health providers.

Women wanted to know everything that impacted their pregnancies and babies, and midwives used many strategies to ensure this occurred. When midwives took the time to ensure women had all their questions answered and checked their shared understanding of everything that was happening to them, women reported they were

well informed, happy with their care, and safe. "*...and I just felt safe with her. Yes*" (Renée W). "*[She gave me] lots of information, and was always asking questions, which made me feel like, safe*" (Lute W). This was seen as an important part of the relationship building and enabled women to make informed decisions. "*...and like the things that I don't know, she explains it to the extreme that I would understand it, and not just explain it and I'm like confused and that. But she'll explain it til I understand everything*" (Nia W). Explaining hospital appointment letters so women understood the importance of keeping the appointments and exactly where to go was critical if women were to attend. In this way midwives filled a gap in the health system to this group of women. Midwives took time to ensure women understood the information. "*...so you actually do have to have a passion to work here. Cos actually you can't do things as quickly as other midwives might do them*" (Janice MW).

7.1.3 Supporting shared decision making

The model of care informed by partnership that the midwives worked out of meant they were committed to using strategies to assist women's decision making. When there were decisions to be made during pregnancy, for example about whether to have offered blood tests, women appreciated midwives talking to them first to ensure they understood what the tests were for and why they were recommended, and then being asked to decide whether to have the test done. Women reported valuing midwives taking the time to share information and ensure they understood information related to pregnancy and the maternity system. This contributed towards shared decision making, which enhanced the development of an effective partnership. Sharing information to ensure shared decision making was an essential element if women were to navigate the maternity system and remain engaged with midwifery care. "*She knew the answer to every question I asked, and she was really informative, and she seemed confident, and she knew what she was talking about*" (Grace W). Being able to provide care that was evidence based, informing a woman why a particular plan of care was being suggested, ensuring she understood and was happy to make an informed decision, was reliant to some degree on the relationship established between the woman and the midwife.

Being supported to make these decisions was important to women. "*I could make the decisions on my own with her just helping me along the way, supporting me*" (Nia W). "*It feels like I have made the decisions she's recommended if I want those kind of things. Yes, so like I said, feeling that I am in charge of something*" (Lucy W). Women felt active participants in the decision making. "*She can't force me to do [anything]...cos you need to know what they're taking our blood for, really*" (Lynette

W). Being involved in the decision making reassured women positively about the relationship they had built with their midwife. Women reported positively about partnership as a result of these strategies.

Most women welcomed the amount of blood tests and scans offered. When women were reluctant to have any of the tests they made their own decisions about whether or not to have them. Women participants reported they appreciated being presented with information to inform their decision making rather than being told by their midwife what to do. *"Not so much of that happens too often. ... I mean, she [midwife] only means well when she says 'go and do a blood test'. I just do it whenever I feel like it [chuckling]"* (Lynette W). When women perceived they were unable to communicate well with their midwife, they reported they had not developed an effective relationship.

7.1.4 Midwives providing preparation for childbirth and early parenting education

Midwives mentioned that this was a group of women who generally did not access regular antenatal classes, and that the majority of Māori, Pasifika, and teen aged women would not be interested as the classes did not address their specific requirements. The midwives reported that perhaps some women felt shy about interacting socially with a whole room of people, or class timing interfering with work commitments. Some women were told by their families that they would look after them so the women did not need to attend antenatal classes. Midwives reported a need to fill this gap by taking antenatal education to the women to avoid women missing important information. This was particularly so with women who had specific obstetric or medical issues which led to frequent acute admissions throughout their pregnancies.

> *These are women who are not going to have a nice low key waterbirth you know, with minimal intervention–that kind of thing. They are going to have a couple of luers stuck in them as soon as they walk into the hospital, and anaesthetists talking to them, and the consultant coming down and checking their bloods, and all that kind of stuff.* (Stacey MW)

When women did not receive the education they required they found their own solutions. Grace returned home after birthing her first baby and the first night went to go to bed and realised that no one had ever told her how to put a baby into the bassinet. Consequently Grace and her baby co-slept for the next two years. Grace did not tell her midwife this as she did not want to get told off and be made to feel she should have known this information. Grace also had little breastfeeding information.

> *I just kind of did it. I just put her on. It was really painful and one side got quite badly damaged, but not bleeding. She obviously wasn't latched properly, and it*

was really painful. But I just kept going because we had no money; I couldn't get formula. So I just kept going. And then it came right. (Grace W)

Educating women about practices that the midwife would not recommend could be challenging. Any discussion with the woman about why she had adopted a non recommended practice had to be done in a careful, non-judgemental way, and her right to make the final decision respected and supported.

> *It's more of an educational opportunity. ... But you ultimately have to leave that decision with them and respect that they are also a family unit who have the right to make their own decisions, but they have the right to the education to make those decisions as well.* (Catherine MW)

Despite the more difficult situations, overall midwives found women were very receptive to information they gave them and their relationships remained intact. "*And then they are just almost so grateful, and willing to try other things as well that you suggest*" (Catherine MW).

Ensuring women understood all the information they were presented with enabled them to make informed decisions around their pregnancy care and assisted the development of effective relationships with their midwives, creating partnerships. Being supported by their midwife in this way meant women were more likely to find navigating the maternity system positive, resulting in them remaining engaged with midwifery care.

7.1.5 Working with extended family

Working with the woman's extended family was integral to the woman continuing to engage with midwifery care. Midwives found this group of women were used to having their family closely involved in their daily lives, and valued their input. Thus, working closely with each woman's family was an important part of providing midwifery care. This was especially true when several generations of family members were sharing a home. Financial considerations also impacted, such as pooling money to pay rent. Family was defined by the women and often included close friends as well as those genetically related.

For the midwife, including the family meant acknowledging their presence and being open to their involvement. Spending time with women and their family helped midwives develop an effective relationship with them. During an antenatal visit when a woman brought family members with her the midwife would chat to them all, including the children. Often accompanying family members would bring up their own birth stories and depending on the available time, midwives would listen.

Working to remember the names of support people in preparation for attending the woman's labour, was one strategy midwives used to include the family in the care. They could then address the family members by name and encourage them to become involved in the woman's care. When the woman was in labour the midwives talked to her family encouraging them to keep supporting the woman by continuing massage or encouraging her to be up and walking around with them, acknowledging the support they were providing.

> *And I talk to them and acknowledge their support of the woman, like things like when they're all rubbing her back and doing everything, and she's breathing and in pain and upset and stuff, but coping, [I'll say] 'it's so fantastic you've got all this lovely support,' and I'll acknowledge everyone's involvement in the labour.* (Elizabeth MW)

Encouraging women to stay at home during early labour, if they felt well supported by the family around them, was encouraged by midwives. Negotiating a plan for when to contact the midwife and when to travel to the birth facility was part of the birth preparation women wanted discussed antenatally. Occasionally women were being so well supported by family that they did not contact the midwives when planned, resulting in the midwives attending the occasional unplanned homebirth. "*'Whoops' you know, 'you're fully. Are you gonna push?' 'Yes?' 'Ok let's just have the baby'*" (Liga MW).

While the midwife's primary role was to address the woman and baby's needs, it was in the woman's best interests to encourage and support her family's ongoing involvement once midwifery involvement had ceased. *"She made sure she told me and my family what was going on, so no one was out of the loop"* (Tina W).

While having a good relationship with the family was ideal, occasionally midwives interacted with family members who were unhappy about some aspect of a woman's care. Even if the family members had been involved in the woman's pregnancy care, the midwife may not have met them previously. Dealing with family members who were frustrated at, for example, the length of time the labour and birth process was taking was difficult and uncomfortable for the midwife. Sometimes misunderstandings occurred resulting in midwives clarifying situations while coping with the professional effects of the interaction.

> *I went up to [one house], and there was this girl that had refused to see me. So the second time I went to her postnatally…I knocked on the door, it was about 7.30 at night, and I'd text her and said 'I'm running late but I have to come and see you cos you weren't home', and I knew she was developing an infection and all sorts of things…. She'd text me and said 'sweet as mate. We're home'. ….*

And I knocked on the door, and I heard her mother [ask] 'who the f**k is that?' and [the woman] came and answered the door and said 'oh it's just the midwife.' 'Well what the f**k's she doing coming here at this time of the night?' And I was like 'would you like me to go? I can just leave. Are you ok?' 'Just come in'. So I went in, did the check and gave her antibiotics…and then the next time I went the mum came out and I went 'oh, am I going to cop it? I'll come at another time if I have to,' and she goes 'oh my God! I'm so sorry! I was so drunk!' And I went 'it's all good mate. I didn't want to be there at 7.30 at night either! I actually wanted to be at home having dinner with my family.' And she goes 'yes, yes, fair enough. Fair enough mate. Sorry about that,' and that was fine. (Liga MW)

When working with any woman, conflict with family members was part of the complexity which all midwives encountered. When working with women living in areas of high socioeconomic deprivation however, navigating the conflict was necessary if midwives were to ensure the women continued to remain engaged with care. When faced with conflict the midwives reported their strategies to stay calm, listen to the family's concerns and acknowledge their thoughts and feelings. They then explained why one particular aspect of care was being suggested over another, while encouraging the family to ask questions and letting the woman know she was entitled to make an informed choice. Midwives found most family members, once given more information, did not continue to complain. Through navigating situations with the family in this way, midwives worked to ensure their relationship with the woman and the involvement of her family continued.

Midwives were sometimes contacted for advice by women with previous experience of their midwifery care and became involved in situations involving women who were not in their current caseload. Midwives were contacted because these women trusted that they could ring them and say "*please can you help me and my family*" (Janice MW)? The midwives responded because they were the family midwife. Becoming involved took time for which the midwife was not compensated, but was something the midwife saw as essential in maintaining the relationship with the woman and the family.

7.1.6 Prioritising the relationship before care

For women, working in partnership with their midwives meant feeling cared for and resulted in them experiencing the pregnancy, birth, and postnatal experience they desired. Women prioritised the relationship they developed with midwives over care concerns.

…of course I wanted the care, but if I was to weigh it up I would go for the relationship before the care, because I feel that if I had a relationship, you

know, a good, a positive relationship with somebody, that the care–that's just a by-product of what will happen anyway. Whereas if it's care first, the relationship becomes secondary. So they [the midwife] can be doing what is required, but … it's probably not required. It may be construed as a given, but it isn't always. (Mary W)

For the women, being well cared for meant the midwives taking time to ask them how they were and whether anything was going on in their lives that may be impacting the pregnancy; rather than doing the regular checks such as blood pressure, urinalysis, and palpation at the beginning of each appointment. "*Someone that cares for your wellbeing, [and] your baby's health and wellbeing as well. Someone that will look after you and–you and your baby–and yes, someone that cares about you*" (Lucy W).

Having midwives respond to concerns in a timely manner, especially when intervention was recommended, was a valued part of feeling well cared for and was reassuring for women.

> *I think she takes real good care, because I was a bit, me and her were a bit concerned about baby, something, I can't remember…oh, about him being sick. And straight away she referred me to a baby specialist. I felt real good about that cos she didn't just go 'oh, just go to the doctors [GP] and see what they have to say'. She [said] straightaway 'I'll get a hold of … a specialist that I know, and you can go and visit him'. And that was a good relief.* (Tina W)

Over time, the women and midwives built an effective relationship. They learned to trust each other. The woman felt she had equal status with her midwife in the relationship. She felt comfortable enough to ask the midwife any questions or communicate any concerns she had, and was able to contact the midwife easily when necessary. If she missed an appointment the midwife contacted her to reschedule. Her appointments with the midwife had not been rushed. When women participants reported they felt well cared for they remained engaged with midwifery care, looked forward to every appointment with their midwife where possible, and wanted to return to the same midwife for their next pregnancy. Feeling safe, respected, and listened to was the vehicle for care. Building an effective relationship with midwives was, therefore, key to the women continuing to access and engage with midwifery care.

7.2 Staying Connected

In the context of previously reported complexity, there were many barriers in the way of women who missed antenatal appointments or were not home for a planned postnatal visit staying connected with their midwives. The midwives regarded trying to engage with this group of women if they had missed appointments, in order to provide them

with care, to be the key point of the midwifery service being offered to them. When unable to find women, midwives continued working to engage with them by keeping the door open to taking them back if they turned up for care.

7.2.1 Barriers to remaining connected

Some barriers to remaining connected were unrelated to the effectiveness of the relationship the woman and midwife had built with each other. However, a less than ideal relationship contributed to other women not remaining engaged with midwifery care. This consequence was attributable to conditions affecting both women and midwives. At times, women's social situations interrupted the relationship that had been developed with their midwife.

Midwives mentioned it being more common for this group of women to move to other areas during pregnancy, contributing to the complexity of remaining connected. Families living in areas of high socioeconomic deprivation were more transient than families in more affluent areas, and sometimes women moved away unexpectedly. "*A lot of the women are…transient, or between homes…The poor rental accommodation they're in–very few own their own homes–all that stuff that goes with that really*" (Stacey MW). The first indication the midwife may have was the woman not being home for visits or not turning up to clinic. The midwife may receive a text saying the woman had moved away and had got a new midwife. If a woman had forgotten to tell the midwife she had moved the midwife may only find out when contacted by another midwife requesting the woman's midwifery notes. Sometimes midwives arrived to do the last visit at the end of the postnatal period and found the woman had moved since the previous visit and they had not been told.

> *…it's our clients [women in caseload] in particular that will often migrate. They'll go up north. You'll get them early in the pregnancy, and late in the pregnancy they'll go. You'll have them all psyched for birth and then they'll tell you the next week they're moving to [city], or even if they forget to tell you you'll get the midwife requesting their notes, and you're like 'what?' You know, no knowledge of that.* (Sophia MW)

Women participants talked about delayed responses from the midwives as a barrier to remaining connected. These women reported calling a midwife's pager system to contact the midwife as per the midwife's instructions, and then not receiving a response for several hours. This resulted in delays in women's concerns being addressed, potentially impacting their or the baby's wellbeing, and in women being unhappy with their midwifery care. Women also relayed stories of contacting their midwife and not hearing back at all. In these situations some women chose to change

midwives either during the pregnancy or for subsequent pregnancies–choosing a midwife who was easily contactable.

> *So that's why I … wanted to pull away from her cos she didn't ring me back. But I know for sure that if it was my own [previous] midwife she would definitely ring me back ….* (Nia W)

Additionally, women reported midwives either not showing up for planned visits, or not ringing to say they were delayed, going to be late, or unable to come that day. This resulted in women feeling undervalued and frustrated. Women spent time waiting for them to turn up. "*I'd wait and wait and wait a couple of hours, and then just be like 'oh, she's not coming'"* (Grace W). When the midwife did not arrive the woman would spend time trying to contact her to organise another appointment. However, if the woman did not have a phone, or lacked financial or transport resources, she would have no ability to contact the midwife. When there was no contingency plan in place this resulted in women not knowing when their next appointment would be and waiting until midwives got in touch to reschedule. This was considered by women to be less than optimal care and viewed poorly, impacting negatively on their relationship. It resulted in women who wished to remain engaged experiencing delays in receiving midwifery care. However, women understood that midwives sometimes needed to reschedule appointments due to attending a woman in labour or some other priority.

It was important to women that they were contacted by their midwives to reschedule if they missed an appointment. Women associated not being contacted with feeling that they did not matter enough to the midwives for them to care how their pregnancy was progressing.

> *Yes I missed some [appointments], but she never rang … to rebook another appointment or anything like that. Cos sometimes I did forget that I had an appointment with her and I would think-until I looked back in my book-and I would think 'oh, damn it! I have to have an appointment with my midwife.' And then I'm like 'why didn't she ring me? It's been like how many weeks now and she didn't ring.' …I kind of felt like it didn't really matter to her. Yes.* (Nia W)

Women receiving care from community LMC midwives sometimes missed midwifery appointments if they were receiving their midwifery care in conjunction with the secondary care obstetric team or a medical team such as the diabetic team. Sometimes women missed secondary care obstetric or medical appointments because they did not have the means to travel to the hospital at which these were held. While some women were able to access free hospital transport services between hospital facilities or had access to marae based transport to enable them to attend, adequate

childcare and the times of available appointments, as well as the time involved, remained some of the barriers to attending. Holding secondary care obstetric and medical clinics closer to the community in which the woman lived enabled attendance.

Women were more likely to attend antenatal appointments with the midwife or the hospital secondary care obstetric or medical team if they were held at a time that suited them. While some midwives held evening clinics or were happy to visit after hours to accommodate women, appointment times were less flexible within the DHB system. For women who were employed, being expected to attend secondary care obstetric or medical team clinic appointments during working hours was problematic, especially if these were ongoing, and could result in women not attending. Instead, being able to attend an appointment after their working day had finished fostered ongoing engagement. This was the same for women needing to wait until their partners or other family arrived home to provide childcare. Informing women that they had some choice over the timing of appointments and supporting them to negotiate arranging appointment times that were convenient for them, were reported by midwives as potential solutions to women remaining engaged. If women missed appointments with secondary care obstetric or medical clinics usually clinic staff, generally a dedicated midwife, contacted them to reschedule and ensured the women kept up to date with scans and blood tests.

7.2.2 Finding women

Midwives used strategies to help find women who had missed midwifery care. Success was sometimes dependent on the effective relationship the midwife had built with the woman and her family. Usually if family or someone else told the woman her midwife was looking for her, she attended the midwife's clinic. If the midwife worked in a community with strong whanau [family] affiliations there was the ability to use the community connections had by the local Kaiawhina (helper or assistant) or the Community Worker attached to the health centre to find women. The Kaiawhina would know where the woman was and contact her and tell her to come into the midwife's clinic, and the woman would turn up. Here midwives again demonstrated trying to stay connected with women by negotiating a way for women to remain engaged with midwifery care. They showed understanding about how women were impacted by other events in their lives.

> *I feel these women have got a lot going on in their lives, and maybe we're not necessarily at the top of the list, and some of them don't quite realise why it should be more important on their list, but they've got a lot more going on, and it's not like they're being disrespectful, or don't turn up because they*

purposefully don't want to. We found them quite keen to engage when you actually got [found] them. (Joanne MW)

Use of an 0800 number so that calling the midwife was free for the woman, and texting women who the midwife knew needed a reminder before their appointments, were other strategies used to engage women, usually successfully.

When women missed a planned appointment, to see if they had forgotten or were delayed and still intending to come midwives first phoned, texted, and left messages. It could be difficult to contact women directly as few people had a land line and most changed their mobiles frequently. A lot of women would not answer the phone if they did not recognise the calling number. One of the difficulties in trying to follow up this group of women was that sometimes mobile phones were being shared amongst family members, or the woman's mobile phone may have been with someone else in the family for the day. Alternatively, it may be the woman had given her mother or someone else's phone number as a contact, which added complexity to trying to get in touch with women. Some midwives left a message with any relative who answered a home phone number; while other midwives never left a message on an answerphone as they did not know if other people in the house knew the woman was pregnant. If the woman answered, an alternative appointment was offered to her. Most of the time women would take the offered appointment. Trying to connect with women in this way was done during any free time the midwife had available, for example during a break in the clinic or at the end of the day once her clinic finished, but generally happened within a day. Occasionally the woman would contact the midwife, apologise, and ask for the appointment to be rescheduled for the following week, which midwives accommodated.

If there was no response, midwives repeated the above the following week in a further attempt to contact the woman. If there was still no response after a couple of weeks some midwives did a drive by or cold call of the woman's house to find her. This may have been only when the midwife was going past the woman's street when doing postnatal visits in the area, or it may have involved a special drive out to the area where the women lived. After several drive bys midwives either left a note on the woman's door, or sent a letter saying that they had been trying to connect with her for care and enclosing a new appointment for the following week, or alternatively asking the woman to get in touch. If the woman missed the appointment again, so had missed two appointments, some midwives sent a letter saying if she did not get in contact they would assume she had left their care. Other midwives wrote to the woman at this point informing her that without staying connected they could not safely provide ongoing

care. They also wrote that if they had not heard from her within a week for an appointment they would shift her to another service, transferring responsibility for her care to the primary care team at the DHB's local hospital, as they would no longer take responsibility for her pregnancy and birth. This usually resulted in the woman contacting the midwife.

Further delays in women receiving midwifery care resulted while midwives were trying to connect with them. "*Sometimes it can take a bit of effort to track people down*" (Stacey MW). Some of the women moved houses regularly so the midwives were redirected.

> *And how many times do you go into a house and they say 'oh she's not here, but if you go up this road it's the house that's orange and it's got two stories, and it's just round the bend with the tree on the left?'* (Sophia MW)

The context of each woman's life affected the ability to stay connected.

7.2.3 Keeping the door open

Sometimes women did not respond and were not able to be contacted or found, despite the midwives' efforts. When a woman did contact the midwife again it was conditional on the woman's gestation, and the plan developed with the DHB when the woman was non contactable, whether the midwife would recommence care for the woman or refer her to the DHB to provide care from that point. Most of the time the midwife would continue to look after the woman if it had not been too long since she had last seen her. This was because she had already engaged with the woman and had built a relationship.

Offering to home visit was an attempt to address barriers to attending midwifery clinics, such as transport and childcare, to enable the woman to remain engaged. The offer of home antenatal visits to women who missed clinic appointments varied amongst the midwives. Some midwives asked women they managed to contact whether it would be easier to have all their visits at home and continued with these if the woman was agreeable. Other midwives felt that if home visits were offered, women may decide not to make the effort to attend the midwives' clinic knowing the midwife would come and see them at home once a couple of appointments were missed. These midwives offered women alternate home and clinic visits antenatally, or just clinic appointments once they were back in touch.

Midwifery groups who in the past had discharged women if they did not turn up to appointments had changed their practice to never discharging them. Instead they continued trying to engage with women by keeping the door open to taking them back if they turned up for care. Midwives also kept the door open by continuing to be

welcoming to women arriving late at their clinic for an appointment, particularly if they had a pattern of non-attendance. They would fit the woman in rather than rebooking her for another appointment. "*Look, that's cool. You made it. Well done! Let's get on with it. We'll have to be quick*" (Elizabeth MW). Realising that things did not always go to schedule and that they too sometimes left women waiting in the waiting room or ran a bit late for home visits, meant some midwives had more flexibility around this than others.

> *So you'd squeeze them in, even though you might have a full day's diary in front of you. If they turned up you got them in…I've done an antenatal visit in my car cos I saw her walking down the street and so I pulled her over and she laid down on the back seat and I listened to the baby! [chuckling] Yes, so you have to have a bit of knowledge and be a bit opportunist.* (Joanne MW)

Accommodating women when they turned up rather than rescheduling an appointment they may well decide to miss, enhanced women's engagement and kept them connected to the midwife.

All the midwives had limits to what they felt was acceptable around the effort they would put into following up women. Notifying DHB staff once they had reached the limit of what they were prepared to do to try and remain connected with a woman was to ensure maternity staff were aware they were having extreme difficulty contacting her. A plan could then be developed outlining who would take responsibility for the woman if she presented to the midwife or the DHB for care. Some midwives chose to transfer the woman to their DHB colleagues at this point. Handing over to colleagues, despite trying to do their best to contact the woman, was about the midwives having assurance that they had done all they could to keep the woman engaged with care, but ensuring the woman was still connected to the maternity service. Others kept the door open to the woman returning to them for care;

> *She knew that I wanted to see her, and I knew that she didn't want to come in because she thought everything was ok, and that's just how it was. So we just accepted that and carried on. Everything is documented at my end including the attempts at contact and what conversation we do have. … As long as I have fulfilled my role in offering suitable care, the choice to engage is theirs. I feel people are more likely to respect you as a practitioner if you show them respect for their decisions, even where you disagree. It is about keeping relationships open. This comes back to taking time to get to know the woman at booking.* (Catherine MW)

Midwives demonstrated having a sense of compassion for the situations the women were in and an understanding of the various complexities of their lived contexts. This was due to the relationship the woman and midwife had built together.

...it's no good chasing up someone that doesn't want to come and see you, if they're not going to come and see you, cos they're actually not going to even listen to your advice. ...but I don't think you need to be [having] kneejerk reactions all the time. ...you can't keep extending yourself to someone who doesn't want to be seen by you. ... And as long as the woman is safe and the baby's not going to come to any harm, you can leave things to lie for a bit. And so it's no good pounding on someone's door if they're not going to open the door to you. So it's definitely about relationships. It's about their understanding of their needs, and respecting their space. (Marion MW)

Although midwives varied in the amount of following up they were prepared to do, some continued to worry about the women whom they were unable to contact to provide them with midwifery care.

Because I just feel that somebody has to take responsibility and be accountable, and if they can't be accountable for their own health and their baby then I'll be even more worried once they have the baby in the home. (Steph MW)

While midwives spent time and resources following up women who did not turn up for a planned visit, after reaching the limit of what they were prepared to do, it was then up to the woman to choose to engage with midwifery care, or not. The relationship midwives had built with women meant knowing the women had limited resources. It also meant knowing that some of these women needed encouragement to engage in care due to, for example, previous unsatisfactory interactions with health professionals. These factors encouraged the midwives to pursue this group of women to the extent they did, wanting them to engage with midwifery care. Most midwives kept the door open to welcome the woman back should she return for care.

Midwife participants were clear that when working with women living in areas of high socioeconomic deprivation, they needed to spend time trying to engage with them if an improvement in their pregnancy outcomes was desired. Midwives tried to catch that portion of women who, for whatever reason, could not get to antenatal appointments. "*It's just what you have to do*" (Marion MW). Midwives worked with this group of women knowing that they fell through the gaps in the health system and had had poorer pregnancy outcomes than more affluent women. "*These people...who are known to fall through the gaps in the service, who are known to have the high morbidity and mortality rate; this is a service that is for them*" (Sophia MW).

Midwives put effort into staying connected to the women because they wanted to provide them with midwifery care and keep them and their babies safe.

7.2.4 Dealing with an unexpected change of midwife

Sometimes staying connected was impacted by other conditions. When midwifery care was transferred to other midwives, for any reason, women faced disconnecting from the midwife they had built a relationship with and dealing with an unexpected change of midwife. Changing midwives was often unanticipated and reported to be difficult for women and midwives.

> *So for the midwife that took over … they really displayed themselves really well as in during the birth. So during the birth she's there, she's in the room, but she isn't there. She isn't the voice in my ear or the one rubbing my back saying 'it's ok, you're doing fine, everything's working well', you know, 'you're doing really well'.* (Mary W)

Trusting each other during care provision in these circumstances required effective relationships to be built quickly.

7.2.4.1 During pregnancy

Learning during pregnancy that their midwife was unlikely to be present at their birth, for any reason, such as going on leave, was disappointing for women. "*I was really disheartened … I found I felt let down … I had really hoped that she would be there*" (Mary W). Although understanding the need for midwives to have time off rationally, emotionally women hoped that their midwife would be at their births. Women related that had they known when first contacting the midwife that she had leave planned when they were due to birth, this may have affected their decision making around choosing the midwife for care.

Finding out there was to be a change in midwife later in pregnancy or close to their birth was challenging and required a greater adjustment for women, as they had already had time to build an effective relationship with their midwives. Learning their midwife was to become unavailable also meant women had little choice over the midwife who was to take over their care. Women relayed that although the midwives who then took over their care were generally nice, given the choice they may not have chosen them.

Women picked up very quickly if they were not going to get the support they were wanting from the back up midwife. This was especially true if they had gone to some effort deliberately choosing a midwife to avoid repeat experiences of previous unsatisfactory relationships, perhaps from a previous pregnancy. However women reported making the best of the situation. Choosing to do otherwise would have required searching for a new midwife and repeating the process of building a relationship with

her, so was no different to needing to build a relationship with the midwife taking over her care; plus, it may have resulted in a delay receiving care.

> ***Was it any different trying to build a relationship with her? The second midwife?***
> *Yes. I had like kind of like sometimes I have doubts in my head because, because, she said she's a new midwife. She hadn't, when I met her she hadn't done any delivery and stuff like that.*
> ***Yes, so she was a new graduate?***
> *Yes. She was brand new and I'm like 'ahhh ok.' And I was like 'oh yes', but yes, it went well.* (Lucy W)

> *She was really good. She was nice. I was her first private birth. Quite new she was. Just strange like going to somebody who's not actually listening [chuckling]. Like she likes things naturally, and cos my waters take too long to break I tell my midwife to break it. She wouldn't break them even though I really, really, really asked her to. Yes [chuckling]. Yes it [the labour] just went on and on. But yes, yes. It was just strange. I didn't like her at all but she was good though. She was a nice midwife.* (Lynette W)

Dealing with an unknown midwife whom they had no relationship with could be difficult. This was significant for a group of women whose engagement with care benefited from having built effective relationships with their midwives.

7.2.4.2 During labour

For some women labour resulted in a caesarean section for the baby's birth. In some DHBs, when this occurred midwives were removed from providing ongoing midwifery care as the women were transferred to the hospital secondary care team. This resulted in women facing a change from the known midwife who had provided their midwifery care to that point to now receiving care from an unknown midwife.

> *...she had to leave cos I was for a caesarean section. ... Yes, so she said she couldn't stay for something like that. But she wished she did. She wished she could of. But because of them doing that [she couldn't]. But if I was going to have a natural birth then she would have stayed right through.* (Renée W)

Some women had a backup midwife providing their labour care if their midwife was unavailable. This again resulted in women receiving care from an unknown midwife who they generally had not met before. It was necessary for midwives stepping in for their colleagues to build up a rapport quickly with women whose care they took over. They quickly developed skills in this area.

> *I think that maybe that is just a skill that you develop...they don't know you. Why should they trust you? And there has been people who've let them down in their life, plenty of people. So why should they trust you? I think you've just got to try to win them over, and get it through to them that you're actually there to help*

them. You're not there to judge them, and you are just going to make it better for them really. (Joanne MW)

Being able to build rapport quickly moved the woman's experience from challenging to comfortable.

> *And in the end she didn't deliver the baby–she was away at that time–so someone else delivered it.*
> **And had you met that person before?**
> *No, it was the first time.*
> **Ok. And what was that like?**
> *That was just ... I feel a little bit weird because it's the first time I met that person, and we haven't had any kind of relationship other than that time [of the labour and birth]. Yes. So that was a bit weird. Yes.*
> **But with the actual care you got, were you happy with the care?**
> *Yes. Yes. Cos she talked to me, she had so many years of experiences, and she delivers so many babies. Yes. So that got me to feel comfortable with it, and ... I trust her. Yes. She's there.* (Lucy W)

While women did not have the time to build up an effective relationship with the change in midwife they were presented with, they were generally happy with the care they received. This was a group of women who brought the complexities they were living with on a daily basis to their maternity experience. Having built an effective relationship with a midwife throughout their pregnancy and developed a trusting partnership, to then lose that midwife, therefore the connection with her, and move to having a change of midwife was disappointing but dealt with pragmatically, and resulted in women reporting positive experiences.

7.2.4.3 During the postnatal period

Having a change of midwife during labour and birth often impacted on the woman's postnatal care, especially when her original midwife remained on leave. "*A bit different though when somebody else is coming around and touching my baby*" (Lynette W). However having a change of midwife postnatally did not seem to bother women as much as when this happened during the antenatal period or their labour and birth, despite having a different relationship with them.

> *... she comes and sees me then she has some time off cos she was sick after that– after I had my baby–so it was [then] three different midwives coming to see me [postnatally]. ... So it was all like a bit –I didn't have the same feeling as my other two [pregnancies]. I felt like ... I trust my [previous] midwife and have a good relationship. But I did still feel good about it because they come and check baby and make sure that everything is good.* (Lucy W)

Having built an effective relationship with their midwives and being supported through the maternity system to meet their complexity requirements, this group of

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women risked being significantly impacted by losing the connection with their community LMC midwife through an unexpected change in midwife. They were dealing with the disappointment of not having their known midwife providing care and needing to feel confident in the care provided by the new midwife.

7.2.4.4 Seeking a satisfactory experience

Dealing with an unexpected change of midwife was conditional on other factors also. When women had built an effective relationship with a midwife who they were not able to have for a subsequent pregnancy, they sought out another midwife. Adjusting to a different midwife could sometimes be challenging, with the woman deciding whether to remain with the 'new' midwife or seek out another. However, as reported above, generally women in this situation were able to build an effective relationship with their midwives, resulting in satisfaction with their midwifery care, even if the relationship was not as satisfactory as relationships they had experienced previously.

> *I think she did her job, but for me I think I wasn't comfortable how I was with my other midwife that I [was] experienced with .... Yes. I think it was just me not being comfortable with her.* (Nia W)

However, when women felt they were not able to build an effective relationship with their midwife, they reacted in different ways. As reported previously these included missing appointments with the midwife, considering definite reasons to transfer to their previous midwife, or searching for an alternative midwife. A consequence of this was a potential delay in receiving midwifery care.

Changing midwives also meant having to get to know a new midwife again and potentially risked repeating an unsatisfactory experience. However, changing midwives for a subsequent pregnancy could be a positive experience, with women developing an effective relationship with the midwife and, as a result, receiving the type of midwifery care they had sought but not found previously.

7.3 Conclusion

This chapter presented '**building effective relationships.**' The complexity of women's lives, in addition to entering a maternity service not always set up to address their maternity care requirements, risked women not engaging and therefore missing care, potentially affecting their pregnancy outcome. Most women built effective relationships with their midwives creating partnership, enabling them to work together to navigate the complexity of the maternity system.

Midwives reported feeling a responsibility to the women to try and support them in making healthy decisions about their lifestyles and pregnancies. Midwives also had an important role in fostering women's self-confidence about things that they were doing well, because a lot of the women had little self-confidence, and did not feel they had much power or control over many aspects of their complex lives. Ensuring women were involved in decisions about their care and had control over what procedures were suggested for themselves and their baby boosted women's confidence about themselves, and their ability to give birth and mother well. It enhanced their relationship with the midwife and kept them engaged with midwifery care.

There were many barriers to women staying connected with their midwives, including women's social situations and perceiving the relationship to be less than ideal. Wanting women to remain engaged with midwifery care, midwives spent time trying to find women who had missed care episodes. While having a limit to how much effort they would put in trying to reconnect with them, midwives kept the door open to the women returning to them for care.

Chapter 8 presents 'negotiating a pathway' to describe the process women experiencing one continuous pregnancy journey found themselves in when moving through a maternity system which divided maternity care into primary and secondary care services. When women's care requirements moved from primary to secondary, midwives wishing to provide continuity of midwifery care centred on the women throughout, or not, were required to negotiate a pathway forward with members of the secondary care team. Women were caught between family, the midwife, and others over advice. Midwives worked with women negotiating a pathway forward trying to meet the women's complex requirements, within a maternity system of limited resources to meet their complexity needs. Woman required midwives' support and advocacy throughout. Midwives needed to sustain themselves professionally and personally if they were to continue working with this group of women.

Chapter 8: Negotiating a Pathway

I just think that if you're going to work in high deprivation communities you've actually got to put aside the time and the energy and have the passion to actually go the extra mile to help women navigate the health system. Whether that's understanding of health literacy, or whether that's help navigating services. (Janice MW)

This chapter presents '**negotiating a pathway**' to explain the process women participants found themselves in when moving through the maternity system. Once they had accessed a midwife, women relied on midwives to negotiate a pathway through the maternity system, wherever their pregnancy journey led. The effective relationships women had built with their midwives and the provision of continuity of midwifery care enabled negotiating a pathway to occur.

At times women reported being caught between their family members, midwives, and others over recommended care. 'Caught' did not mean women were passive in the process, as they could react, move, or change their minds. They worked with midwives to negotiate a pathway forward. For example, women caught between family, the midwife, and others over recommended care were often assisted by midwives to negotiate solutions, therefore a pathway forward, so moving out of being caught between.

Women prioritised continuity with their midwife but when faced with a complex pregnancy, labour, and/or birth, were often caught in the middle of a maternity system not always set up to resource their needs, and in which they had little voice. When women developed complications while they were experiencing one continuous pregnancy journey, depending on the context and the conditions operating at particular times, they were caught between a maternity system which divided their pregnancy journey into primary and secondary care categories, and the midwifery model of care supporting continuity centred on the women. Finding and **negotiating a pathway** forward was required if women were to move through the primary/secondary interface remaining engaged with midwifery care. Women relied on the midwives' support and advocacy negotiating solutions that would facilitate an acceptable pathway for them through the maternity system. Some midwife participants prioritised providing continuity to women, but also needed to remain available for their caseload of women. Other midwives chose to hand over the care of women. Therefore, **negotiating a pathway** with their midwife resulted in women receiving care which may be

continuous, disrupted, or resulted in care being handed to a core facility team with the loss of continuity.

Most facilities, impacted by staffing and financial resource shortages, had in recent times moved to supporting the community LMC midwife to continue to provide care to the woman. Influencing the negotiation for a solution were other elements of **negotiating a pathway**, including the facility resources of staffing and funding, and the resources women and midwives had available. For women considerations included their obstetric or medical condition, everyday expectations, and family support i.e. for childcare, transport, and finances. Midwives were influenced by their geographical location, practice context, philosophy, and the resources of funding, time, caseload mix, cross cultural knowledge, and sustaining themselves. **Negotiating a pathway** resulted in midwives using strategies, some of which have been mentioned in previous findings chapters, such as advocating on behalf of women, for example working with women to negotiate appointments at the best times for all concerned, attending secondary care appointments with women and the accompanying negotiating of a care management pathway with the woman, midwife, and secondary care team.

To sustain themselves in practice, while addressing the particular complexities working with this group of women entailed, midwives negotiated solutions such as developing boundaries around how they worked. Boundaries included the time midwives spent advocating for women negotiating a pathway through the maternity system and midwifery care when they were requiring secondary care, whether wanting to continue providing continuity, or not. Midwives engaged in gap filling, supporting women to receive care that met their individual requirements optimising their pregnancy outcome. Figure 9 (p. 167) highlights the theoretical category of **negotiating a pathway**. Figure 10 (p. 167) is a diagrammatic representation of the subcategories of this theoretical category.
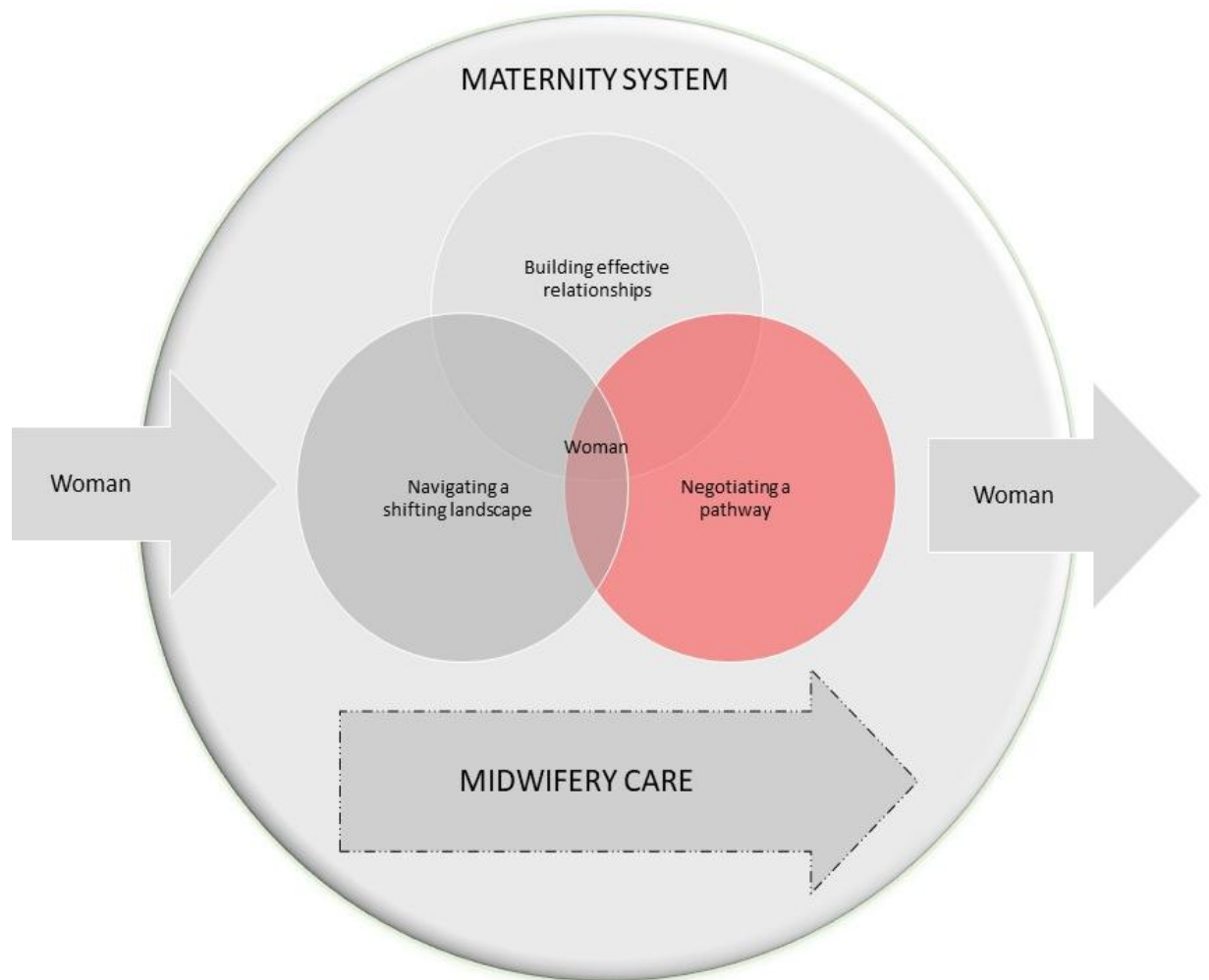
Figure 9. Theoretical category 'Negotiating a pathway'
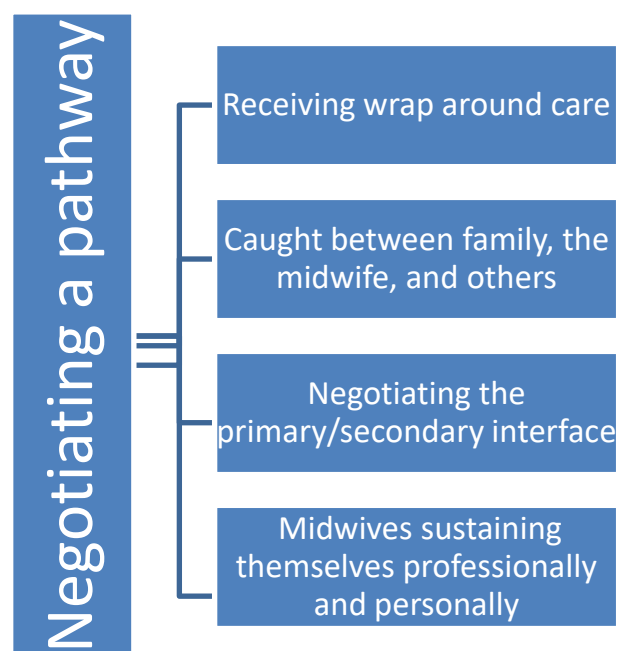
Figure 10. Subcategories of 'negotiating a pathway'

8.1 Receiving Wrap Around Care

The situational complexity of the women in this study meant that if they were going to effectively access and remain engaged with midwifery and other care required in pregnancy, this care was best located in the communities in which they lived. Continuity of midwifery care supported women's individual care requirements being met through receiving wrap around care in their own communities. In this study, wrap around care refers to a health service where women and their families had easy and affordable access to a midwife and other primary, medical, social, and service providers appropriate to meet their care requirements, and was reported as benefiting this group of women and their families. Negotiating a pathway through the maternity system began wherever women met with their midwives and resulted in women being more likely to remain engaged with midwifery care.

8.1.1 Services close to home

Having midwives co-located at a health centre whether as employees or through holding their midwifery clinics there was seen by both women and midwives as beneficial for this group of women and their families, contributing to better pregnancy outcomes. When midwives were co-located with a health service, access to additional resources, services and health practitioners, for example, to medical care for their children, or to community health workers, made it easier for women to receive wrap around care. This enhanced their engagement with midwifery care resulting in early registration.

> *I think ... the service that we provide is a one stop shop. It's very good for the low socioeconomic [women] as it has everything there that they could need, and ... hopefully coinciding appointments can be arranged so that will help them, given that they've made the trip in.* (Sophia MW)

The benefits of a midwife having a clinic, where women go for all their health care, was important for addressing other issues. If, while attending the midwife's clinic, an issue was identified which required consultation with another health professional or allied provider, a pathway to address the concern could be negotiated between the woman and the midwife resulting in the woman being able to access another professional for advice or treatment at the health centre. Having an effective relationship with the woman enhanced this process.

> *But, I feel I know them well enough to say 'hey look, these things–this needs sorting out. You'll feel much better if this was treated'. Or, the kiddies, you know, the little toddlers that have come in with them with thick green runny noses or horrible hacking coughs; 'before you go from the clinic I'm just going to nip in to the room next door and ask the GP to just quickly pop in here and do*

a script for them', or 'I'll ask the practice nurse to pop you in for your flu vac [vaccination] before you walk out that door. How about that?' (Janice MW)

Some health centres required women to make a planned appointment to see a GP, while in others women had the option of a daily drop in clinic where they and family members could be seen on the same day at specific times. "*…so it's like a one stop shop for them which I am sure is better for their care requirements*" (Elizabeth MW). The ability to ascertain if women had issues that they were not seeing anyone about and to negotiate a pathway with them to ensure they received treatment, meant the women were not going to go home and keep on trying to manage their other health problems or ignore that they were there.

While each health centre worked a little differently, in addition to receiving midwifery care appointments could be arranged for women with other multidisciplinary providers at the health centres. These included GPs, practice nurses, social workers, community health workers, physiotherapists, nutritionists, counsellors, translators, and dieticians all under the same roof. Referring women to allied health professionals such as social workers or agencies such as WINZ was a regular feature of working with this group of women. Being able to access these services in their local community was much easier for women who had so much complexity in their lives. If a woman phoned to say she needed to see the midwife, the GP, and the social worker, the receptionist would negotiate convenient appointment times with the woman, aiming to schedule them together so that this would involve only one trip for her. When a woman was involved in the negotiation she was more likely to turn up for the appointments and receive the services she required.

For women and their families, being able to negotiate a pathway to access health services easily and quickly was economical in terms of time, money, and transport. It was also beneficial for the health centre as women and families were having their other medical requirements met quickly and with ease, without them having to wait around or return for another visit. Women reported liking this aspect of attending the health centre for care.

8.1.2 Having familiarity with services

Midwives who provided co-located services relayed how women liked coming to their clinics for midwifery care because attending the health centre became like a social hub for them. The women were used to going to the health centre with their other children and their own health problems, so were familiar with the health centre and staff,

including the midwives, who were seen as just another attachment of the service. "*I'm used to going to there cos our own doctor is there*" (Lucy W). Being focused on the health care requirements of the population it served, and health centre staff ensuring they developed effective relationships with the women and each other, enabled women to be able to easily negotiate pathways to address their health requirements. Women reported feeling welcomed and comfortable in the health centre setting.

The women saw the midwives around in the community once they were discharged, so knew who the midwives were. Women may also have been to the health centre with other pregnant family members or friends, so knew where they were going to go to access midwifery care and who they were going to see. Although accessing care may have been challenging for some, it was easier if women were familiar with the place they were going to and knew the people that were there well, without having to go somewhere new. Being familiar with the setting and having a relationship with the staff made it easier for women to access the midwives once pregnant.

According to the co-located midwives, GPs enjoyed being able to work with midwives collegially, having someone they could ask an opinion about maternity care, and being a resource to ask medical questions. It was important to have GPs in the health centres who valued midwives, as they valued the physiotherapist or the pharmacist working there. Midwives reported that the GPs they were co-located with had embraced midwifery as a service that complemented their specialty and was a more convenient approach to health care. When the health providers at the health centre women were accessing had effective relationships with each other, the care provided to women benefitted. Having a midwife in a health centre was "…*about a better service and being more convenient"* (Janice MW). Being co-located in a health centre that was easily accessible to women and their families, affordable in terms of ease of travel and other costs, and seen as appropriate by women, enhanced their ability to access and engage with midwifery care. Being co-located was strongly recommended by those midwives this applied to as being positive both for women and themselves. "*…there's absolutely no down side to this and lots of up sides"* (Molly MW). It enabled negotiation of pathways to address the health care requirements of women and their families.

8.1.3 Stand-alone midwifery clinics

Midwives working in stand-alone midwifery clinics knew their communities well and spent time assisting women to access any other resources required to complement the

midwifery care they were providing, together negotiating a pathway forward. At times they needed to be quite resourceful.

> *It can be pretty tricky, and there's a lot of detective work in trying to find out what sort of help they can get and who they can get it from, because there isn't really a defined sort of support structure for LMCs of where we can go and get answers to 'I've got a refugee who speaks no English. Where can I get an interpreter from? How much is it going to cost?'– that sort of thing. That's how I get around it really; just detective work. Looking it up on the internet. Asking other midwives. ... Yes. I think it is unfair, and I think my time is valuable. And I think that we do it because we love what we do, but that goodwill only stretches so far and it's unfair.* (Catherine MW)

Midwives relied on the effective relationships they had built with other midwives, and local health and other providers of community resources, to assist them in accessing resources for women. Wrap around care remained their focus; however, midwives reported that accessing resources could take more time, and be challenging and frustrating. Yet, midwives provided wrap around care to try and ensure women were able to access the resources they required to meet their complex requirements as they moved through their pregnancies.

While receiving wrap around care to ensure all the woman's care requirements were addressed was important for every woman, midwives related how this was especially important for women living in areas of high socioeconomic deprivation. Women participants often had complicated medical and/or obstetric backgrounds, varying levels of health literacy, and a history of unsatisfactory previous interactions with health services. Having access to a multidisciplinary team of health providers enabled women to receive wrap around care which was reported as being beneficial to this group of women and their families and was an example of the maternity system working well. Together the woman and the midwife negotiated a pathway supporting the woman to receive multidisciplinary care to meet her care requirements.

8.2 Caught Between Family, the Midwife, and Others

As they attempted to follow their midwife's advice, sometimes women were caught between cultural differences or differing practices between family members and the midwife over aspects of care. In these situations negotiating a pathway forward was necessary.

It was difficult for women being caught between family members and their own or their midwife's different views or expectations. It was more difficult when women and midwives had negotiated an agreed plan which was contrary to the women's family

expectations and perspectives of how things 'should' be managed. Women did not want to be at odds with their families whose ongoing support they required, and who they were often sharing homes with, but they also wanted to follow the agreed plan. When women's families had immigrated to New Zealand their expectations may have been based on differing cultural views. In this situation if women were born in, or had received most of their education in New Zealand, and had access to current research based knowledge which they wanted to utilise, it could be complicated to negotiate solutions for a pathway forward that were agreeable to both themselves and their families. "*Yes. It's hard to say 'no' to your [chuckling] family, especially if you live with them"* (Trish W). On the other hand, when family were keen to adopt the Western lifestyle they saw New Zealand as offering, this also had the potential for women being caught between differing viewpoints. When these conditions were operating it was difficult for women who wanted to stay aligned with their cultural values and at times found they were at loggerheads with family who wanted to assimilate into the New Zealand culture.

To negotiate a pathway forward the midwives and women discussed strategies that the woman could use to try and meet an agreeable solution with her family, for example encompassing solutions that met some of both the woman and her family's expectations. Another strategy midwives used was to facilitate discussions between the woman and her family, advocating on the woman's behalf for her choice, giving them information showing why one aspect of care may be suggested over another, to assist them in making an informed decision.

> *I try to empower them with that aspect of their care. Like informed choice. 'Ask questions. It's ok to ask questions'. And most people are reasonable, and they're not going to go on and on about something if they've had the information … just to be difficult or something.* (Elizabeth MW)

Being able to negotiate a pathway forward by coming to a mutually agreeable decision that was acceptable to the woman, her family, and the midwife, was beneficial for the woman's ongoing care, working to ensure the woman received optimal pregnancy care. When a midwife advocated, she strengthened her connection with the woman and her family.

8.3 Negotiating the Primary/Secondary Interface

During pregnancy women entered a maternity system which categorised their single pregnancy journeys into primary and secondary care. Negotiating a pathway through

this interface was required by women and midwives if women were to have their complex care requirements met. In these situations the woman relied on the midwife's support and advocacy as the primary/secondary interface was negotiated and a solution to give a pathway forward, obtained.

Negotiating the primary/secondary interface was not straightforward for women or midwife participants. The women worried about who was going to know about their history when they went into hospital for appointments or admission, the background of the medication they were on, and what their problems were. Ensuring all relevant information was documented in the woman's notes so that the relevant health practitioners involved could see what had happened with the woman, and could take these details into account when negotiating a pathway forward, was therefore important. In these situations the midwife was the constant person who supported the woman and sought clarification of plans for management. The midwife would mediate back and forth between the woman and the secondary care team ensuring the woman's concerns were addressed in the negotiation that took place.

Some women were unable to receive midwifery continuity due to the maternity system or outside processes. Midwives reported that women in prison, for example, were a very transient population for the midwife providing care. Being released into the community or moving to other facilities resulted in these women often receiving sporadic episodes of midwifery continuity. In this situation, midwives negotiated as much as possible for incarcerated women, working towards them having a more satisfactory birth experience within the time the midwives were involved in their care. "*'Can we not loosen the handcuffs and keep the guard, if we have to?' cos I think when a woman births with handcuffs on … [silence]*" (Sophia MW).

Despite midwives being experienced working within the maternity system, navigating women requiring secondary care through the various referral systems and procedures took time and energy, whether or not the midwife wished to continue providing midwifery care. This was further complicated by the complexity of the women's lives, whereby barriers such as availability of transport, satisfactory childcare, level of health literacy, and previous experience of health providers, impacted each woman's ability to remain engaged with care and, therefore, the negotiations of a pathway forward. Midwife participants were aware that some community LMC midwives would not take on women with known obstetric or medical risk factors, even though they would be working in a shared care capacity with the hospital based secondary maternity care team. Having risk factors potentially resulted in women losing

midwifery continuity, demonstrating women being caught in a maternity system not set up to meet their complexity requirements. When midwives were unable to continue providing midwifery care as part of the negotiated pathway forward, they reported that some women were accepting while others were not.

8.3.1 Being referred to another provider

When the midwife perceived women's conditions or circumstances would be better met by other care providers, their negotiations of a pathway forward with women usually resulted in women being referred to maternity providers better able to meet their care requirements. Referring women to other providers was undertaken for many reasons and a normal part of midwifery care. However, the way the maternity service was provided was reported to indicate limited understanding of the daily lives of these women. Needing to attend a secondary care clinic often escalated the complexity for women who, for example, were lacking transport and reliable childcare. Women were required to balance the advantages and disadvantages of attending a secondary care clinic in a hospital an hour away requiring two return bus trips with accompanying small children, when money was limited and waiting for tests and review at the clinic could result in a trip lasting several hours, and the complexity of their daily lives. In these circumstances, negotiating solutions with the woman, such as the midwife arranging for her to travel by free hospital transport, meant women were more likely to attend the hospital clinic for care.

Midwives could be caught between a woman's lifestyle and health messages they were expected to deliver during pregnancy. Marion wanted to ensure a woman remained engaged with care but reported being caught between the women's health behaviour around smoking and alcohol intake, and the maternity system's expectation that she (Marion) addressed these issues at each visit. Marion was concerned that doing so might result in the woman deciding to miss antenatal visits, so she negotiated a solution utilising her midwifery practice partner, hoping that receiving these health messages from a different person may alter the woman's health behaviours.

> *And I said to her last time, I said 'look! You and I don't get on. I'm happy to see you. You know I'm happy to see you whenever you want to come in, but how about you get most of your care with [midwifery practice partner], and then you and her will be happy, and you're not going to be cross with me all the time because I won't be telling you you're smoking too much, and you drink too much, and your baby's not doing well.' And she was fine with that and she will still come in.* (Marion MW)

In the example above, the importance of the woman developing an effective relationship with her midwife if she was to remain engaged with care is highlighted. Marion identified that being referred to her practice partner may serve the woman's requirements better and negotiated this pathway with the woman. This was important when health messages were threatening the continuation of their relationship.

Midwives found themselves negotiating with women about which aspects of the maternity service would best suit their specific requirements to come up with an acceptable solution for a pathway forward. For example, if women had difficulty accessing transport and did not live in the area where the midwife's clinic was situated, they had difficulty getting to midwifery appointments. Referring the woman to a midwife closer to where the woman lived was a good solution to encourage her to remain engaged with midwifery care. Similarly, some midwife participants referred women who required significant translation services to the hospital primary midwifery team after helping them to understand they would receive a face to face translator. This was despite Language Line, a national phone translation service, being available. "*But it's not the same, and there's a lot of medical information and there's a lot of important decision points in the pregnancy, so they would definitely be better off*" (Elizabeth MW). There was some confusion about whether community LMC midwives could access Language Line freely for women in their caseload, with some midwives believing this was only possible if they were members of the Midwifery and Maternity Provider Organisation (MMPO), a claiming and payment provider for midwives in New Zealand. This lack of clarity may have resulted in more women being referred to hospital primary care midwives to access translation services than was required, as midwives reported they believed that otherwise they would be expected to fund the cost of the translation services themselves. An outcome of this was women losing continuity of care. Wanting to ensure women received the translation services they required yet knowing referring to the hospital primary team would result in the women losing continuity of midwifery care, was a difficult position for midwives.

8.3.2 Stepping forward together antenatally when acuity increases

All midwife participants reported the medical or obstetric acuity of women in their caseload had increased in recent years. Some estimated this to be by as much as 50 percent. "*There are a lot more medical problems. Yes definitely*" (Steph MW). For some midwives, having women with high acuity had not changed their practice apart from increasing referrals to secondary care clinic. These midwives were determined to remain involved with women when they were notified by the secondary care team they

were going to take over a woman's midwifery care, in addition to providing her obstetric care. Although seeing the woman less frequently antenatally, these midwives kept in touch by working more in a support role. In this role, given their knowledge of the woman's circumstances such as constraints on transport, childcare, and financial challenges, midwives supported the woman encouraging her to keep attending secondary care appointments and remain engaged with care, despite now not being her main care provider. Being able to negotiate together was an outcome of the partnership the woman and midwife had formed and enabled a pathway through the maternity system for women, keeping them engaged with care.

Midwife participants reported working with women with medical or obstetric complexity who did not perceive they had a complicated pregnancy. This meant that these women did not always mention significant health issues to the midwife. This resulted in midwives being caught between the different world views around health and wellbeing, and the expectation of the maternity system. While midwives referred women to the secondary care team occasionally saying they could not continue to provide care, they would more often than not get some advice following secondary care review about managing a woman's issue, and negotiate continuing providing midwifery care "*because that's the job that you're in*" (Stacey MW).

When women developed complexity antenatally that required ongoing secondary care management, the maternity system recommended handing care over to secondary services as the care required was no longer primary. Women then found themselves in a system which did not support their ongoing care being provided within a continuity of care model. Negotiating a pathway through this situation was challenging when women wanted to continue receiving midwifery care from their known midwife. They relied on their midwives to negotiate an ongoing management plan covering specific requirements and responsibilities. Midwives wishing to continue providing continuity of care did so due to the relationship they had built with the women.

> *I just think they live on the edge so much that they don't really think about it [how unwell they are]. They just carry on as good as they can. ... So I think word gets around that we were prepared to walk with them a little bit. ... We always stayed involved with them. I guess we felt that after establishing that amount of trust that we wouldn't walk away and leave them.* (Joanne MW)

Midwives went to great effort supporting women by negotiating a path forward that enabled them to remain involved in their care.

8.3.3 Midwives engaging in gap filling

Midwives reported some women transferring to secondary care often without a three way conversation between the woman, the midwife, and the secondary care team taking place, thus losing continuity with their community LMC midwife. More recently however, after being seen at the secondary care clinic, women with some conditions were being referred back to the midwives by the secondary care team to continue their midwifery care, rather than their midwifery care being transferred to secondary services.

For example, women with diabetes used to be transferred to the Diabetic Clinic to be looked after by the diabetic team which included midwives. In recent years some midwives found that the Diabetic Clinic only looked after women with Type 1 diabetes, while women with Type 2 diabetes or gestational diabetes continued to receive midwifery care by community LMC midwives. These women received medical care concurrently from the hospital secondary care clinic staff. While being committed to providing continuity and working in collaboration with the secondary care clinic, midwives expressed frustration at the clinic's expectation they had the availability to provide any additional monitoring the woman required that the secondary care services could not, and being used to fill gaps in the maternity system, for example, recording a blood pressure several times a week. Filling the gaps in a service which could not provide women's care requirements was not a pathway negotiated by midwives, and represented an under resourced maternity service. It created tension for midwives who wanted to ensure the women remained engaged with care but were also balancing the requirements of the remaining women on their caseload.

Sometimes when a woman had complications and her midwife wanted her to be seen by the secondary care team, instead of the requested review the midwife was instructed to monitor the woman herself instead. The woman and midwife were then caught between the secondary care clinic's lack of resourcing to undertake the requested surveillance, and the expectation that the midwife would fill this gap in secondary service resourcing by continuing to monitor the woman, despite not being involved in the decision making. Midwives then felt vulnerable and used strategies such as documenting comprehensively in case something untoward happened to the woman or baby.

> *I sent a referral off this morning about someone. She was in hospital for a few days cos her blood pressure kept going up. She kept throwing off these high blood pressures, and her preeclamptic screen came back normal. I checked her the other day. She's 34 weeks. She's had a growth scan and the estimated fetal weight is over the 90th centile but the AC [abdominal circumference] is below the 5th. Her blood pressure is 140/90 and her booking blood pressure was*

108/60. To them it's a borderline blood pressure but they wouldn't do anything with it. But for me I'm thinking 'it's so far above her booking blood pressure I think she is developing hypertension, and that it's having an effect on the growth of the baby.' So I referred her again last night to clinic and said 'this is what I think is happening. Please consider seeing her because I would value your medical opinion.' I have it documented that I think this is what is going on so that if they didn't want to do anything with her and the worst happened, at least I've documented that I have tried to refer her, and I've said what I think is happening. I've done that cos I feel a bit vulnerable, in that things haven't tipped over yet for her but they're on the borderline of it. ... And also, when you get knocked back and [they] say 'oh yes well just keep an eye on it' well sometimes it reaches a point where you're not happy just keeping an eye on it. You want them to be seen again. (Catherine MW)

The midwife, Catherine, was caught between the responsibility she felt for the ongoing monitoring of the woman she was working with, and knowing that if she chose to not provide this surveillance the maternity system did not have the resources, which may result in the woman missing care and increase her potential risk. Having no ability to negotiate a pathway with the secondary care team in this circumstance was managed by midwives negotiating a pathway with women to ensure their care requirements were met, filling the gaps in a situation highlighting a maternity service not working well.

8.3.4 Being kept informed when attending secondary care appointments

When women who had agreed to referral attended a secondary care clinic, the lack of any three way discussion or involvement in any decision making or negotiation about a management plan between the woman, her midwife, and the secondary care team, despite the requirement for this being set out clearly in the Referral Guidelines (MoH, 2012b), was an added source of midwives' frustration. Often midwives knew when referring a woman that the secondary care team were not going to do anything more than they, themselves, had already done, but the midwife was required to recommend referral to meet the maternity service requirements.

But for arse covering I'm going to refer you because if anything happened it would be 'well why didn't you refer?' ... I've had people with essential hypertension and really high BMIs [body mass indexes] and pre diabetic, like all the stuff that they would have taken before, then now they just see them a few times and I continue being LMC, which is fine as long as I get a say in what goes on. The problem is where they want you to keep doing the donkey work but actually don't involve you in any of the decisions. They go and book people for induction and then expect you to turn up without telling you [it's happening]. (Molly MW)

Midwives wanted to ensure women were kept informed and involved in the decision making around their pregnancies at secondary care appointments, and concern

around this was an issue raised by midwives. Women sometimes did not understand the medical jargon at secondary care appointments and/or had decisions about ongoing care management made without their involvement. Being faced with this situation, while concurrently receiving continuity from a midwife whose model of care supported women's informed choice and decision making, was recognised as complex for women by midwives. In support, midwife participants many times transported women to and from secondary care appointments waiting with the woman to attend her appointment so they could both take part in negotiating a pathway for the woman's ongoing care management. Attending was complex for the midwives due to the amount of time this took and their obligations to the women in their practice as well as their practice partners.

Steph attended some secondary care clinics run out of the local facility with women. This was because she found it beneficial liaising with the secondary care team in person with the woman present, to ensure she had a full understanding of the woman's ongoing care management plan requirements. Most clinics were held on days when Steph held her own midwifery clinic, which meant rescheduling her booked appointments and instead spending time sitting at the secondary care clinic with a woman, waiting for her allocated appointment. Some days the clinic ran smoothly so kept to time; other days Steph and the woman would be sitting waiting with time passing by. Once seen, the woman requiring a scan resulting in additional waiting time. "*...but that's like three hours you know! It's a lot of time*" (Steph MW). Eventually, due to the amount of time involved and the disruption to the rest of her practice, Steph made the decision to stop attending secondary care appointments. This was a hard decision because she knew how much attending benefitted the woman's experience, enabling both the woman and Steph to be involved in negotiating a pathway for the woman's ongoing pregnancy management, ensuring her understanding, and involvement in the decision making around her care. "*At the end of the day something had to give, because otherwise I was just giving it so [pause], a lot of myself. ... It was, to protect myself. And [pause, becoming tearful], and I feel bad about that [crying]*" (Steph MW).

Midwives wanted to know the management plan for the women to ensure they received the care required; yet, the secondary care clinic did not normally ring midwives to update them of the plan. Women and midwives had developed strategies to work around being involved in negotiating a pathway forward in these circumstances which included women texting their midwife if they did not understand the information they were being told during their secondary care appointments. The midwife would then ring

the woman and talk to the health professional to clarify anything the woman did not understand. Generally, either the secondary clinic staff were talking too fast and wanted to move on, or they were not spending enough time gaining the information they required from women's clinical notes, so that women had to repeat their story. Apart from frustrating the women, this took extra time, and having their appointments running late added to women's unsatisfactory clinic experiences. Women and midwives also negotiated that the women would call their midwife at the end of the secondary care appointment to relay the management plan, or, if they did not hear from the woman, midwives would ring the secondary care clinic staff to get a verbal update so they knew the ongoing plan. This too took time.

Following review by the secondary care team, having a clearly written, well documented management plan of the woman's ongoing secondary care requirements, enabled the midwife to continue to offer midwifery care in conjunction with her secondary care colleagues. Sometimes however, the management plan was not followed; "*sometimes it's difficult because you write out these plans –about what's to happen in labour and what needs to happen postpartum –and it's frustrating when it doesn't actually happen*" (Stacey MW). This could result in confusion for all involved, but mostly impacted the woman.

8.3.5 Ensuring expertise

Providing care to women with high acuity required expertise. Midwives who wished to continue supporting women who had or developed risk factors ensured they kept their knowledge and practice around medical and obstetric complexity current. This strategy was used by midwives so they could continue to provide midwifery care in collaboration with the secondary care team. For some midwives this required building expertise to update their skills and knowledge to be able to provide the more complex midwifery care the woman required. This enabled women and midwives to continue their journey together, rather than the woman's midwifery care being provided by core midwives.

Having expertise was important when working with this group of women due to their high acuity. Some midwife participants had developed expertise through their experiences of providing care for women while working in conjunction with secondary care colleagues over time. These midwives reported being well prepared to work with women of higher acuity. For other midwives, working with women with medical or obstetric complexity required building their knowledge. Researching information on conditions women or babies were developing, reading journals, and attending study

days, were some strategies midwives used to increase their knowledge for working with women with high complexity. Midwives also attended complex care days, completed post graduate complex care courses, facilitated short teaching sessions, presented at study days or at combined community LMC and core midwives meetings to disseminate information, and discussed care requirements with their secondary care core colleagues. Ensuring expertise enabled women experiencing medical or obstetric complexity who wanted midwifery continuity, and their midwives, to negotiate a pathway to provide care within a maternity system which now labelled the women as requiring secondary care services, but did not have the resources to ensure the continuity of care model was supported.

Sophia gave an example of midwives being supported by their midwifery practice colleagues to learn specifics for providing care to meet women's care requirements within a maternity system that was not resourced to supply these. Sophia arrived at a woman's house for an appointment to find all the woman's belongings were on the front lawn and it was starting to rain. The woman had been kicked out of the house by whomever she was staying with because she had spent her week's rent on getting her dog out of the dog pound where it had been as she could not afford to register it. Sophia had not known what to do, so she called her midwifery colleague who joined her at the house. Her colleague helped her contact two refuges to find a place for the woman to go. Sophia had not been working in the area long enough to know this information herself. This knowledge enabled Sophia to support the woman she was providing care to by negotiating a pathway with her out of her housing crisis, while keeping the woman engaged with midwifery care.

When they first began working in areas of high socioeconomic deprivation some midwife participants had noticed their colleagues resisted negotiating continuing the provision of midwifery care to women with higher acuity, resulting in women having their midwifery care transferred to the hospital secondary care team. Wanting to retain a primary care focus, some midwife participants still chose not to provide midwifery care to women in their caseload once they experienced some level of secondary complexity, including an epidural or labour augmentation. They were more comfortable providing care in a primary care environment. These midwives lacked confidence in their skill and expertise when providing secondary care services. They reported the pressure they felt from the secondary care team and their core midwifery colleagues to continue providing continuity to women in these situations, and their dissatisfaction with being expected to work in this way. They wanted to be fully available to their primary caseload of women,

letting the core midwives provide secondary care maternity requirements. The required negotiation around handing over a woman's care to the secondary care facility staff was tiring and often resulted in conflict with the hospital staff and no resolution, especially recently due to a lack of core staff to hand over the woman's midwifery care to. For one midwife this proved too much, resulting in her decision to take a break from midwifery practice a month prior to being interviewed for this study.

> *I'm a primary care midwife. ... I don't like secondary which in the area that I was in of course I got caught up with secondary care quite a bit. In fact in the last few years it got under my skin a bit. But I actually put on my access agreement that I was not competent to do secondary care, you know, inductions, synto [syntocinon]. In the last couple of years I haven't done syntocinon or the epidurals. It's not the kind of midwifery for me ... It's not what I like. I like the primary unit at [city] and I don't like the drips and the machines. It's just not my thing. And from that I have got out.* (Joanne MW)

The midwife's choice to discontinue following a woman if her pregnancy journey resulted in secondary care maternity services, impacted the woman significantly. This was a group of women who were reported to have been treated poorly by other health professionals in the past. Losing the person they had built a relationship with and the benefits of receiving continuity of midwifery care was reported by women participants to be a significant loss, leaving them in vulnerable situations as they faced trying to rapidly build effective relationships with new caregivers who did not know them or the daily complexity they lived through.

At the time this research took place most midwife participants negotiated continuing to provide midwifery care to this group of women whenever possible. Women wanted their midwives to remain involved, and midwives wanted to continue providing the woman's midwifery care. Building expertise and working together to negotiate a pathway forward with the secondary care team in a shared care capacity when a woman had risk factors, enabled midwives to meet the woman's acuity requirements, and continue providing continuity of care.

8.3.6 Negotiating midwifery responsibility for induction, labour and birth care

When women required an induction of labour, or secondary care during labour and birth, midwife participants negotiated ongoing midwifery responsibility with core midwifery staff, and at times with obstetric colleagues. Negotiating midwifery responsibility was required even though women were requesting midwifery continuity, and whether or not midwives were wishing to continue providing continuity in these circumstances. There were various conditions operating around midwives continuing

the provision of care once a woman moved from primary to secondary maternity services. Conditions included their own expertise, the time involved especially if the woman required induction, their responsibilities to their primary caseload of women, the requirement for back up caseload cover, and lack of remuneration. An additional complexity was where the facility positioned itself about midwifery care responsibility when the woman's requirements moved from primary to secondary. Successful negotiation could be dependent on which midwife was coordinating the Birthing Suite shift that day and depended on what else was happening on the maternity unit, and how strong the community LMC midwife felt when negotiating responsibility. In these circumstances midwives wanting to continue providing midwifery care to women were faced with negotiating a pathway to enable this to occur.

8.3.6.1 Negotiating care of women requiring induction

Many midwife participants reported that hospital maternity staff had shifted from their previous expectations to continue providing the woman's ongoing midwifery care when a woman moved from primary to secondary maternity care during labour. Similarly, the core facility's expectation had been that when a woman was to have her labour induced, her community LMC midwife would provide midwifery care from the beginning of the induction, a process which often took several days. In the past this had resulted in some midwives negotiating transferring the midwifery care of women requiring an induction of labour to hospital core midwives, resulting in the woman losing the continuity she sought. Other midwives wanted to support women wanting them to continue providing their care. Midwives had previously tried negotiating providing the woman's midwifery care from the time she was established in labour following an induction. If the negotiation was unsuccessful they reported arriving at the core facility once they knew a woman's labour was established and staying in a supporting role from that point, while the woman continued to receive midwifery care from core midwives. While not being involved in the decision making in these situations, being present was a way to ensure women did not lose the midwifery continuity they sought.

Due to hospital core staffing resource issues, participants reported there were recent regional variations around care management, particularly with obese women or women with diabetes who required insulin. More recently, midwives reported they were attempting to negotiate plans with the core midwives around ongoing responsibility so they could continue to provide continuity of midwifery care in a way that both supported the woman being induced, and sustained themselves in practice, so they could be available for their remaining caseload of women. Midwives were happy to support a

woman's request for continuity of midwifery care when the woman required secondary care. "*... because that's what I see my midwifery role as. Just because she has a condition that's secondary [care] doesn't mean I am going to withdraw my care*" (Steph MW). However midwives wished to do this in a sustainable way.

The current practice context with secondary care facilities being short of core midwifery staff impacted, usually positively, on the success of these negotiations, being driven by the need to provide women with safe care. When they turned up at the core facility to support a woman in established labour following an induction, midwives were increasingly being supported by the core staff to provide the woman's ongoing midwifery care. Likewise, midwives were also finding the core staff willing to negotiate calling them in to resume providing the woman's midwifery care once the woman was established in labour. This was welcomed by the midwife participants who reported being happy to be called to the facility to provide midwifery care from this point. However, while midwives were able to claim the primary labour and birth fee once a woman established in labour, secondary funding was paid to the facility to provide the woman's secondary maternity care requirements. This meant community LMC midwives were not paid for the provision of care which had moved from primary to secondary. However, the midwives' wishes to be able to stay with the women providing continuity once labour was established overrode their not receiving funding for this care. In this way community LMC midwives were again gap filling a maternity system not set up to support continuity and the needs of this group of women. Another consequence of wishing to remain involved providing continuity of care to women experiencing medical or obstetric complexity was the midwife deciding whether to decrease her caseload to give her the time to do so, with the resultant drop in income. More rarely were midwives prepared to remain in a support role only.

A maternity system which is under resourced in both staffing and funding for providing care to women with medical or obstetric complexity was reported to be a barrier to women receiving the best care available. Negotiating a pathway through a maternity system dividing care into primary and secondary services and focused on service delivery, and the woman centred care within a continuity of care model that women were requesting and midwives were trying to provide, was complex for women and midwives. Women and midwives were required to negotiate a pathway through a maternity system more focused on meeting the needs of their care providers, than placing the woman at the centre of that care.

8.3.6.2 Receiving continuity through high acuity labour and birth

Women who were faced with complexity around labour and birth wanted their community LMC midwives to continue to provide their care. This required negotiation by the LMC midwife with core colleagues. Midwives attributed their ability to successfully negotiate this to the relationships they had developed with their core colleagues over time.

> *But I get on with my doctors. I've never had an argument with any of them. There's only one that I really don't [pause], she's so unpredictable I don't know how she's going to react with anything! But most of them; they know me and I'll just [say], you know, 'I'll be there. You need to just get over it. That's all there is to it'.* (Liga MW)

Midwives reported the positive feedback they received from women who had continued receiving midwifery care from their known midwife after developing medical or obstetric complexity. This reinforced their commitment to continue to negotiate a pathway to providing women with labour and birth care in these circumstances; again demonstrating supporting women's wishes to receive continuity when they required secondary maternity services.

> *…they were like 'you are our only constant. You've been our only constant. You know, there's people in the room but you're our constant' … and I am so proud that I have been able to do that for them. I get quite emotional about it.* (Liga MW)

8.3.7 Rural women being unable to receive midwifery continuity

Women living rurally faced additional complexity if they were not able to birth at home or in a local primary unit through either risk or choice. The rural midwife participant reported having one on call rural midwife available in their area at any time resulted in the midwifery care of this group of women being transferred to either an urban community LMC midwife, or the secondary care core midwives in the nearest secondary facility. Midwives prepared women for this possibility early in pregnancy, negotiating transfer to an urban community LMC midwife from when they were 36 weeks pregnant to enable them to build a relationship. Women with risk factors received obstetric care from the secondary care team, and midwifery care from either an urban community LMC midwife or the core midwifery staff. Circumstances sometimes resulted in the 'new' midwife not being available for the birth, resulting in the woman receiving care from the back up midwife whom she had not met. Women transferred

back to the rural midwives postnatally and easily resumed the relationship again, despite the midwife not providing the woman's labour and birth care.

> *The relationship is, actually I have to say it is still quite good. So while we don't like to see that–we don't like to see them go and we not be with them–the practicalities of just having one midwife on is how it is, and they actually understand that.* (Marion MW)

A consequence of women accessing a maternity system not able to provide their ongoing care requirements, so not being able to receive labour and birth continuity from their rural midwife if they chose to or risk factors led to them birthing in a secondary care facility, was women moving to other areas during pregnancy to stay with family members and receive midwifery continuity for a portion of their childbirth journey from other midwives. This also impacted the financial viability of remaining a midwife in a rural setting; hence being employed by the local DHB to ensure midwives remained in the area.

8.4 Midwives Sustaining Themselves Professionally and Personally

Dealing with the various complexities of working with this group of women meant midwives needed to sustain themselves both professionally and personally. Midwives spent a lot of time advocating, negotiating, supporting, and navigating women through the maternity system, taking into account women's situational complexities. They did this to encourage and enable women to remain engaged with care. In order to sustain themselves midwives put boundaries in place around how they worked with both women and their midwifery group practice colleagues. When midwives developed strategies to ensure they looked after themselves well, they continued to enjoy their work and stayed in their roles for many years. Not sustaining themselves adequately resulted in midwives gaining less work satisfaction. If this continued, some choose to join a different midwifery group, to work in a different area of midwifery, to take a break from midwifery practice, or to stop working as a midwife altogether.

8.4.1 Having agreed midwifery group practice boundaries

All but one of the midwife participants were working as part of midwifery group practices of between two to six midwives. The midwife who was taking a break from midwifery had been working in a group practice until the month prior to interview. All the midwives worked with a designated midwifery partner within each midwifery group practice. It was important this relationship worked well which meant sharing relevant practice information regularly, and informing each other of, for example, when they

were called out to attend a woman. Knowledge of each other's personal context was also helpful. Effective communication was considered important between all members of the midwifery group. This extended to having the support from group colleagues to be able to talk through any challenging practice issues. Being able to call another midwife to provide back up with no questions asked was considered an important aspect of working within an effective midwifery group practice long term. Having a clear group strategy around negotiating with core midwives about providing midwifery care for women who were experiencing medical or obstetric complexity, for example, women having their labour induced, was supportive, and enabled midwives to sustain themselves for their primary caseload of women. Having documented agreements within the midwifery group practice about practicing in specific geographical areas, caseload numbers, regular group meetings, rostered time off call, expectations around calling in colleagues for support, birth payments, clinic hours, and how problems within the group would be resolved, meant there were clear parameters for all midwives within the group, and the document could be referred to when required.

Midwives reported having clear group understandings with their midwifery group practice partners about their agreed boundaries of working arrangements were the foundation for group members building strong relationships with each other. The resulting relationships, when effective, enabled midwives to sustain themselves through the many complexities associated with working with this group of women, including the times they worked with women negotiating pathways for them through the maternity system, enabling them to feel supported and strong.

8.4.2 Setting expectations between women and midwives

All midwives mentioned the importance of setting expectations between the women and themselves early in their relationship as they negotiated a pathway for the pregnancy. This covered, for example, women contacting the midwife with non-urgent matters during office hours and only ringing with urgent matters overnight, rostered time off, and back up midwifery cover arrangements. When they started working as community LMC midwives, because of the effective relationships they had built with the women, most midwives had been happy to be called to labour and births when they were supposed to be off call. "*Sometimes I was actually off, and often I would say 'if my women ring, just let me know and I wanted to be there*" (Catherine MW).

> *Yes well there were four of us, so we would have every second weekend off so if I was off my offsider was on, and there was also another midwife. I guess the problem with that is that we would often still go anyway. I certainly stopped that*

in my later years of practice, but in the beginning we would probably go anyway, even if it was our weekend off. (Joanne MW)

This was a practice some midwife participants continued. Midwives spoke of the complexity of this group of women's lives, and the effort they themselves had put in to building effective relationships to encourage them to remain engaged with care, as reasons for choosing to stay on call rather than taking planned time off when women in their caseload were due to birth. Deciding whether to remain available for women or take time off in these circumstances was a dilemma for the midwives. Alternatively, they made plans with their backup midwives that they were to be called in during their time off if particular/any of their women laboured. Despite most often knowing the midwife who would be taking over the woman's care, and the woman being aware they might not be there, midwives felt disappointed if they could not be at a birth of a woman in their caseload. Part of this was a desire to continue to offer continuity to the women knowing their context and the complexity around receiving care from a midwife they did not know, and navigating the maternity system.

Yes. I like to be on for some of my clients [women]. Yes. So if someone particular went into labour I would say 'once she's in established labour can you give me a call so I can be there.' I'm a bit … possessive of my clients, yes so, I think you know because some of the clients that I've had that are returns, I mean, why would I want another midwife to touch her abdomen and deliver her baby? I mean it sounds sad, but [shrugs]. (Steph MW)

For some midwife participants, the way the maternity system was funded under Section 88 (MoH, 2007) also impacted their decision to remain on call. Unless they worked in a salaried capacity, not attending a labour and birth had financial consequences for the midwives due to the bulk of the pregnancy funding attached to the woman's labour and birth. This meant it depended on the arrangement each midwife had with her midwifery group practice partners as to how much income she would potentially lose if another midwife provided the midwifery care to a woman in her caseload during this time. "*…and sometimes I've only got two a month*" (Catherine MW). While being on call for labouring women when being rostered off call ensured continuity for the woman, it impacted on the midwife's ability to have time off, and potentially her ability to sustain herself in practice long term. This dilemma was reported as being difficult for midwives. Over time, midwives recognised that for their own sustainability they needed to be totally unavailable when off call.

After missing the birth of a woman in their caseload, some midwives found it hard to face the woman's disappointment when visiting postnatally, while other

midwives found debriefing with a woman about her birth when they had not attended to be of value. Midwives usually offered postnatal women the option of transferring to the midwife who had attended her labour and birth. While some women accepted this offer, most were happy remaining with their primary midwife postnatally. While it was challenging for women when midwives became unavailable for their labour and birth, resulting in the woman receiving care from a midwife who was unknown, this also presented challenges for midwives. Using strategies such as offering women a transfer to the midwife who attended their labour and birth, midwives attempted to make the experience the best they could for the woman, given their need to ensure their own sustainability. Women choosing to remain with their primary midwife postnatally was evidence of the relationship they had created remaining intact.

Sometimes midwives felt pressured by women to be available for their labour and births when they were off call. "*I'm like 'come on, I've got young kids. Give me time off too. Don't put the guilts on me'*" (Molly MW); whereas most women understood midwives having days and other time off call to attend engagements such as school activities. Being caught in the middle of feeling pressure from women to be constantly available but knowing the importance of having time off to sustain themselves personally and professionally was a difficult dilemma for midwives. Setting expectations early with women and offering them the opportunity to meet the midwife who would most likely attend their labour and birth if the lead midwife was away, were strategies midwives used to feel comfortable enough to be truly off call when rostered off. Although most women were offered the opportunity to meet their midwife's backup in case their own midwife was unavailable when they went in to labour, most declined to do this.

> ***And did you meet the partner midwife?***
> *I think it was mentioned you know, 'if anything were to go wrong,' or 'I'm not on this weekend,' so I was aware, but I hadn't met them unless I was due a visit, and usually it was a postnatal [visit]. … It would have been good to probably meet them antenatally just in case you do go to the delivery with a new midwife … Just to kind of say 'hi' and familiarity.*
> ***Yes, ok. But when they came to do some of your postnatal stuff?***
> *I wasn't so [bothered].* (Trish W)

Having shared group pagers and not giving out home phone numbers to women meant being uncontactable during time off. Days off were looked forward to as a break from being available 24/7 and never being away from phones.

8.4.3 Stepping away

Midwives reported the importance of being able to switch off from work when not on call. Working with women who had a lot of complexity meant the midwives needed to be able to step away knowing that women were not going to contact them for a few days, as if they did ring they would be talking to another midwife. Indulging in pampering activities was one way of stepping away. "*That's my treat for working through the middle of the night and feeling like crap some days when I've got to get up for postnatals*" (Elizabeth MW). Spending time off with family and friends was highlighted. However, caution was expressed around spending all time off involved in family activities, as it was important to ensure midwives caught up on sleep and had some quality time just for themselves. Having days off during the week or keeping any children in daycare during rostered time off were strategies that enabled time for self.

> *I always put the little one in crèche and I used to keep him out cos I'd feel bad that if I am at home he should be home with me, but I'm like 'no'. So I have two days every fortnight that I don't have anybody [at home].* (Molly MW)

Midwives found it beneficial trying not to dwell on work issues when off call; however, they also reported using time off to reflect on challenging practice experiences working towards moving on from them. Midwives who had worked in the community for several years felt that what was expected of them had changed over time, being much more than when they first started. Being the woman's contact point for maternity services could lead to the midwives feeling overwhelmed with the responsibility of trying to get complex concerns addressed which were not necessarily the woman's priorities, and a maternity system that sometimes lacked the resources required. "*…sometimes midwives try and fulfil all roles, and sometimes that becomes overwhelming when a client's [woman's] expectation is just something that we can't meet*" (Steph MW).

> *I do enjoy working with them. Some can be high maintenance, as in their health issues or social issues, but I think that cos I've worked in this area for such a long time I don't actually see it being anything to be concerned about. It's just that becomes part and parcel of the community, yes. So, I mean, new graduates say that they like working in this area because the women are uncomplicated and they birth fast. That may be so, but when I hear that I just smile and say 'yes, they're a lovely bunch of fruit'. There's more to it than that.* (Steph MW)

Being able to step back and gain perspective on what they could reasonably achieve while working with each woman was vital to enabling midwives to sustain their roles.

8.4.4 Employing sustaining strategies

Midwife participants employed strategies to enable them to continue sustaining themselves in practice when working with this group of women. Sustainability principles midwives adhered to included being careful with nutrition, staying adequately hydrated, taking regular exercise, having adequate sleep, and referring women to appropriate services when required. While working with like-minded midwifery colleagues and being supportive of each other was necessary in any midwifery group practice, this was important for these midwives due to the daily complexities they were involved with. "*...just feeling that someone had your back*" (Joanne MW). Having colleagues who were happy to share information about where to access resources, especially when a midwife had not been working in the community for long, was helpful. Needing a degree of resilience to deal with the realities of these women's lives was also reported to be a requirement. "*...looking after this clientele it's not for the faint hearted ... you have to be a little bit hardy in this area for everything you see*" (Sophia MW). Maintaining vigilance around personal safety by taking notice of what was happening surrounding them was also mentioned. While some midwives had not experienced threats to their personal safety, others gave examples of being verbally abused and needing to take care around some home visiting, including the threat of unknown dogs running free on properties. Dealing with women who had gang members as partners required care, as midwives sometimes found their facial tattoos intimidating and were unsure how they would behave. Midwives had safety plan arrangements in place to use if required.

Receiving care from a midwife working in an effective midwifery practice, where she was supported by colleagues and had regular time off call and was thus able to sustain herself positively in practice, benefited the women. For midwives, using strategies to sustain themselves both professionally and personally enabled them to cope with the complex requirements of the women with whom they worked, and a maternity system not set up to provide them with all the resources they required to provide the care.

8.5 Conclusion

This chapter has presented '**negotiating a pathway**' to explain the process women participants found themselves in when moving through the maternity system. The

effective relationships women had built with their midwives and the provision of continuity of midwifery care enabled **negotiating a pathway** to occur.

Women participants found themselves caught between family members/others and midwives over aspects of care, requiring the midwife's support and advocacy to negotiate an agreeable pathway forward. Women had entered a maternity system which divided their continuous pregnancy journey into primary and secondary maternity care categories. There was some variation in how midwives coped with women living in areas of high socioeconomic deprivation who were also high risk. For some women medical or obstetric complexity was known at the beginning when they first began accessing midwifery services. This meant that the transition to, for example care from the hospital diabetic team, was immediate, so there was no disruption to accessing midwifery care. Being referred to other services in a best practice approach resulted in some women losing continuity from their midwives, resulting in discontinuous service; however, this was not the case for all women. When women developed medical or obstetric complexity, wanting midwifery continuity and working with midwives wanting to provide women centred care, within a continuity of midwifery care model, could be difficult and complicated for both women and midwives. Most midwife participants negotiated to continue providing midwifery care to women with risk factors in a shared care arrangement with hospital based secondary care teams, trying to ensure women received the most appropriate care which met their specific requirements. If they decided to remain involved, midwives developed and/or maintained expertise in the provision of care to this group of women, and spent time negotiating with core staff over midwifery responsibility.

Midwives wanting to provide care continuity faced multiple disadvantages when choosing to continue to provide care to women with high acuity. They chose to stay to support women's request for midwifery continuity and because, as the midwife known to the woman, they wished to support her negotiating the maternity system working towards an optimal pregnancy outcome. This was despite the implications for themselves, their caseload of women, and financially. Due to hospital resources issues around staffing and resources, in most areas under study, following referral to secondary care clinics women with complexity were increasingly returned to community LMC midwives for their ongoing midwifery care rather than being transferred to the secondary care obstetric team. Using strategies to support their professional and personal sustainability enabled midwives to continue working with women living in areas of high socioeconomic deprivation.

Chapter 9: Discussion

9.1 Introduction

In this study, the theory of 'Working through complexity' was identified as the major process women living in areas of high socioeconomic deprivation in New Zealand undertook as they accessed and engaged with midwives. Women participants were constantly working through complexity as they accessed and engaged with midwives, moving between the three categories of '*navigating a shifting landscape*', '*building effective relationships*', and '*negotiating a pathway*', working together with the midwife, or not. In this chapter the findings from this research study are discussed. The strengths and limitations of the study are identified. The recommendations for practice, research, education, and maternity system development, are then explored.

9.2 Discussion of study findings

9.2.1 The complexity of accessing and engaging with pregnancy care

Women living in areas of high socioeconomic deprivation constantly balance complex personal, relational, and situational aspects of their lives within an ever changing landscape. Women's engagement in pregnancy care was conditional on available resources and the need to prioritise competing demands. Upon entering the maternity system women brought these complexities with them. Within this context this group of women were accessing and engaging with pregnancy care in a maternity system which was not always resourced to meet their requirements. Women were expected to understand the maternity system and act in certain ways within it without having received any information about this. Similarly, McLeish and Redshaw (2018 in press) reported that a variety of reasons including language obstacles, or not knowing how to use the service (Renfrew et al., 2014), meant many of their participants did not understand the purpose of the complex maternity system or how it worked. For women participants in my research, these conditions, accompanied by their life complexities such as transport availability or reliable childcare, resulted in them experiencing the process of accessing and engaging with pregnancy care in a variety of ways. When this process did not go smoothly this could result in a delay accessing a midwife, and therefore delayed engagement with pregnancy care, putting women at risk of poorer pregnancy outcomes.

Women participants experienced a delay between getting their pregnancy confirmed by their first primary health contact, usually a GP, (MoH, 2018e), and accessing a midwife for ongoing pregnancy care. For example Grace, a woman participant, lacked the resources to contact a midwife after receiving pregnancy confirmation and consequently did not access a midwife for several weeks. Experiencing a delay in accessing a midwife was due to there being no clear process for these women to do this. Makowharemahihi et al. (2014) reported that while young Māori women engaged early with primary health care services to confirm their pregnancy and initiate maternity care, transitioning to a LMC was often complex, a finding also of my study. Findings highlighted the impact fragmentation between primary non maternity care and LMC services had in disrupting access to early antenatal care, despite a publicly funded maternity system. Reibel, Morrison, Griffin, Chapman, & Woods (2015) reported that young women were usually vulnerable when their pregnancy was confirmed, and relied on family support to access antenatal care. When family support was not present the risk of erratic or no antenatal care attendance increased.

An important factor identified in Makowharemahihi et al's study and supported by others (Alshawish, Marsden, Yeowell, & Wibberley, 2013; Hatherall et al., 2016; Rowe et al., 2008; Scott, 2014), is that once a woman decided to seek antenatal care, access to a LMC, such as a community midwife, needed to be quick and easy through a process of direct referral. A delay in this process could result in a delay in accessing and engaging with pregnancy care, as evidenced by women in my study who, for a variety of reasons, experienced delays in accessing a midwife once they knew they were pregnant. Carter et al. (2018) recommended systems navigation as one strategy to reduce barriers to primary health care for populations with complex health and social need, reporting that access and coordination of care for complex individuals was most efficiently provided through primary care services e.g. their GP. Use of navigators to speed up access to a midwife following the first contact with a health provider when pregnancy is confirmed is crucial to improving the timing of engagement with a midwife or other LMC for pregnancy care. This is true, particularly for women living in areas of high socioeconomic deprivation, who are more at risk of receiving less antenatal care. Women participants in this study who were referred by their primary provider directly to a community LMC midwife engaged early with pregnancy care.

Early engagement with antenatal care enables women to build effective relationships with their midwives through continuity of midwifery care, and has been

reported to improve a number of pregnancy outcomes. Some women participants reported being aware there was a shortage of community LMC midwives in their areas, and that this had resulted in them booking with a midwife earlier, so engaging early with midwifery care. However, while women participants had responded to the message to book with a midwife early, they were doing this due to the midwifery shortage, rather than for the potential improvement this could make to their pregnancy outcomes. This demonstrated that the message to engage early with a midwife and the potential benefits to their pregnancy this could make needed to be highlighted to women and those closely involved with them, such as whanau. Much of the work done by systems navigators in Carter et al.'s (2018) review was already being undertaken by midwife participants in my study to meet the complexity requirements of women in their caseload.

9.2.2 The impact of differing world views on antenatal care attendance

Differing world views impacted women participants' attendance for antenatal care. At times women participants prioritised competing requirements over midwifery care attendance. This is a finding supported by other research as when pregnancy was progressing normally woman did not see attending antenatal care as a priority (Gaudion & Homeyard, 2010; Haddrill, Jones, Mitchell, & Anumba, 2014; Reid & Taylor, 2007). Midwife participants reported that when women developed some complexity during pregnancy keeping them engaged in care could be problematic. This was primarily related to the woman often viewing herself as well while the complexity actually required her to have more frequent visits and attend secondary care appointments. These findings demonstrated a need for women to be given information that they can engage with and readily understand about the New Zealand maternity system and the recommendations around antenatal care attendance. It would appear that there is a great need for this, especially when women develop some complexity during pregnancy. These findings also suggest the potential for discussions between the woman and the midwife around how much antenatal care is required when the pregnancy is progressing normally, and negotiation around their individual requirements.

These findings are also supported by previous research which reported engagement being influenced by community, cultural, and service factors (Reibel et al., 2015), women seeing little perceived urgency in accessing antenatal care (Callaghan et al., 2011; Hatherall et al., 2016), and practical difficulties delaying access (Haddrill, Jones, Mitchell, & Anumba, 2014). Further, as demonstrated in this study, a lack of information about pregnancy related issues, and perceiving the midwife didn't take

them seriously, contributed the most to dissatisfaction with antenatal care (Hildingsson, Hanes, Cross, Pallant, & Rubertsson, 2013).

9.2.3 Timing of engagement with antenatal care

The women participants wanted pregnancy care and had begun seeking a midwife when they were confirmed pregnant. However various complexities resulted in them often accessing a midwife after 10 weeks gestation, and so they were labelled 'late bookers' by the maternity system. This inferred that it was their fault they couldn't access a midwife until after 10 weeks gestation, and even that they did not want the best for their pregnancy, rather than being the fault of the current maternity system where there was no straight forward pathway to access midwifery care. Labelling women as late bookers demonstrated limited understanding of the women's contexts where the complexity of their daily lives competed with their needs as a pregnant woman. Labelling also failed to acknowledge the responsibility of a maternity service not putting resources into meeting the New Zealand maternity standards of women being able to access a midwife early in pregnancy. An example of this is assuming a woman would have access to money to pay for public transport to access a midwife's clinic, or that women with English as a second or third language are comfortable ringing 10 or more midwives off a list. Midwives who recognised this mismatch responded by stepping in to fill the gaps to keep women engaged with midwifery care.

NICE (2008) recommends women access antenatal care before 10 weeks gestation as early engagement with antenatal care results in more antenatal visits and is associated with better birth outcomes (Ayoola, Stommel, & Nettleman, 2009; Ayoola, Nettleman, Stommel, & Canady, 2010). Early engagement is also supported by PMMRC recommendations in New Zealand (2013, 2014, 2015, 2016, 2017, 2018). Factors identified in my research as influencing timing of accessing care are supported by previous research (Anderson, 2014; Ayoola et al., 2010; Bartholomew, Morton, Atatoa Carr, Bandara, & Grant, 2015; Callaghan, Buller, & Murray, 2011; Cresswell et al., 2013; Hatherall et al., 2016; Kapaya et al., 2015; MoH, 2018e; Rayment-Jones, Butler, Miller, Nay, & O'Dowd, 2017; Renshaw & Henderson, 2015; Rowe, 2008). Lynette, a woman participant, reported sometimes needing time to adjust to the pregnancy before accessing midwifery care. Her experience is supported by Haddrill, Jones, Anumba, & Mitchell (2018) who identified that recognition and acceptance of the 'personal' pregnancy was required prior to accepting the 'public' pregnancy, when the social consequences of the pregnancy, including the relevance and priority around initiating antenatal care, was considered.

Once they had accessed a midwife, women participants valued not feeling rushed at appointments, the midwife taking time to explain test results so that they understood, and involving them in decisions about their pregnancy. These strategies resulted in women being more likely to remain engaged with midwifery care. My findings concur with other results demonstrating that creating an environment where engagement with care is facilitated is important if women are to remain engaged with care (McRae et al., 2018), and engagement relying on ease of access, and the provision of continuity and choices by trusted providers (Reibel et al., 2015).

When circumstances meant women in the current study missed antenatal care, midwives negotiated with women to keep them engaged, utilising strategies such as enlisting family support, using incentives to encourage attendance, or organising to home visit. This required midwives having the time and resources to be able to utilise these strategies to keep women engaged with pregnancy care, and so required resourcing from the maternity system.

9.2.4 Integrated model of health care

There are important benefits to this group of women of accessible, acceptable, culturally appropriate integrated health services for accessing and remaining engaged in midwifery care. Integrated models of health care have the capacity to provide broad, specialised and preventative care, including midwifery care, in the one primary health setting (Rumball-Smith et al., 2014). This is particularly true amongst populations such as the women in this study, whose life complexity often led to high stress and poor health (Southwick et al., 2012). Accessing midwifery care at a health centre located where the health care requirements of the women and her family were usually met was reported as beneficial for women participants. Within the health centre, women were able to access integrated health services specifically focused on their social or health complexity, could be given information and support to understand pregnancy, and be guided through the unfamiliar maternity system and procedures. The women who accessed midwifery care in this way experienced little difficulty navigating the system (Gray, 2015; McLeish & Redshaw, 2018 in press; NICE, 2010, 2014 updated 2017). An integrated model of health care supported women to access and remain engaged with care. Within this model of health care the primary care practitioner at the health centre the woman first accessed took responsibility for first trimester screening and navigation to a LMC. This resulted in an easy transition to accessing midwifery care. Being registered with a health centre which employed or had co-located midwives meant women, their health histories, and their various life complexities, where known. In

addition, women were attending a familiar setting where they knew the staff, resulting in their individual requirements being more easily met. This integrated model of health care resulted in women engaging early with a midwife and remaining engaged with care. This finding is supported by a report written about midwifery care in one integrated health centre which showed that the engagement the women already had with the health centre resulted in earlier registration during pregnancy (Priday & McAra-Couper, 2016, 2011), which is a longstanding requirement of the PMMRC (2013).

Conversely, Guilliland (2015b) supported integrating maternity services around the needs of the woman who is the recipient of care in whatever setting she is in, rather than within an integrated model of health care. It was her view that integration around the needs of the woman enabled the woman to transition seamlessly from one service to another if required. Guilliland saw this as the role of the community LMC midwife for most women. Women then had continuity of midwifery care from the person navigating their care, and accessed secondary care services if required, while keeping their LMC midwife to provide the primary support (Guilliland, 2015b). Midwives in my study reported the complexity of trying to provide the extra resources and support this group of women required. Those midwives who were not based in or employed by a health centre spent a lot of time sourcing information for women about resources available, such as social services, and sometimes coordinated care requirements across several agencies. Having clear referral pathways for women requiring extra social support was a recommendation from Cross-Sudworth (2015), who found that midwives' knowledge of these varied. This contrasted with the experience of their colleagues associated with an integrated health centre who had immediate access to this information through the variety of health related personnel working there. Clear referral pathways would positively impact midwives time and length of appointments.

When women reported unsatisfactory experiences of attending appointments they risked not attending for care. The findings of this research demonstrated that if women were to continue to attend and engage with care when they developed complexities, the secondary care clinics needed to be accessible comfortable environments, with welcoming personnel who communicated well with women, and provided respectful care. This is important when attending is often at much inconvenience to this group of women and their families. Secondary care clinics being held in the communities where the women live, in environments familiar to the women, rather than within large hospital facilities, e.g. their health centre, are preferred by women, and enhance engagement when pregnancy complexity is present.

9.2.5 Receiving culturally appropriate care

Women in this study expressed mixed views about the importance of being cared for by a midwife of the same ethnicity. This was an unexpected finding, as previous study findings have supported the benefit to women of having continuity of care from midwives of the same ethnicity (Homer et al., 2012; Kelly, West, Gamble, Sidebotham, & Carson, 2014; Reeve, Banfield, Thomas, Reeve, & Davis, 2016). For women participants, support and concerns about having a midwife of the same ethnicity were around the connections they may have with a midwife and confidentiality issues; *"Yes people might talk, even though they're not allowed to"* (Lute W). For some the competency of the midwife was more important than care being provided by a midwife of the same ethnicity, while other women mentioned the importance of a cultural understanding *"there is something that makes the difference"* (Mary W).

New Zealand's model of midwifery care incorporates the practice frameworks of cultural safety and Turanga Kaupapa to enhance midwives relationships with women and families (MCNZ, 2012a). Cultural safety is centred on the woman, and is about respecting her social and cultural contexts when providing midwifery care which meets her individual requirements. In this way, the woman decides whether the service she received was culturally safe or not (Durie, 2001). Turanga Kaupapa comprises a set of statements about the cultural values of Māori regarding childbirth developed to guide midwives about how to recognise and incorporate the cultural values of Māori women into their midwifery care, working towards the provision of culturally safe practice for Māori wahine/all women (NZCOM, 2015; Nga Maia, 2018; Pairman & McAra-Couper, 2015).

While it is possible that being asked by myself, a non-Māori researcher, about the importance of having a midwife of the same ethnicity provide their care may have made women participants feel that they should respond with an answer I would want to hear, this was not the sense I had from the women when I asked this question. Not all the women who had a midwife of the same ethnicity provide their care, or had this choice available, would choose to have a midwife of the same ethnicity with a subsequent pregnancy. When being cared for by a midwife of a different ethnicity, the study findings indicated that the midwifery care women received was perceived by them to be culturally safe. As mentioned earlier, this was an unexpected finding that warrants further discussion within the midwifery profession and with consumer groups.

9.2.6 The importance of building effective woman midwife relationships

A crucial element to women participants remaining engaged with pregnancy care was

building an effective relationship with their midwife. The women in this study who historically had not always experienced positive interactions with health professionals, reported valuing the importance of developing an effective relationship. The importance of developing an effective relationship was a key finding of this research, and is supported by others (Origlia, Jevitt, zu Sayn-Wittgenstein, & Cignacco, 2017). Midwives in this study utilised many strategies and behaviours to facilitate building effective relationships with women, many of which have been previously reported (Acquino, Edge, & Smith, 2015; Murry & McCrone, 2015; Sword et al., 2012). Previous research has shown that women valued good communication and consistent information, and having their views acknowledged and questions answered consistently in their maternity care (Puthussery, Twamley, Macfarlane, Harding, & Baron, 2010). Women participants valued these aspects of an effective relationship.

Women in this study valued the quality of the relationship they developed with midwives more than any other aspect of care. Perceiving that the midwife took the time to get to know them a little was important to women and strengthened the developing relationship. The quality of the relationships between women and midwives has been reported as fundamental to the quality of maternity care (Hunter, Berg, Lundgren, Ólafsdóttir, & Kirkham, 2008), especially for women living in social disadvantage (Ebert, Ferguson, & Bellchambers, 2011). Midwife participants valued the relationships they developed with the women with many reporting this as the most rewarding aspect of their work. '*…I think that's what it's about for me. Every birth was really just the icing on the cake. For me it wasn't the [main] thing; it was always the woman; the relationship*' (Joanne MW). Hunter (2006) reported these relationships as the main factor keeping midwives practicing with women living in areas of high deprivation.

Trusting each other was important to women and midwife participants, and trust developed as effective relationships were built, as previously reported (Calvert, 1998; Menke, Fenwick, Gamble, Brittain, and Creedy, 2014). Building trusting relationships with women took time and effort (Murry & McCrone, 2015). Midwives having the time available to get to know the women so they could build effective relationships with them was difficult within a maternity system where midwives were not resourced to have this time. However the midwives took the time as they valued the relationship that developed, as when the relationship worked well women were more likely to remain engaged with pregnancy care. When the relationship was perceived as being unsatisfactory by women, they chose to shift midwives for their current or a subsequent pregnancy, potentially resulting in missing episodes of antenatal care.

Women participants highlighted the importance of involving their partner and support people in their care, and midwives worked to include them, sometimes becoming involved in advocating for women when they were negotiating between family and themselves or other health professionals over various recommendations for their or their babies' care.

9.2.7 Continuity of midwifery care

Another finding of this study was that continuity of midwifery care supported the development of a relationship between woman and midwife participants, as previously reported by others (Hunter, 2006; Puthussery et al., 2010). Being kept informed and involved in decision making about their care was important to women participants. Receiving continuity of midwifery care resulted in women receiving individualised care, being trusted, listened to, and being involved in decision making about their ongoing care in an environment where they were treated with respect and kindness. These findings are supported by earlier research (Boyle, Thomas, & Brooks, 2016; Gaudion & Homeyard, 2010; Gould, 2011; Homer et al., 2012; Jenkins, Ford, Morris, & Roberts, 2014; NICE, 2010, 2014 updated 2017; Redshaw & Henderson, 2015; Renfrew et al., 2014; Stapleton, Kirkham, & Thomas, 2002; Williams, Lago, Lainchbury, & Eagar, 2010; World Health Organisation, 2018) demonstrating continuity to be an effective model of midwifery care for women from disadvantaged groups, including those living in socioeconomic deprivation. Continuity of care appears to improve a number of pregnancy and childbirth outcomes for women and babies living in areas of high socioeconomic deprivation, such as the women in my study (Bohren, Hofmeyr, Sakala, Fukuzawa, & Cuthbert, 2017; Hatem, Sandall, Devane, Soltani, & Gates, 2008; Hicks, Spurgeon, & Barwell, 2003; Hodnett, Gates, Hofmeyr, Sakala, & Weston, 2012; Homer et al., 2001; Homer, Leap, Edwards, & Sandall, 2017; Howarth, Swain, & Treharne, 2011; Leap et al., 2010; McLachlan et al., 2012; Rayment-Jones, Murrells, & Sandall, 2015; Tracey et al., 2013; Sandall, Hatem, Devane, Soltani, & Gates, 2009; Sandall, Devane, Soltani, Hatem, & Gates, 2010; Sandall, Soltani, Gates, Shennan, & Devane, 2013, 2016; Zachariah, 2009). Previous research results also demonstrated that community based midwives were more likely to trust women and facilitate their choices by advocating on their behalf (Kirkham et al., 2002; Stapleton et al., 2002). In this study, being more likely to trust women and advocate for them was due to the relationship which developed and was supported by the provision of continuity of midwifery care. Findings of other studies have reported that some women prioritised being treated kindly, and professional competence, over continuity of care (Davey &

Brown, 2005; McLeish & Redshaw, 2018 in press), concurring with results of an earlier literature review about aspects of continuity which mattered to women (Green, Renfrew, & Curtis, 2000). In my study those women who perceived these aspects of their care as being unsatisfactory chose to shift midwives. When an effective relationship was built with a midwife they came to know, women were more likely to remain engaged with pregnancy care. In contrast to these findings an earlier study (Freeman, 2006) reported that receiving continuity of midwifery care was not a high priority for women, nor a clear predictor of their satisfaction with care. Instead women focused on the content of the care provided. In my study women valued the relationship with their midwives over the care provided. Freeman (2006) also reported that while providing continuity of care was found to increase job satisfaction and autonomy for midwives, it did not necessarily lead to them developing meaningful relationships with women. This is not supported by the results of my study where midwives strongly articulated the relationships they built with women to be one of the main reasons that kept them working with women living in these areas.

Women participants reported continuity of midwifery care to be more important during pregnancy and birth than the postnatal period. This finding is supported by Hildingsson and Rádestad (2005), however contrasts with the results of Dahlberg, Haugan, & Aune (2016) who reported the importance to women of being visited postnatally by a known midwife. The finding from my study that women participants valued the opportunity to discuss their labour and births with their LMC or attending midwife, concurred with the results of Dahlberg et al. (2016). The development of an effective relationship between the woman and her midwife antenatally resulted in women participants remaining engaged with pregnancy care, and was enhanced by the provision of continuity of care. Even when continuity was not provided, ensuring women were able to debrief their experience with a midwife remains an important aspect of care provision.

The complexity of the women's daily lives meant there were many barriers to staying connected with their midwife. Midwives went to great effort to remain connected with women who missed appointments, trying to keep them engaged with care, being aware that this was a group of women who frequently fell through gaps in the maternity system. However midwives had a limit to the effort they employed. This was conditional on a lack of resources from the maternity system to enable them to continue following up women who had missed care, and their obligations to other

women in their caseload. Midwives in this study clearly required more resources to support the time required following up women who missed appointments.

9.2.8 Working in partnership

Building an effective relationship between women and midwives was a prerequisite for the creation of partnership. Women reported that once a partnership developed, they worked together with their midwife to address their pregnancy requirements towards an optimal pregnancy outcome. Midwives in this study reported gaining satisfaction from working in partnership with women and perceived they could make a difference to the women's lives.

The New Zealand midwifery model of care being based on partnership has been explored in the literature. An earlier critique of the partnership model (Guilliland & Pairman, 1995) by Skinner (1999) found equality in the partnership was not achievable, and questioned the assumption that all women wanted partnership, which, in Skinner's experience of working with low income women, was often not true. Benn (1999) responded with her belief that understanding the parameters of partnership depended on how partnership was defined, rather than focusing on what the relationship was called. Benn pointed out that the important issue was to focus on how the woman and midwife worked together, and the difference this made to the woman, her baby, family, and the midwife involved. Kenney (2011) has criticised the New Zealand model of midwifery partnership for not representing Māori world views and minimising the presence of whanau. Pairman (2010) describes the midwifery partnership model as a framework rather than a prescription, with wide scope for women and midwives to interpret and implement it in practice. The women in my study who reported working in partnership with their midwives, based their perception on the quality of the relationship developed. Women were proud to say they were working in partnership and clearly valued the attributes within the relationship that they perceived contributed to this, such as feeling comfortable, and having mutually agreed decision making. Calling their relationship a partnership, for the women this applied to, reflected their appreciation at how the relationship between themselves and their midwives had been demonstrated.

9.2.9 Continuity of midwifery care supporting the negotiation of a pathway through the primary/secondary interface

New Zealand research (Skinner, 2011; Skinner & Foureur, 2010) identified that 35% of women were referred to secondary care obstetric services sometime during their childbirth experience. Of these referrals, 70% occurred antenatally, with midwives

accompanying women to the first consultation appointment 40% of the time. Although consultation resulted in responsibility for clinical care being transferred for almost half of the women, almost three quarters of the women continued to receive some midwifery care from their LMC midwife. Midwives considered that when risk was identified their input was even more important within the trust relationship developed with the women, and they remained with them providing care (Skinner, 2011). Most midwives reported satisfaction with the collaboration with secondary care providers in these circumstances, and felt well supported to continue providing continuity of midwifery care to women experiencing complexity during pregnancy or childbirth. Results reported that 30% of the midwives agreed with only providing care for women identified as low risk. The need for midwives to pay ongoing attention to whether midwives were changing how they provided care to women with identified risk was identified by Skinner & Foureur (2011). This was timely advice, as only a few years later when interviews for this research were taking place, midwives wishing to provide continuity once secondary care services were required were reporting the complexity around negotiating their ongoing involvement in women's care with core staff.

Negotiating ongoing involvement was in response to the current national shortage of both LMC and core midwives, the increased complexity of women in community LMC midwives caseloads, and the lack of remuneration to LMC midwives for providing midwifery care once secondary care was required. Negotiating ongoing involvement was also necessary to support their sustainability as a community LMC midwife, for example negotiation was required around being called to provide labour care once women requiring induction were established in labour, rather than providing induction care often over several days prior to labour commencing. Midwives highlighted the importance of effective interprofessional communication and collaboration in the negotiations, if women were to receive care that was effective to meet their requirements (Romijn, Teunissen, Bruijne, Wagner, & Groot, 2018). Concepts of effective collaborative practice have been identified as communication, trust, respect, and shared power (Smith, 2016). The need for these concepts to be used in an effective way during negotiations were identified by midwife participants.

Midwife participants reported variation in the success of negotiations with core staff around their ongoing involvement in these situations, with conditions such as the shortage of core midwives more often leading to satisfactory outcomes to the negotiation. However an unsuccessful negotiation resulted in the loss of midwifery continuity for the woman. Some midwife participants were not wanting to continue

following women once they developed complexity requiring secondary care. Midwives were aware their colleagues were working within a hospital environment where resources such as staffing were scarce. This added to the complexity of negotiating a pathway through the primary/secondary interface. Australian research around providing continuity within maternity units has reported similar findings (Reiger & Lane, 2013). So in my study, the shortage of core midwives had recently often led to successful negotiations enabling community LMC midwives to continue providing midwifery care to women experiencing clinical complications of pregnancy. However this was more a response to the lack of resources such as staffing, in core facilities, rather than a maternity system wanting to support community LMC midwives to provide continuity of midwifery care in these circumstances.

Whatever the outcome of the negotiation, women reported the importance of each caregiver having access to their health information when they required secondary care services. This result is important when seen in the context of women in the current study negotiating a pathway through the maternity system, especially if they lose continuity from their LMC midwife if they required secondary care, and is supported by others (Jenkins et al., 2015).

9.2.10 The impact of a maternity system not working for women living in areas of high deprivation

Midwives were aware of the expectations of the maternity system regarding women's behaviour, and also women's experience of the maternity system's responses to their complex requirements. Examples of this were the inflexibility of secondary care clinic appointment times, and the long waiting times women encountered when attending these hospital based appointments. This resulted in women's dissatisfaction with the service and was more likely to result in disengagement with care, also reported by Thomson, Dykes, Singh, Cawley, & Dey (2013). Using strategies such as advocating to change hospital appointments to suit the women, and transporting women to clinic, midwives choose to work outside their role to assist women through the health system. Identifying gaps in maternity service provision for women with social risk complexity, and trialling different initiatives aiming to improve access and engagement for this group of women was recommended by Rayment-Jones et al. (2017). An example of this for my study would be women having more ability to access secondary care services in the community where they live, as previously mentioned. While in two study areas this was possible for some secondary care obstetric clinics, women were still required to travel to the main hospitals for other secondary or medical complexity, for example to

attend diabetic clinics. The complexity around being required to travel, and the subsequent associated waiting time at the clinic, put this group of women at risk of not remaining engaged with care, and so potentially serious consequences for them and their babies.

9.2.11 The importance of midwives sustaining themselves for working with this group of women

This study identified the importance of community LMC midwives sustaining themselves professionally and personally for working with this group of women. Midwife participants worked towards maintaining a work/life balance while being on call for long periods, continually available to provide continuity of midwifery care for women in their caseloads who had a variety of complexities. Using strategies to foster sustainability was crucial, and while some midwives struggled with elements of this, for example being fully off call when rostered off, others worked hard to ensure they sustained themselves. Midwives highlighted the importance of working in effective midwifery practices in which they felt well supported and cared for. Community based midwives in some places have been found to have much higher levels of burnout than hospital based midwives (Yoshida & Sandall, 2013). Other research has reported hospital employed midwives having higher levels of work and personal burnout than community LMC midwives or those midwives working a combination of employed and community LMC midwifery practice (Dixon et al., 2017), some of which is due to inadequate resourcing and management support, and a lack of professional recognition. Having occupational autonomy and working effectively as a midwifery team increases job satisfaction, and has been shown to offset burnout (Jordan, Fenwick, Slavin, Sidebotham, & Gamble, 2013), as has feeling empowered and having professional recognition (Dixon et al., 2017; Hunter & Warren, 2013). In my study, midwife participants were able to work autonomously, and most were providing continuity, following the woman wherever her childbirth experience led, while negotiating elements to sustain themselves, such as being called in once labour was established when women required induction. The importance of being part of a well-functioning midwifery group practice was highlighted by several midwives as contributing to their sustainability to work with this group of women.

Previous research results illustrated the extensive work undertaken on sustainable practice and emotional wellbeing in New Zealand, highlighting the potential for a high emotional cost for passionate midwives needing to be on call when providing continuity of midwifery care to women with increased social, obstetric, and medical

complexity. Giving so much of themselves with no boundaries around care provision risked midwives burning out, potentially triggering the need to leave this model of midwifery practice (Cox & Smythe, 2011; Donald, Smythe, & McAra-Couper, 2014; Young, Smythe, & McAra-Couper, 2015). Other factors affecting midwives' levels of burnout include the number of women in their caseload with psychosocial issues, working as a midwife for over 20 years, and exercising regularly (Mollart, Skinner, Newing, & Foureur, 2013). These contributed to midwife participants' ability to sustain themselves working in these areas.

Midwife participants reported that the quality of the relationships that they developed with women and their midwifery and medical colleagues, in addition to being able to provide continuity of care, supported and sustained them in practice. This is well supported in the literature (Dixon et al., 2017; Gilkison et al., 2015; Hunter et al., 2016; Kirkham, 2011; Leap, Dahlen, Brodie, Tracy, & Thorpe, 2011; McAra-Couper et al., 2014; Wakelin & Skinner, 2007), though Wakelin & Skinner (2007) found these were also the reasons that caused midwives to leave practice. Seeking additional support to deal with the emotional and physical demands of their work were recommendations from these and other studies including (Hunter & Warren, 2013; Jordan et al., 2013). Being recognised by women as professionals with families and personal needs, and feeling they were providing quality care, contributed to the midwives reporting high job satisfaction (Jepsen, Nøhr, Foureur, & Sørensen, 2016). Midwives in my study employed many of the strategies suggested by the researchers cited above in their efforts to sustain themselves long term in midwifery practice for caring for this group of women. Mostly they were successful. For some it meant leaving practice.

The findings of this research are firmly grounded in the data obtained from the participants. Hence as the current pay issues for community LMC midwives in New Zealand (NZCOM, 2019) were not a focus of the midwife participants, pay equity was not a focus of the research findings. However, there are many efforts within the midwifery profession currently involved in seeking pay reform, including the work on a co-designed contract framework for primary midwifery services by the NZCOM and the MoH (NZCOM, 2019). A positive outcome to these negotiations will contribute to the ability of community LMC midwives to be able to sustain themselves in practice towards ensuring they can continue to best serve this population of women.

9.2.12 The impact of ethnicity on study findings

As stated in Chapter 4 (pp.84-85) six of the 11 women participants identified their first or second ethnicity as Māori, and the remaining five as Pasifika. These results reflected the social context of the women in the settings, rather than specifically focusing on Māori and Pasifika women. This was a thesis about socioeconomic deprivation, and some ethnicities are overrepresented in areas of high socioeconomic deprivation, specifically women of Māori and Pasifika ethnicity. However socioeconomic deprivation was the focus of my thesis, not the ethnicity of the participants. Ethnicity was not raised by the women participants themselves as an issue for them and therefore was not explored separately. The findings of this research demonstrated that deprivation was the barrier to accessing and engaging with midwives, not the ethnicity of the women participants. However the effect of ethnicity on assessing and engaging with care could be a focus for future research, but it would be more appropriate for researchers of the same ethnicity to explore this topic'.

9.2.13 Symbolic interactionism

As noted earlier (Chapter 3) symbolic interactionism is one of three theoretical perspectives underpinning grounded theory. To gain an understanding of what is happening in a situation, the researcher examines the interactions between individuals to uncover the structural processes at both the symbolic and interactional levels (Wuest, 1995). Therefore, symbolic interactionism can be described as the putting of oneself in the place of the other to be able to gain an understanding of a particular group of people (Crotty, 2010). In this thesis findings revealed that women worried about who was going to see their history when interacting with health services thus indicating the importance of maintaining and ensuring privacy for this group of women living in vulnerable situations. By carefully entering the participant's world with the lens of symbolic interactionism it enables not only clarity of information, but provides a safety for participants to divulge difficult information.

'Complexity' has use in everyday language indicating the complex lives that women live, which is why the word 'complexity' has been used in my thesis. Some women participants, as shown in the findings, lived in a situation of relational, social, and societal complexity which influenced how they worked within the maternity system. When these women developed complications during pregnancy the situation was compounded. Complications during pregnancy then intersected with the complexities of their lives with the potential for missing required care. Thus the term

'complexity' in this thesis was used to capture these intersections. However it is interesting to note that complexity theory does provide some insight for explaining structural complexity.

Complexity theory focuses on interacting and self adjusting systems which influence how people receive care (Wilson & Holt, 2000). These dynamic systems are unpredictable, interconnected, and adaptive (Plsek & Greenhalgh, 2001). Findings did indicate that complexity theory has relevance to the study presented in this thesis in terms of the systems, particularly in the context of participants need to navigate between midwifery and DHB secondary care services if women required services long term.

This research took place in areas of high socioeconomic deprivation in three North Island cities. Constant comparative analysis did not uncover any differences location in particular communities made to either the women or midwife participants. For this reason the effect of place was not explored.

9.3 Strengths and Limitations of this study

9.3.1 Strengths of this study

A strength of this study, as demonstrated in Chapters 3 and 4, was the care taken in the planning and development of the study to ensure the woman participants, who were living in vulnerable situations, were kept safe throughout the research process. These chapters also show the rigor undertaken to ensure the results remained grounded in the data as the methodology was employed. Charmaz (2009) for example, believes a theory must demonstrate credibility, originality, resonance, and usefulness. How the methodology was applied and followed, as shown in Chapters 3 and 4, strengthens the rigor of my study and the claims I can make from the developed theory.

While it cannot be known whether a study undertaken in another area of high deprivation in New Zealand with another group of women and midwife participants would have yielded similar results, when these results were discussed with participants, colleagues, and presented at public fora, there was agreement that the processes presented in the findings were transferrable. This means the processes should be able to be applied in other situations where the studied phenomenon can be found (Glaser and Strauss, 1967). The strong resonance reported by those present when I was member checking the processes identified in the theory, as previously discussed, demonstrated validity (Glaser & Strauss, 1967), and added to the credibility of the processes identified as representing what was going on in the data, confirming the theory represented the

reality of those working or living in the study areas (Cluett & Buff, 2000). The processes could therefore be transferable across a range of health professions, for example patients entering hospital for surgery or rehabilitation, or investigations and treatment after a cancer diagnosis, and nurses or other health professionals involved.

The findings chapters (Chapters 5-8) demonstrate how the theory arose from the data (Stern, 2010). These chapters show the theory has specificity by demonstrating that the categories are firmly grounded in the data, and by showing linkages between categories, and the conditions and consequences of the processes taking place, demonstrate the explanatory power of the theory (Holloway & Wheeler, 1996). This theory also offers midwives using this theory control (Cluett & Buff, 2000; Glaser & Strauss, 1967), in that it should enable midwives to adjust use of the theory to situations they are involved in or in response to the effects of the consequences it has on mothers and babies. An example of this was given in Chapter 3 (p. 79).

9.3.2 Limitations of this study

Women participants met part of the study criteria if they lived in specified areas of the three North Island cities utilised for the study. I did not ask women any details about their individual or family economic position. I also did not ask whether they were in paid employment, and if they were, about whether this was in skilled or unskilled work, though several women offered me this information spontaneously. I was aware that just because a woman was living in an area categorised as being one of high socioeconomic deprivation, did not necessarily mean her individual circumstances met this criteria, nor that she considered herself to be highly deprived. Whether having this information would have had any impact on the study findings is unknown.

I also did not ask women participants their current age, nor their age at first pregnancy. Two of the women reported having their first babies when they were young. Some of the difficulties participants in my study reported about accessing pregnancy were the same as those previously reported about pregnant college students (Copland et al., 2011), with barriers including uncertainty about how to access care, lack of transport, and concern about privacy. Whether information about woman participant's ages would have had any impact on the study findings is uncertain.

When a woman participant had more than one child, I asked details of her experience with each pregnancy, following the Interview Guide. Woman participants reported a variety of experiences accessing a midwife and remaining engaged with care, individually as well as a group. If I had only asked for details of their most recent pregnancy, or their first pregnancy, much of richness of the data obtained may have

been missed.

I did not ask women whether they had personally experienced miscarriage, stillbirth, neonatal death, or any other less than optimal pregnancy outcomes, and none of the participants volunteered this information. When I asked women about each pregnancy, I audio recorded the information they gave me, without requesting this further detail. Whether their responses to any request for this information would have impacted my findings is unknown.

9.4 Recommendations from the study

While pregnancy was experienced as one continuous event for woman in this study, this occurred within a maternity system which divided her single pregnancy journey into primary, secondary, and sometimes tertiary episodes. There was a mismatch between this and the New Zealand midwifery model of continuity of midwifery care centred on the woman and her complex care requirements that midwives were working to provide, to ensure this group of women remained engaged with pregnancy care. Women living in areas if high socioeconomic deprivation entered a maternity system within a health system where they were disadvantaged and often invisible. They had care requirements which were different from those of other, more affluent, women. Midwives recognised this and used several strategies to make the maternity system more equitable for this group of women. For example, midwives recognised that the women needed more time during antenatal visits so that pregnancy related information could be discussed in a way that the women clearly understood, so that they were well informed prior to making decisions about their ongoing care.

A number of recommendations for practice, research, education, and maternity system development have been identified from this study which if implemented, could make a difference to how women living in areas of high socioeconomic deprivation access and engage with midwives. The majority of them are as a consequence of the current maternity system not always being resourced to meet the complex care requirements of women participants. This has implications for maternity system development due to the resourcing required, if recommendations known to support this group of women to remain engaged with midwifery care are to be implemented, to ensure appropriate service provision. Equity is a lens that health professionals in New Zealand bring to all that they do when working with women living in areas of high socioeconomic deprivation, and in the recommendations from this study equity is threaded throughout.

9.4.1 Recommendations for practice

- Access to a LMC needs to be a timely, effective, high quality, smooth process from the first primary health contact. Key to this process is having an integrated system of maternity health care.

- Co-located services are recommended to best meet the needs of this group of women and to resource the midwives working with them.

- It is recommended that midwives and integrated health services consider offering group antenatal classes to women living in these areas.

- It is recommended that midwives working longterm in areas of high socioeconomic deprivation utilise the strategies known to foster their professional and personal sustainability.

9.4.2 Recommendations for research

- Culturally appropriate and safe care, and being cared for by a midwife of the same ethnicity, requires further national investigation.

- Investigation into core midwives and secondary care obstetric staff about their experiences of providing pregnancy care for women living in areas of high socioeconomic deprivation.

- Following women's pathways through the primary and secondary services to identify gaps in service provision.

9.4.3 Recommendations for education

- Include in undergraduate and post graduate midwifery programmes context specific information influencing women living in areas of high socioeconomic deprivation.

- Midwives require further interprofessional education on working with complexity.

9.4.4 Recommendations for maternity system development

- A national publicity campaign informing women living in areas of high socioeconomic deprivation of the advantages to themselves and their pregnancy of early engagement.

- A national publicity programme led by the MoH representing midwives and midwifery positively is recommended to encourage recruitment into undergraduate midwifery programmes.

- Secondary care clinics are held in the communities where women live, in an accessible, welcoming, familiar environment, such as their health centre.
- Midwives working in areas of high socioeconomic deprivation decrease the size of their caseload to support their long-term sustainability.
- A maternity system that is based on continuity of care to this group of women as this improves outcomes for mothers and babies.

9.5 Conclusion

This research has identified the processes which take place as women living in areas of high socioeconomic deprivation in New Zealand access and engage with midwives. The study findings demonstrate a maternity system in New Zealand which is not set up to provide all the resources women living in areas of high socioeconomic deprivation require to meet their maternity care requirements, or accommodate the complexity requirements of their daily lives. Women are trying to access and engage with care in a maternity system which is not geared up to meet their needs. While the midwifery model of care in New Zealand is based on continuity of midwifery care, which, as is well established, enhances women's engagement with midwifery care, funding and resources for the provision of midwifery continuity by the maternity system for women living in these areas, are inadequate. This lack of resourcing becomes more problematic once a woman moves to having secondary care requirements, and exacerbates the complexity of accessing and engaging with midwives for a group of women already working through significant complexity in their daily lives. For women to be able to access and engage with midwives, and remain engaged with that care, requires significantly more maternity system resourcing.

Until this point in New Zealand's contemporary midwifery history, midwives, such as those who participated in my study, have filled the gaps they have identified in the maternity system to ensure this group of women do not miss care. This has taken a lot of time and effort on their part, and has relied largely on their good will to the women, and their commitment to ensuring the women receive care that is individualised to meet their complex requirements. However in New Zealand, midwifery as a profession is currently negotiating a shifting landscape. How midwives are wanting to work, and their expectations around what is possible, are changing, and the transition may result in the group of women who most benefit from receiving continuity of midwifery care–such as those in my study-not receiving continuity, potentially

impacting their ongoing engagement with pregnancy care, and their pregnancy outcomes.

While it is important that as midwives we ensure our own sustainability to work with women living in areas of high deprivation, it is also important that we always remain focused on the woman and her complexity requirements. For women living in areas of high socioeconomic deprivation in New Zealand, accessing a midwife early in pregnancy, developing an effective relationship with the midwife, enhanced by the provision of continuity, and receiving support to negotiate a pathway through the maternity system, increases engagement with pregnancy care and improves a number of pregnancy outcomes. Given the high proportion of childbearing women who live in areas of high socioeconomic deprivation in New Zealand, this is important information to consider and integrate into midwifery practice, research, education, and maternity system development, as we seek resourcing for our maternity system into the future.

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Glossary

Aotearoa – Originally referring only to the North Island of New Zealand, this term is now used as the Māori name for the country of New Zealand (Māori Dictionary, 2018a). Aotearoa translates to 'land of the long white cloud' (Maori.com, 2018).

Community Lead Maternity Carer (LMC) midwife – LMC (see definition below) midwife working in the community and taking responsibility for a caseload of women (NZCOM, 2018b).

Core facility – All secondary or tertiary maternity facilities (maternity wards/units) which are part of publicly funded hospitals.

Core midwife – Midwives employed on shifts within some primary maternity facilities, and all secondary or tertiary maternity facilities, to provide core midwifery services; including, 24-hour care to women and babies in the facilities and working in collaboration with LMCs. These midwives are often referred to as 'core' midwives because they provide the core essential care to women in hospital (NZCOM, 2018b).

Cultural competence – The ability to interact respectfully and effectively with people from different backgrounds to one's own (MCNZ, 2012a); and addressing power relationships between midwives and the recipient of their care (Pairman & McAra-Couper, 2015). For midwives, cultural competence means recognising the impact of their own culture and beliefs on their midwifery practice, and being able to acknowledge and incorporate each woman's culture into the provision of individualised midwifery care (Durie, 2001). "…*cultural competence focuses on the capacity of the health worker to improve health status by integrating culture into the clinical context*" (Durie, 2001, p. 2).

Cultural safety – Like cultural competence, cultural safety "*is about the relationship between the helper and the person being helped, but cultural safety centres on the experiences of the patient, or client*" (Durie, 2001, p. 2) enabling those receiving the service to define whether the service received was safe, or not.

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 (MoH, 2007). LMCs are selected by women to provide their lead maternity care and can be either midwives, general practitioners (GP) with a diploma in obstetrics, or obstetricians. LMCs take responsibility for the care provided to women throughout pregnancy and the postpartum period, including the management of labour and birth. One LMC is expected to take responsibility for all modules of care (registration, second trimester, third trimester, labour and birth, and services following birth) so that each woman receives continuity of care. (NZCOM, 2018c).

Māori – Indigenous person of Aotearoa/New Zealand (Māori Dictionary, 2018b).

Midwifery partnership – Defined as "*a relationship of 'sharing' between the woman and the midwife, involving trust, shared control and responsibility and shared meaning through mutual understanding*" (Guilliland & Pairman, 1995, p. 7). Relies on the integration of the principles of individual negotiation, equality, shared responsibility and empowerment, and informed choice and consent (Guilliland & Pairman, 1995).

Neonatal death. – The death of any baby showing signs of life at 20 weeks gestation or beyond, or weighing at least 400g if gestation is unknown, that occurs up until midnight of the 27th day of life. Early neonatal death is a death that occurs up until midnight of the sixth day of life. Late neonatal death is a death that occurs between the seventh day and midnight of the 27th day of life (PMMRC, 2017).

Pakeha – Māori language term for people of European descent (Māori Dictionary, 2018c).

Perinatal mortality – Fetal and early neonatal death from 20 weeks gestation (or weighing at least 400g if gestation is unknown) until midnight of the sixth day of life (PMMRC, 2017).

Stillbirth – Birth of a baby who does not breathe or show any other signs of life at, or after, 20 weeks of pregnancy or weighing 400 grams or more if gestation is unknown (excludes termination of pregnancy) (PMMRC, 2017).

Tangata whenua – Indigenous people of the land. Refers to Māori people.

Tangi/tangihanga – Māori language term for rites for the dead, funeral. Most tangi are held on marae, the courtyard or open area in front of the wharenui (Māori meeting house, large house, main building of a marae where guests are accommodated), where formal greetings and discussions take place. The term 'marae' is also often used to include the buildings around the marae. The body is brought onto the marae by the whanau of the deceased and lies in state in an open coffin for about three days in a wharemate (house of mourning). The wharemate may be a special separate structure to the left of the meeting house, or the place where the body lies on the veranda, or inside the meeting house, depending on the traditional practice of the particular marae. During that time groups of visitors come onto the marae to farewell the deceased with speech making and song. Greenery is the traditional symbol of death, so the women and chief mourners often wear pare kawakawa (mourning wreath) on their heads. On the night before the burial, visitors and locals gather to have a pō mihimihi (final night at a tangi when informal farewells to the deceased are made using speech and song) to celebrate the person's life. More recently, on the final day the coffin is closed and a church service is held before the body is taken to the cemetery for burial. A takahi whare ritual (tramping the house - ceremony performed after the burial for clearing the house of the spirit of the deceased and the tapu/spiritual restriction on the house and possessions) is performed by a tohunga (religious leader), reciting karakia (prayer, grace, blessing), and sprinkling water while walking through the rooms of the home of the deceased. A hākari (sumptuous meal, feast, banquet) concludes the tangi (Māori Dictionary, 2018d).

Tohunga – Religious leaders/Māori healers. Experts in sacred lore, spiritual beliefs, traditions, and genealogies of the tribe (Māori Dictionary, 2018d).

Turanga Kaupapa – Developed by Nga Maia Māori Midwives Aotearoa, the national body representing Māori midwives, Māori women, and Māori birthing in New Zealand (Nga Maia, 2018) in 2006 to enhance Nga Maia kaupapa (principles) and to provide cultural guidelines. Turanga Kaupapa are a set of statements about the cultural values of Māori regarding childbirth. They were developed to guide midwives on how to recognise and incorporate the cultural values of Māori women into their midwifery care (Pairman & McAra-Couper, 2015) as a framework for culturally safe practice for Māori

wahine/all women. Turanga Kaupapa have been adopted formally by the Midwifery Council of New Zealand (MCNZ) and the NZCOM (2018d), and are made up of;

> Whakapapa *[geneology]*: *The wahine and her whanau is acknowledged.*
> Karakia *[prayer, grace, blessing]*: *The wahine and her whanau may use karakia.*
> Whanaungatanga *[relationship, kinship, sense of family connection]*: *The wahine and her whanau may involve others in her birthing programme.*
> Te Reo Māori *[Māori language]*: *The wahine and her whanau may speak Te Reo Māori.*
> Mana *[prestige]*: *The dignity of the wahine, her whanau, the midwife, and others involved is maintained.*
> Hau Ora *[health]*: *The physical, spiritual, emotional and mental wellbeing of the wahine and her whanau is promoted and maintained.*
> Tikanga *[the correct procedure]* Whenua *[ground, placenta]*: *Maintains the continuous relationship to land, life, and nourishment; and the knowledge and support of kaumatua [a person of status within the whanau] and whanau is available.*
> Te Whare Tangata: *The wahine is acknowledged, protected, nurtured, and respected as Te Whare Tangata (the "House of the People").*
> Mokopuna: *The mokopuna [descendent] is unique, cared for and inherits the future, a healthy environment, wai u and whanau.*
> Manaakitanga**: *[Hospitality, kindness, generosity, support]**. *The midwife is a key person with a clear role and shares with the wahine and her whanau the goal of a safe, healthy, birthing outcome.* (NZCOM, 2015, p. 16)

Wahine – Māori language term for Māori woman (Māori Dictionary, 2018e).

Whanau – Māori language term for extended family, family group; a familiar term of address to a number of people. In the modern context, the term is sometimes used to include friends who may not have any kinship ties to other members (Māori Dictionary, 2018f).

Appendices

A. AUTEC application approval

B. Locality Committee Approval: Whanganui District Health Board

C. Locality Committee Approval: Counties Manukau Health

D. Locality Committee Approval: Capital & Coast District Health Board

E. Feedback following consultation with Nga Maia

F. Feedback following consultation with the AUT University Kawa Whakaruruhau Komiti

G. Advertisement for Midwives notices (x 3)

H. Participant Information Sheet – Woman

I. Participant Information Sheet – Midwife

J. AUT Counselling Support

K. Researcher Safety Protocol

L. Consent Form – Woman

M. Consent Form – Midwife

N. Interview Guide – Woman

O. Interview Guide – Midwife

Appendix A: AUTEC application approval

A U T E C
S E C R E T A R I A T

5 September 2014

Judith McAra-Couper
Faculty of Health and Environmental Sciences

Dear Judith

Re Ethics Application: **14/222 Women accessing and engaging with midwives in areas of high socioeconomic deprivation in New Zealand.**

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 5 September 2017.

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 5 September 2017;

- 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 5 September 2017 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: Christine Griffiths

Appendix B: Locality Committee Approval: Whanganui District Health Board

WHANGANUI
DISTRICT HEALTH BOARD
Te Poari Hauora o Whanganui

22 October 2014

100 Heads Road, Private Bag 3003
Whanganui 4540, New Zealand

Christine Griffiths
Email: pmr7474@aut.ac.nz

Dear Christine

**RE: WOMEN ACCESSING AND ENGAGING WITH MIDWIVES IN AREAS OF HIGH
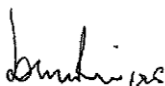SOCIOECONOMIC DEPRIVATION IN NEW ZEALAND**

Thank you for the invitation to participate in your research, as described above.

Your application was presented to the Clinical Board of the Whanganui District Health Board on the 22nd of October 2014.

I am writing to advise you that the Clinical Board would like to formally approve your application and I look forward to receiving a report to show results of the study.

On behalf of this Board I wish you every success in your research endeavours.

Yours sincerely

Dr John Rivers
Chief Medical Officer
Whanganui District Health Board

Chief Medical Officer Directorate | Phone 06 348 1234 | Fax 06 3459390

Appendix C: Locality Committee Approval: Counties Manukau Health

COUNTIES MANUKAU HEALTH

Ko Awatea Research Office
Counties Manukau DHB
Clinical Support Building
Room 253, Level 2
Middlemore Hospital

24 October 2014

Dear Christine

Thank you for the information you supplied to the Ko Awatea Research Office regarding your research proposal:

Research Registration Number: 1911

Ethics Reference Number: 14/222

Research Project Title: Women accessing and engaging with midwives in areas of high socioeconomic deprivation in New Zealand

I am pleased to inform you that the CMDHB Research Committee and Director of Hospital Services have approved this research with you as the CMDHB Co-ordinating Investigator.

Your study is approved until 5th September 2017.

Amendments:
- All amendments to your study must be submitted to the Research Office for review.
- Any substantial amendment (as defined in the *Standard Operating Procedures for HDECs*, May 2012) must also be submitted to the Ethics Committee for approval.

All external reporting requirements must be adhered to.

Please note that failure to submit amendments and external reports may result in the withdrawal of Ethical and CMDHB Organisational approval.

We wish you well in your project. Please inform the Research Office when you have completed your study (including when a study is terminated early) and provide us with a brief final report (1-2 pages) which we will disseminate locally.

Yours sincerely

Alex Poor
Health Intelligence and Informatics Lead
Counties Manukau District Health Board
Under delegated authority from CMDHB Research Committee and Director of Hospital Services

Appendix D: Locality Committee Approval: Capital & Coast District Health Board

Capital & Coast
District Health Board

Locality sign off for Ethical Approval

Full project title:	Women accessing and engaging with midwives in areas of high socioeconomic deprivation in New Zealand
Short project title:	

1. Declaration by principal investigator

The information supplied in this application is, to the best of my knowledge and belief, accurate. I have considered the ethical issues involved in this research and believe that I have adequately addressed them in this application. I understand that if the protocol for this research changes in any way, I must inform the ethics committee.

Name of Principal Investigator (please print):	Christine Griffiths
Signature of Principal Investigator:	*Christine Griffiths.*
Date:	2 November 2014

2. Declaration by Clinical Leader in which the Principal Investigator is located

I have read the application, and it is appropriate for this research to be conducted in this department. I give my consent for the application to be forwarded to the ethics committee.

Name (please print):	Dr John Tait		
Signature:		Institution:	CCDHB
Date:	4.11.14	Designation:	Executive Director Clinical SWCD

- Where the Clinical Leader is also one of the investigators, the Clinical Leader declaration must be signed by the Clinical Executive Director.

3. If the application is for a student project, the supervisor should sign the declaration.

I have read the application, and it is appropriate for this research to be conducted under my supervision. I give my consent for the application to be forwarded to the ethics committee.

Name (please print):	Judith McAra-Couper		
Signature:		Institution:	Auckland University of Technology
Date:	3/11/2014	Designation:	Associate Professor

Appendix E: Feedback following consultation with Nga Maia

Christine Griffiths

From:	Jean Tehuia <jean.tehuia@gmail.com>
Sent:	Friday, 23 May 2014 9:01 p.m.
To:	Christine Griffiths
Subject:	Re: Consultation with Nga Maia

Tena koe Christine. Ka nui te Aroha I Te Kaupapa. Kei Te tautotoko ahau I Te panui. Jean Tehuia. Basically I've said. Fantastic topic. Happy to be of any assistance.

Sent from my iPhone

On 22/05/2014, at 12:15 pm, Christine Griffiths <Christine.Griffiths@op.ac.nz> wrote:

> Kia ora Jean, I am a PhD student at AUT University. I am currently working on my ethics application to the AUT ethics committee. As my study may involve Maori I am wanting to consult with Nga Maia to inform them of my study and to invite their advice about any features of the study they feel require addressing regarding Maori participants. I have discussed who to approach within Nga Maia with Ngarangi Pritchard. She has suggested that you would be an appropriate person within Nga Maia to seek advice from, so I am hoping you are willing to do this for me. Please let me know if you are not able to for any reason.
>
> Could you please read the attached document and let me know your feedback. I look forward to hearing back from you. Kind regards, na Chris
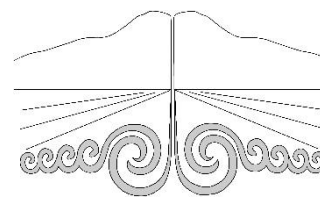

<Consultation with Nga Maia. FINAL 24_4_14.docx>

1

Appendix F: Feedback from Kawa Whakaruruhau Komiti

Kawa Whakaruruhau Komiti
School of Health Care Practice
AUT University
Disciplines of Nursing, Midwifery &
Paramedic and Emergency Management

The symbol represents the evolving
bicultural relationships within the
School of Health Care Practice

12 June 2014

Dear Christine

Re: Support of research for PhD
Topic: Midwives accessing and engaging with women living in areas of high socioeconomic
deprivation in New Zealand

Thank you for the presentation of your research study which was made to the members of the Kawa Whakaruruhau Komiti by Barbara McKenzie-Green (your PG supervisor) at the last meeting.

The Komiti values the opportunities that consultation of research can bring to both the researcher and to the members of the Komiti. We thank you for making available to us your proposal of research for review and discussion at the meeting.

Barbara, in her role as your PhD supervisor, addressed queries and participated in discussion around your research which was informative and helpful for all involved. Barbara compiled a thorough and detailed summary around the dialogue that took place at the meeting. We hope the recommendations which came together as a consequence will be deserving of further consideration and ultimately beneficial in your movement forward with this research.

The Komiti would like to acknowledge the benefit and value it sees in your research and would welcome the opportunity for you to seek further consultation from us, should this be valuable to you. We also invite you to periodically update us on the progress of this important study.

Naku noa

Tui O'Sullivan (Chairperson)
on behalf of the Kawa Whakaruruhau Komiti

LMC midwives

AUT
UNIVERSITY
TE WĀNANGA ARONUI O TAMAKI MAKAU RAU

An invitation to participate in important midwifery research

Women accessing and engaging with midwives in areas of high socioeconomic deprivation in New Zealand

Tena tatau. My name is Christine Griffiths. I am a midwife currently employed in the School of Midwifery at Otago Polytechnic. I am also a Doctor of Philosophy (PhD) student at AUT University.

If *over 50% of the women you provide care to live in the areas listed below* I would like to invite you to participate in my study. This study will contribute towards my PhD qualification.

Porirua Central
Porirua East
Elsdon
Takapuwahia
Titahi Bay East
Cannons Creek
Waitangirua
Ascot Park

For an Information Sheet please contact me: Christine Griffiths
Email: pmr7474@aut.ac.nz or Mobile: 021 037 8656

Approved by the Auckland University of Technology Ethics Committee 5.9.2014. AUTEC Reference number 14/222

LMC midwives

AUT
UNIVERSITY
TE WĀNANGA ARONUI O TAMAKI MAKAU RAU

An invitation to participate in important midwifery research

Women accessing and engaging with midwives in areas of high socioeconomic deprivation in New Zealand

Tena tatau. My name is Christine Griffiths. I am a midwife currently employed in the School of Midwifery at Otago Polytechnic. I am also a Doctor of Philosophy (PhD) student at AUT University.

If *over 50% of the women you provide care to live in the areas listed below* I would like to invite you to participate in my study. This study will contribute towards my PhD qualification.

Castlecliff
Gonville
Aramoho
Whanganui East
Whanganui Central

For an Information Sheet please contact me: Christine Griffiths
Email: pmr7474@aut.ac.nz or Mobile: 021 037 8656

LMC midwives

AUT
UNIVERSITY
TE WĀNANGA ARONUI O TAMAKI MAKAU RAU

An invitation to participate in important midwifery research

Women accessing and engaging with midwives in areas of high socioeconomic deprivation in New Zealand

Tena tatau. My name is Christine Griffiths. I am a midwife currently employed in the School of Midwifery at Otago Polytechnic. I am also a Doctor of Philosophy (PhD) student at AUT University.

If *over 50% of the women you provide care to live in the areas listed below* I would like to invite you to participate in my study. This study will contribute towards my PhD qualification.

Otara
East Tamaki
Mangere
Mangere East
Wiri
Clendon Park
Homai
Takanini

For an Information Sheet please contact me: Christine Griffiths
Email: pmr7474@aut.ac.nz or Mobile: 021 037 8656

Participant Information Sheet - Woman

5 September 2014

Project Title: Women accessing and engaging with midwives in areas of high socioeconomic deprivation in New Zealand.

An Invitation

Tena tatou. My name is Christine Griffiths and I am a midwife who works at Otago Polytechnic. I am also a Doctor of Philosophy (PhD) student at AUT University. I would like to invite you to be a part of my research study. This study will help towards my PhD qualification. Taking part in this study is voluntary and you may withdraw at any time before you return your interview transcript to me.

What is the purpose of this research?

Women living in poorer areas of New Zealand have a higher chance than others of having a baby who is not born alive or who dies before they are four weeks old. In this research I want to find out how women work with midwives to try and find a reason for the higher rates in poorer areas. The results of this study may make a difference to the midwifery care received by women and their families in the future.

I plan to make people aware of what I find in this study, so I will present at conferences and publish in journals.

How was I identified and why am I being invited to participate in this research?

You have been identified because you meet the entry criteria into this study. These are

1. you live in an area of high socioeconomic deprivation in one of the three North Island cities being used for this study

2. you have experienced maternity services during the last seven years

3. you speak English and

4. you have not received midwifery care from me, the researcher.

Midwives are also being recruited for this study.

What will happen in this research?

If you are interested in taking part in my study you will be interviewed in a place where you are comfortable; for example, a midwifery clinic or your home. Interviews will probably take 60-90 minutes and, with your consent, will be recorded on a dictophone. Just before the interview you will have the opportunity to read this form again and I will answer any questions you may have. I will ask you to sign a Consent Form agreeing to take part in my study and to me recording our interview. I will then ask you to choose or be given a different name (a pseudonym) to maintain your confidentiality. I will then ask you to tell me about working with midwives.

The interview will be typed out by either myself or a typist who has signed a confidentiality agreement. I will return the typed transcript to you a few days after our interview for you to read and to make any changes you wish. If you have not returned the transcript to me within two weeks I will contact you to encourage you to return it.

I may wish to interview you again to check out some ideas coming out of my research. This would be either separately or as part of a focus group of up to five women. Focus groups would take place in a room at your local hospital or in a community clinic, and may take up to two hours. I may have a cultural advisor to co facilitate the focus group.

From this study a theory will be developed which will describe how women access and engage with midwives living in areas of high socioeconomic deprivation in New Zealand.

What are the discomforts and risks?

I will try to ensure you are comfortable before and during the interviews, but I cannot know beforehand if you will bring up any events which may upset you. It is also possible that I may unintentionally ask a question which upsets you.

How will these discomforts and risks be alleviated?

Should you become upset during the interview I will remind you that you can; decline to answer any question, ask for the dictaphone to be turned off, and ask to take a short break at any time. I hope that this will enable this situation to be dealt with in a safe and appropriate way. If you feel you needed to talk through the issue with another person I would offer you the contact details of the local New Zealand College of Midwives Resolutions Committee. You would also have the opportunity of counselling through the Counselling services at AUT University. This service can be contacted on 09 921 9303.

What are the benefits?

The results of this research will provide information for midwifery practice, research and education about the care provided by midwives to women living in poorer areas. This may result in recommendations for changes to the midwifery care provided by midwives to the women and families living in these areas. This study will contribute towards me gaining my PhD qualification. Journal articles and conference presentations based on this study may benefit me professionally.

How will my privacy be protected?

As previously stated, before being interviewed I will ask you to choose or be given a pseudonym to maintain your confidentiality. The interview will be transcribed by either myself or a typist who has signed a confidentiality agreement. There will be no identifying information about you or the area you live in in my thesis or any article or presentation related to this research. All information related to you, including quotes, will use the pseudonym. Only me and my two research supervisors will have access to the study data. All information relating to the research will be stored securely during the research and for 10 years afterwards. It will then be shredded.

What are the costs of participating in this research?

Taking part in this research will cost you in time to attend the interview and time to read and return the transcript to me. Interviews will probably take 60-90 minutes. Reviewing the transcript will probably take another hour. I may ask to interview you a second time, or invite you to be a member of a focus group. Attending the second interview or a focus group will also cost you in time. There may be a cost travelling to the interview/focus group locations.

What opportunity do I have to consider this invitation?

If you would like to take part in this study I would appreciate hearing from you within two weeks. If I do not hear from you by then I will assume you have decided that you do not wish to be in my study.

How do I agree to participate in this research?

If you wish to take part in my study you can give your name and contact details to the midwife who provided you with this form to pass on to me and I will then contact you. Or, you can contact me yourself via either the phone or the email address below. We will then agree on a time and venue for the interview to take place.

Will I receive feedback on the results of this research?

You will be offered a summary of the study findings when the study is finished. The written thesis will be available through the AUT University library.

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

If you have any concerns about this research study please contact the Primary Supervisor, Dr. Judith McAra-Couper, *judith.mcara@aut.ac.nz* Phone: 09 921 9999 ext. 7193. If you have any

concerns about the conduct of the research please contact the Executive Secretary of AUTEC, Kate O'Connor, *ethics@aut.ac.nz* Phone 09 921 9999 ext. 6038.

Whom do I contact for further information about this research?

Researcher Contact Details:

Christine Griffiths

Email: pmr7474@aut.ac.nz Mobile: 021 037 8656

Project Supervisors Contact Details:

Dr.Judith McAra-Couper

Email: judith.mcara@aut.ac.nz Phone: 09 921 999 ext. 7193.

Dr. Barbara McKenzie-Green

Email: Barbara.mckenzie-green@aut.ac.nz Phone 09 921 999 ext.7352

Approved by the Auckland University of Technology Ethics Committee on 5.9.2014. AUTEC Reference number: 14/222

Participant Information Sheet - Midwife

5 September 2014

Project Title

Women accessing and engaging with midwives in areas of high socioeconomic deprivation in New Zealand.

An Invitation

Tena tatou. My name is Christine Griffiths and I am a Doctor of Philosophy (PhD) student at AUT University. I would like to invite you to participate in my research study. This study will contribute towards my PhD qualification. Participation in this study is voluntary and you may withdraw at any time prior to the completion of data collection.

I am a midwife currently employed by the School of Midwifery at Otago Polytechnic as a Senior Lecturer and the Bachelor of Midwifery degree Programme Coordinator. I also work the occasional shift as a casual midwife at Hutt Hospital, Lower Hutt.

What is the purpose of this research?

In New Zealand, women living in areas of high socioeconomic deprivation have more babies who are stillborn, or die within the first four weeks following birth, than any other socioeconomic group. A factor potentially contributing to these high rates is lack of access to, or engagement with, maternity services. The aim of this research study is to develop a substantive theory which will describe how women access and engage with midwives in areas of high socioeconomic deprivation.

Knowledge generated by this theory will inform midwifery practice, research and education around the care provided by midwives to women living in areas of high socioeconomic deprivation to ensure the women receive appropriate and adequate care. Findings from this study have the potential to make a difference to the midwifery care received by women and families who are most at risk for a range of less than optimal pregnancy outcomes, particularly stillbirth and neonatal death.

This study will contribute to my PhD degree. It is anticipated that conference presentations and journal articles will be generated from the research findings from this study.

How was I identified and why am I being invited to participate in this research?

You have been identified as a potential participant because you meet the entry criteria into this study. The entry criteria are that you are a community based case loading LMC midwife for whom at least 50% of the women you provide care to live areas of high socioeconomic deprivation in one of the three North Island cities being used for this study.

Women who live in areas of high socioeconomic deprivation of the same North Island cities are also being recruited for this study.

What will happen in this research?

If you are interested in participating in my study I would like to interview you in a mutually agreed venue; probably a midwifery clinic or in your home. Interviews are expected to take 60-90 minutes in length and will, with your consent, be digitally audio recorded. Immediately prior to the interview you will have the opportunity to read the Participant Information Sheet again, and I will be happy to answer any questions you have. I will ask you to sign a Consent Form agreeing to participate in my study and to me recording our interview. I will then ask you to choose or be

assigned a pseudonym to maintain your confidentiality. You will then be asked to tell me how you access and engage with women living in areas of high socioeconomic deprivation.

The interview will be typed out by either myself or a typist who has signed a confidentiality agreement. I will return the typed transcript to you a few days after our interview for you to review to ensure the transcript reflects our interview and to make any changes you wish. Once you have returned the transcript to me I will begin data analysis. If you have not returned the transcript to me within two weeks I will contact you to encourage you to return it.

I will need to return to some of the midwife participants to test the emerging theory to ensure it represents their reality of working with this group of women, so I may contact you again during the data collection and analysis stages of my research to clarify some ideas emerging from the data.

All information relating to the research will be stored securely for the duration of the research and for 10 years once the research is completed. It will then be shredded.

From this study a substantive theory will be developed which will describe how midwives access and engage with women living in areas of high socioeconomic deprivation in New Zealand.

What are the discomforts and risks?

While every effort will be made to optimise your relaxation prior to and during the interviews, it cannot be anticipated in advance whether you will bring up any events which may cause you some level of discomfort or distress. Likewise, it is possible that I may ask a question which causes you some level of discomfort or distress.

How will these discomforts and risks be alleviated?

Should you experience or exhibit some level of discomfort or distress during the interview, I will remind you that; you can decline to answer any question, ask for the dictaphone to be turned off at any time, and request to take a short break at any time. My intention is that use of these strategies will enable this situation to be dealt with in a safe and appropriate way. Should you feel you need to talk through the issue with another person you have the opportunity to have counselling through the Counselling services at AUT University. This service can be contacted on 09 921 9303.

What are the benefits?

Knowledge generated by the theory developed from this research will inform midwifery practice, research and education around the care provided by midwives to women living in areas of high socioeconomic deprivation. This may result in recommendations for changes to the midwifery care provided by midwives to the women and families living in these areas, to ensure the women receive appropriate and adequate care. This study will contribute towards me gaining my PhD qualification. Journal articles and conference presentations arising from this study may benefit me professionally.

How will my privacy be protected?

As previously stated, prior to being interviewed I will ask you to choose or be assigned a pseudonym to maintain your confidentiality. The interview will be transcribed by either myself or a typist who has signed a confidentiality agreement. There will be no identifying information about you or the area you live in in my thesis or any article or presentation related to this research. The researcher and her two supervisors will have access to the data during the data collection and analysis stages. All information relating to the research will be stored securely for the duration of the research and for 10 years once the research is completed. It will then be shredded

What are the costs of participating in this research?

Participating in this research will cost you in time to attend the interview and time to read and return the transcript to me. Interviews are anticipated to take 60-90 minutes in length. Reviewing the transcript is anticipated to take another hour. In addition, I may contact you a second time to clarify some ideas emerging from the data. This will also cost you in time. There may be a cost in time spent travelling to interviews and travel expenses associated with this.

What opportunity do I have to consider this invitation?

If you would like to participate in this study I would appreciate hearing from you within two weeks. If I do not hear from you within this timeframe I will assume you have decided that you do not wish to participate in my study.

How do I agree to participate in this research?

If you wish to participate in my study you need to contact me using either the phone number or the email address below. We will then agree on a time and venue for the interview to take place.

Will I receive feedback on the results of this research?

A summary of study findings will be offered to all participants at completion of my study. The written thesis will 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 Primary Supervisor, Dr. Judith McAra-Couper, *judith.mcara@aut.ac.nz* Phone: 09 921 9999 ext. 7193. Concerns regarding the conduct of the research should be notified to the Executive Secretary of AUTEC, Kate O'Connor, *ethics@aut.ac.nz* Phone 09 921 9999 ext. 6038.

Whom do I contact for further information about this research?

Researcher Contact Details:

Christine Griffiths

Email: pmr7474@aut.ac.nz Mobile: 021 037 8656

Project Supervisors Contact Details:

Dr.Judith McAra-Couper

Email: judith.mcara@aut.ac.nz Phone: 09 921 999 ext.7193.

Dr. Barbara McKenzie-Green

Email: Barbara.mckenzie-green@aut.ac.nz Phone 09 921 999 ext. 7352

Approved by the Auckland University of Technology Ethics Committee on 5.9.2014. AUTEC Reference number 14/222

Appendix J: AUT counselling support

AUT UNIVERSITY | **STUDENT SERVICES**

MEMORANDUM

TO   Christine Griffiths

FROM   Kevin Baker

SUBJECT   Psychological support for research participants

DATE   6th May 2014

Dear Christine

I would like to confirm that Health, Counselling and Wellbeing are able to offer confidential counselling support for the participants in your AUT research project entitled:

'Midwives accessing and engaging with women living in areas of high socioeconomic deprivation in New Zealand'

The free counselling will be provided by our professional counsellors for a maximum of **three** sessions and must be in relation to issues arising from their participation in your research project.

Please inform your participants:

- They will need to contact our centres at WB219 or AS104 or phone **09 921 9992 City Campus** or **09 921 9998 North Shore campus** to make an appointment

- They will need to let the receptionist know that they are a research participant

- They will need to provide your contact details to confirm this

- They can find out more information about our counsellors on our website: **http://www.aut.ac.nz/students/student_services/health_counselling_and_wellbeing**

Yours sincerely

Kevin Baker

Head of Counselling

Health, Counselling and Wellbeing

Appendix K: Researcher Safety Protocol

<u>Researcher safety protocol</u>

1. No participant interviews will take place in the researcher's home.
2. Individual interviews with woman and midwife participants will take place in a mutually agreed venue; probably a midwifery clinic or the woman's own home and are anticipated to take 60-90 minutes each. Focus groups will take place in a hired room at the local District Health Board facility or in a community clinic room.
3. I will have my mobile phone with me at all interviews.
4. A contact person who is not involved in the study will have my mobile number and be informed of the address of any interviews taking place in a participant's home.
5. I will have a code phrase which I will notify the contact person of.
6. I will notify the contact person when I am about to enter the participant's home, and again when I am about to start the interview.
7. The contact person will ring me on my mobile 60 minutes later.
8. **If I do not answer, the contact person will ring me again 5 minutes later. If I do not respond to this call the contact person will ring me again 5 minutes later. If there is no response to this second 5 minute call, the contact person will ring the Police. If I use the code phrase in any call with the contact person, the contact person will call the Police immediately**.
9. If I answer the 60 minute call and say that all is well, the contact person will ring me again 30 minutes later. See # 8.
10. If I answer the 30 minute call and say that all is well the contact person will ring me again 30 minutes later. See # 8.
11. The contact person will then continue to ring me every 30 minutes using the same protocol (see # 8) until I make contact to confirm that I have left the participant's home.
12. If in a participant's home I feel my safety is threatened, I will leave the address immediately.
13. If I am unable to leave the address I will call the Police.
14. I will always act in a culturally and socially sensitive manner when in a participant's home.

Christine Griffiths
24 April 2014

Consent Form
- Woman

Project title: Women accessing and engaging with midwives in areas of high socioeconomic deprivation in New Zealand

Project Supervisors: Dr. Judith McAra-Couper and Dr. Barbara McKenzie-Green

Researcher: Christine Griffiths

○   I have read and understood the information provided about this research project in the Participant Information Sheet dated 5 September 2014.

○   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 the transcript of my interview will be returned to me to review to ensure the transcript reflects the interview and to make any changes I wish.

○   I understand that I may withdraw myself or any information that I have provided for this project at any time up until I return the transcript, without being disadvantaged in any way.

○   If I withdraw, I understand that all relevant information including tapes and transcripts, or parts thereof, will be destroyed.

○   I agree to take part in this research.

○   I wish to receive a summary of the research findings (please tick one): Yes ○   No ○

Participant's signature:

Participant's name:

………………………………………………………………………………………..

Participant's Contact Details:

………………………………………………………………………………………..

………………………………………………………………………………………..

………………………………………………………………………………………..

Date:

Approved by the Auckland University of Technology Ethics Committee on 5.9.2014. AUTEC Reference number 14/222

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

Consent Form
- Midwife

Project title: Women accessing and engaging with midwives in areas of high socioeconomic deprivation in New Zealand

Project Supervisors: Dr. Judith McAra-Couper and Dr. Barbara McKenzie-Green

Researcher: Christine Griffiths

○　　　　I have read and understood the information provided about this research project in the Participant Information Sheet dated 5 September 2014.

○　　　　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 the transcript of my interview will be returned to me to review to ensure the transcript reflects the interview and to make any changes I wish.

○　　　　I understand that I may withdraw myself or any information that I have provided for this project at any time up until I return the transcript, without being disadvantaged in any way.

○　　　　If I withdraw, I understand that all relevant information including tapes and transcripts, or parts thereof, will be destroyed.

○　　　　I agree to take part in this research.

○　　　　I wish to receive a summary of the research findings (please tick one): Yes ○　　No ○

Participant's signature :

Participant's name:

………………………………………………………………………………………….

Participant's Contact Details:

…………………………………………………………………………………………..

…………………………………………………………………………………………..

…………………………………………………………………………………………..

Date:

Approved by the Auckland University of Technology Ethics Committee on 5.9.2014. AUTEC Reference number 14/222

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

Appendix N: Interview Guide – Woman

Interview guide – Woman (30.9.14)

PARTICIPANT NUMBER:
INTERVIEW NUMBER:

Come back to an earlier point   *Validate*
Get in-depth description   *Stop to explore a statement or topic*
Request more detail

BEFORE INTERVIEW
- Thank you for your interest in being a participant in my study
- Ensure participant has read the Participant Information Sheet -Woman
  - Purpose of the study
  - Explanation of what participating in the study will involve
- Any questions answered?
- Taking written notes during the interview
- Participant rights (from Consent Form)
  - Sign Consent Form consenting to participate and to me recording the interview
- Reminder; participant can decline to answer any question, take a short break or ask for the dictaphone recording to be stopped at any time
- Turn on dictaphone
- Choose/give a pseudonym to ensure confidentiality

DEMOGRAPHIC DATA
Pseudonym
Sex
Ethnicity
Country of birth
Years in New Zealand
Age of youngest child?
Where was this child born?
Have you had other children?
Where were these children born?
Are these children all well?
How long have you lived in this city?

INTERVIEW
Tell me how you went about finding a midwife/midwives/midwifery care?
How did you decide on the midwife you chose?
Was there anything you particularly were looking for in a midwife?
What was it like to find a midwife/midwives/midwifery care?
What happens/ed after that?
Tell me how you/got on with/developed a relationship with/got care from/worked with the midwife /midwives/midwifery care?
What was it like to do that?
Could you describe the events that led up to …?
What, if anything did you know about midwives/midwifery care before this?
What did you expect might happen?
How did you think midwifery care might work?

Was this your experience?

What happened next?

Are there any other events that stand out in your mind about finding a midwife/midwives/midwifery care?

Are there any other events that stand out in your mind about working with your midwife/midwives?

Other people have told me …. . Could I ask you what you were thinking/feeling/doing … then?

After having these experiences, what advice would you give to a woman who has just discovered they are pregnant?

Who has been the most helpful to you during this time? How has that person been helpful?

That's interesting. Can you tell me more about that?

Walk me through that step by step.

Can you tell me how you define that so I have that in your own words?

What did you think about that?

How did you feel about that?

What did you do about that?

Is there something that you might not have thought about before that has occurred to you during this interview?

Is there something else you think I should know to understand … better?

Is there anything you would like to ask me?

AFTER INTERVIEW
- Thank you for your participation
- Typed transcript returned by post/email. Can change text or delete quotes
- Return reviewed transcript to me within two weeks
- May be necessary to contact you again to clarify some ideas emerging from the data
- Offer voucher

Appendix O: Interview Guide – Midwife

Interview guide – Midwife (30.9.14)

PARTICIPANT NUMBER:
INTERVIEW NUMBER:

Come back to an earlier point   *Validate*
Get in-depth description   *Stop to explore a statement or topic*
Request more detail

BEFORE INTERVIEW
- Thank you for your interest in being a participant in my study
- Ensure participant has read the Participant Information Sheet -Midwife
    - Purpose of the study
    - Explanation of what participating in the study will involve
- Any questions answered?
- Taking written notes during the interview
- Participant rights (from Consent Form)
    - Sign Consent Form consenting to participate and to me recording the interview
- Reminder; participant can decline to answer any question, take a short break or ask for the dictaphone recording to be stopped at any time
- Turn on dictaphone
- Choose/give a pseudonym to ensure confidentiality

DEMOGRAPHIC DATA
1. Pseudonym
2. Sex
3. Ethnicity
4. Country of initial midwifery education
5. Year of midwifery registration
6. Years spent practising as a LMC midwife
7. Annual caseload of women
8. Percentage of annual caseload of women living in areas of high socioeconomic deprivation
9. Prime location of women in your caseload?
10. Number of years working with women living in these areas?
11. Contract to access maternity facilities at?
12. Post graduate education?

INTERVIEW
Tell me how you go about accessing pregnant (or postnatal) women living in areas of high socioeconomic deprivation?
What happens/ed after that?
Tell me how you set about engaging with pregnant (or postnatal) women/developing a relationship with this group of women?
What is it like to do that?
What is it like to work with this group of women?
Could you describe the events that led up to you working with this group of women?
What, if anything did you know before about accessing/providing care/working with this group of women?
What did you expect might happen?

How did you think midwifery care with this group of women might work?

Tell me about the women you provide care for…ages, ethnicities, anything else?

Are there any other events that stand out in your mind about accessing this group of women/providing their midwifery care?

Are there any other events that stand out in your mind about engaging/developing a relationship with this group of women?

What advice would you give to midwives wishing to provide midwifery care to women living in areas of high socioeconomic deprivation?

After having these experiences, what advice would you give to a woman living in this area who has just discovered they are pregnant?

Who has been the most helpful to you during this time? How has that person been helpful?

What do you do to sustain yourself when working with women in these areas?

Is there something that you might not have thought about before that has occurred to you during this interview?

Is there something else you think I should know to understand … better?

Is there anything you would like to tell me about?

That's interesting. Can you tell me more about that?

Walk me through that step by step.

What happened next?

Can you tell me how you define that so I have that in your words?

What did you think about that?

How did you feel about that?

What did you do about that?

Other people have told me …. . Could I ask you what you were thinking/feeling/doing … then?

AFTER INTERVIEW
- Thank you for your participation
- Typed transcript returned by post/email. Can change text or delete quotes
- Return reviewed transcript to me within two weeks
- May be necessary to contact you again to clarify some ideas emerging from the data
- Offer voucher