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Socially disadvantaged women's views of barriers to feeling safe to engage in decision-making in maternity care

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ABSTRACT

Background: Although midwifery literature suggests that woman-centred care can improve the birthing experiences of women and birth outcomes for women and babies, recent research has identified challenges in supporting socially disadvantaged women to engage in decision-making regarding care options in order to attain a sense of control within their maternity care encounters.
Objective: The objective of this paper is to provide an understanding of the issues that affect the socially disadvantaged woman's ability to actively engage in decision-making processes relevant to her care.
Research design: The qualitative approach known as Interpretative Phenomenological Analysis was used to gain an understanding of maternity care encounters as experienced by each of the following cohorts: socially disadvantaged women, registered midwives and student midwives. This paper focuses specifically on data from participating socially disadvantaged women that relate to the elements of woman-centred care-choice and control and their understandings of capacity to engage in their maternity care encounters.
Findings: Socially disadvantaged women participants did not feel safe to engage in discussions regarding choice or to seek control within their maternity care encounters. Situations such as inadequate contextualised information, perceived risks in not conforming to routine procedures, and the actions and reactions of midwives when these women did seek choice or control resulted in a silent compliance. This response was interpreted as a consequence of women's decisions to accept responsibility for their baby's wellbeing by delegating health care decision-making to the health care professional.
Conclusion: This research found that socially disadvantaged women want to engage in their care. However without adequate information and facilitation of choice by midwives, they believe they are outsiders to the maternity care culture and decision-making processes. Consequently, they delegate responsibility for maternity care choices to those who do belong; midwives. These findings suggest that midwives need to better communicate a valuing of the woman's participation in decision-making processes and to work with women so they do have a sense of belonging within the maternity care environment. Midwives need to ensure that socially disadvantaged women do feel safe about having a voice regarding their choices and find ways to give them a sense of control within their maternity care encounters.

1. Introduction

Not all women experience health care interactions in the same way. Previous research suggests that socially disadvantaged women have lower health literacy levels, fewer resources from which to find health information[1] and have less choice concerning their maternity care options.[2] In addition, they are more frequently categorised by maternity care providers as 'high risk' and subsequently assigned to non-continuity of midwifery carer models of maternity care. Socially disadvantaged women have

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poorer birth outcomes and a higher maternal mortality rate than the general population of birthing women.[3,4] In 2007, Carolan and Hodnett examined the models of maternity care available to Australian women. They reported that socially disadvantaged women's experiences of maternity services are likely to be different to the experiences of women of higher socio-economic status. The discrepancies in access to models of care are complex and not only related to the woman's economic status. However, women of lower socio-economic status understand their maternity care is of lower quality than women of higher socio-economic status and express their powerlessness to change the situation.[5] Furthermore, Stapleton et al. argue that women are socially positioned through discourse used within maternity care encounters and that health professionals will often judge women prior to offering what they perceive are appropriate choices for this group of women.[6]

The importance of collaborative relationships between health care professionals and socially disadvantaged women emerged as a major finding in a Canadian study involving women living in temporary accommodation.[7] In this study, participating women felt 'respected' and 'valued as members of society' when they perceived that their relationship with their doctor was collaborative. Similar findings were reported nearly a decade earlier in a Swedish study involving women and birth centre midwives.[8] Berg et al.[8] concluded that women perceived their birthing experience as positive when the midwife respected them, treated them as an equal and was able to meet their needs as an individual. Emotional wellbeing can be improved when women have positive maternity care encounters. A randomised controlled trial involving 1000 women receiving various models of maternity care reported that the quality of individual interactions with health care providers is a significant indicator of women's satisfaction of care.[9] Biro et al. concluded that midwifery-led models of care provide women with both a higher level of emotional support and more opportunity for involvement in decision-making processes.[9] In Australia, an evaluation of the Southern Aboriginal Maternity Care Project, implemented in South Australia, was undertaken in 2008. An outcome of the evaluation process was a recommendation that health care professionals develop "trusting and respectful relationship[s]" with Aboriginal women to improve their maternity care experiences (10, p. 29).

A supportive relationship between the woman and the midwife throughout the childbirth continuum can improve the woman's physical health and reduce poor birth outcomes associated with social disadvantage.[11] These findings are supported by a recent Cochrane review by Sandall et al., who reported that women receiving midwife-led continuity models of maternity care where less likely to experience instrumental births, episiotomies, regional analgesia and preterm birth and more likely to experience a spontaneous vaginal birth, care from a known midwife and greater satisfaction with care.[12] The provision of woman-centred maternity care has the potential to reduce the health disparity of premature birth. In 2011, Wisanskoonwong and colleagues undertook a systematic review of the effectiveness of medical interventions aimed at preventing pre-term birth. The authors concluded that medical interventions are not effective in the prevention of pre-term birth and that the provision of holistic, woman-centred midwifery care holds great promise in addressing the health disparity of pre-term birth at a population level.[13] Furthermore, medical interventions performed during labour and birth, by staff perceived as strangers by birthing women, impacts negatively on women's childbirth experiences and may influence their future childbearing choices.[14]

Thus, recent research has identified challenges in supporting socially disadvantaged women to engage in decision-making regarding care options in order to attain a sense of control within their maternity care encounters. The objective of this paper is to present research that explored the issues that affect the socially disadvantaged woman's ability to actively engage in decision-making processes relevant to her care.

2. Research design

The qualitative research approach, Interpretative Phenomenological Analysis,[15] was used to explore the idiographic perspectives of woman-centred care and the translation of theory into practice, as perceived by three different socially and culturally constructed participant groups. The three groups of participants included in the study were socially disadvantaged women, midwives working with socially disadvantaged women, and student midwives observing maternity care encounters involving socially disadvantaged women. Interpretative Phenomenological Analysis (IPA) is informed by phenomenology, hermeneutics and idiography.[15] The basis of IPA is phenomenological and idiographic in focus because it explores the individual's lived experiences as well as perceptions or accounts of an event, situation or phenomenon as a stand-alone unit of understanding. It is interpretative in that meaning is always constructed by means of the participant's recounted experiences that are narrated through the researcher. Tomkins and Eatough suggest however, that an idiographic focus does not necessarily pertain to the individual person, but to an individual experience.[16] In anthropological methodology, an idiographical study examines a cultural or socially constructed group, by acknowledging that every group is unique, with specific properties that set it apart from other groups.[17] This concept is applicable to maternity care encounters where interactions between childbearing women and health care professionals occur within a socially constructed situation. It was with this sense of the idiographical focus that we sought to understand the idiographic experience of maternity care encounters experienced by three different socially and culturally constructed participant groups.

This paper focuses specifically on the data from participating socially disadvantaged women that relate to the elements of woman-centred care-choice and control to provide an understanding of how socially disadvantaged women experience their maternity care encounters and to identify the issues that influence their ability to actively engage in decision-making processes relevant to their care. Data and findings derived from participating midwives and student midwives will be presented in future papers.

2.1. Participants

The aim of this study was to gain new understandings of woman-centred care through the recounted descriptions and interpretations of maternity care encounters in which socially disadvantaged women were the recipients of care. It is therefore appropriate that purposeful sampling was employed for recruitment and selection processes. Purposeful sampling involves selecting participants for their ability to recall personal experiences and understandings of the phenomena being studied, woman-centred care. For this study three focus groups with a total of 17 socially disadvantaged women were undertaken between September and December, 2009. The women were purposefully recruited through two Schools as Community Centres (SaCCs) within one local government area of a coastal region in New South Wales, Australia. Schools as Community Centres operate in local government areas classified as having high levels of disadvantage. The SaCCs provide educational, social and health programmes for parents generally but in particular for women who are pregnant or have young children. The local government area from which participating women were recruited is the eighth most