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The midwifery capabilities theory: How midwives enact woman-centered care to address systemic inequity

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Abstract

Background: Healthcare for childbearing women with complex needs demands a multi-disciplinary approach requiring transitions between care providers, paradigms, and models of care. These transitions may create disconnects between women and the maternity care "system." Poorly managed care transitions can lead to women becoming hostage to the power struggles between healthcare organizations and the professionals working within them, further increasing the risk of poor outcomes. This paper presents the findings of a study that aimed to better understand how midwives provide woman-centered care for women with complex needs in the real world of maternity services.

Methods: A constructivist grounded theory approach, using Clarke's situational analysis to extend critical and feminist perspectives in data analysis. Qualitative data were obtained from two sources: publicly available data, and individual interviews with providers of care (midwives) and recipients of care (women with complex pregnancies).

Results: Woman-centered care is defined as care in which the woman is seen, heard, and known. "The midwifery capabilities theory" describes the process whereby midwives create opportunities to develop women's capabilities. Capabilities are enabled through the midwifery relationship creating space, moments in time, and equalizing power and positionality.

Conclusions: Aligning with contemporary theories surrounding the provision of midwifery care, the *midwifery capabilities theory* recognizes the individual health and social status of women and the rights to self-determination. This centers care around each individual's needs, which, in addition to improving health and well-being outcomes, contributes to improved self-confidence, enhancing engagement through authentic professional relationships.

KEYWORDS
complex, high risk, maternity care, midwifery, models of care, respectful, trauma informed, woman centered

1 | INTRODUCTION

Contemporary midwifery practice must extend beyond "normal," to fulfill midwives' professional responsibilities, their contribution to improving maternal and neonatal outcomes, and achievement of the sustainable development goals (SDG).[1] Although pregnancy is generally accepted as a sign of wellness, perceived levels of risk and complexity govern the types of maternity care women receive.[2] It is, however, important to recognize that the factors used to determine levels of risk during the childbearing continuum differ across contexts.[3] Despite this, women are often bundled together when considered "high risk" or deemed to have a "complex pregnancy."[4]

In this study, the term "woman/women" is used interchangeably with "woman/women with complex pregnancy." The term "complex pregnancy" is used to refer to women with complex health and/or social backgrounds requiring multi-disciplinary support to achieve optimal outcomes. For example, complex pregnancies may be the manifestation of the impact of social determinants on health or well-being and/or underlying medical conditions, longstanding, or pregnancy induced.[4] Accordingly, women experiencing complexities during pregnancy, in turn, require safe, quality care to minimize the risk of adverse outcomes.[5] Quality maternity care strengthens women's capabilities in the context of respectful relationships, and midwives are integral to this approach.[6] When care becomes complex, access to multi-disciplinary teams across facilities and community settings is needed.[6] This requires women to transition between different models of care, health professionals, and care paradigms to access the appropriate care required.[7] When these transitions are poorly managed, there is a risk that women can "fall through the gaps"[8] becoming caught up in the disconnects between service providers.[9]

A woman's relationship with care providers and the healthcare system during childbearing can empower or conversely inflict emotional trauma, detracting from self-confidence.[10] Disrespectful maternity care is a global phenomenon linked to traumatic experiences and post-traumatic stress disorder (PTSD).[11] Disrespectful care includes system and individual factors that result in a lack of choices, loss of autonomy, poor communication, unbalanced information, and inadequate support.[11]

This paper presents the findings of a study conducted in Australia and New Zealand that explored the role of midwives in providing woman-centered care (WCC) for women with complex pregnancies. The findings include the proposal of an operationally relevant definition of WCC, which until now has been central to models of care and philosophical midwifery approaches but are vague and difficult to enact. Further, this paper presents the *midwifery capabilities theory*, the grounded theory that emerged from the data.

1.1 | Background

Midwifery philosophy and practice is grounded in providing WCC, although a universally accepted definition of WCC does not exist.[12,13] There is, however, consensus that essential elements of WCC include continuity, choice, autonomy, and meeting the needs of the individual woman within her social and cultural context.[14] These elements are visible in many models of care and service provision frameworks, but barriers to the implementation of WCC for *every* pregnant woman persist. Health professional workloads, organizational structures, access to services, and geography can prevent one midwife from journeying alongside a woman experiencing a complex pregnancy who is required to transition between models of care and care providers.[7]

Conceptual and operational solutions to overcome these barriers and increase a woman's satisfaction with care revolve around the continuity of midwifery care models, which, in principle, may be implemented across all contexts.[15] The reality however is that such models of care are not available to all women, particularly to those experiencing complexities during pregnancy or those whose care is transferred to higher level services in order to access appropriate pregnancy or birthing care.[16]

Evidence shows that quality maternity care requires all women to have access to midwives in the perinatal period.[6] Midwifery care is skilled, knowledgeable, and compassionate and involves working in partnership with women to strengthen their own capabilities.[6] Challenges arise when care moves from one set of 'owners' to another, positioning midwives as the gatekeepers to the portal and facilitators of the transfer.[7]

The aim of this study was to explain how woman-centered midwifery care is provided for a woman with complex pregnancy. The objective was to theorize a process for how midwives provide WCC for women with complex pregnancies that accounts for the situational and contextual relationalities that exist in "the real world" of maternity services within which this study occurred. This study sought to answer the following research question: *How do midwives provide woman-centered care in complex pregnancy?*

2 | METHODS

2.1 | Study design

Constructivist grounded theory methodology was used in this study. Constructivist grounded theory is a qualitative research methodology that acknowledges subjectivity and that there can be multiple truths. Meaning is co-constructed with participants to then develop a theory on complex social processes. Situational analysis is compatible with and was used to extend constructivist grounded theory to introduce a critical, feminist, anti-racist, social justice approach in data analysis.[17] Describing and analyzing the situation as a whole through the situational analysis mapping method moved the study beyond interviews to focus empirically and analytically on the conditions of the situation that constitute the situation. Mapping all the human and non-human elements and analyzing the relationalities, and positions taken and not taken in discourses, reveals the dense complexities and power relations that exist in the 'real world' of maternity services and midwifery care provision. The research framework was further underpinned by Fairclough's (2001)[18] critical discourse understandings of maintaining social dominance through linguistic choices and the power within and behind discourse as an overall theoretical perspective. This enabled the emerging phenomena to come to the analytic forefront.[17] Human ethics approval was obtained in line with institutional human research ethics committee requirements (approval number 0000022288), compliant with the National Statement on Ethical Conduct in Research.[19]

2.2 | Data collection

Data for this study were drawn from two sources. Existing publicly available discourse data were sourced from the internet including social media, blogs, online government documents, and podcasts. These data were sourced to identify elements in the situation across a forum where anyone can say anything about a certain topic in "real world" environments. Initially, relevant word combinations related to the study were entered into search engines, for example, "best birth," "midwives," and "choice in childbirth" to begin moving around the data. Search terms were refined as the study progressed to create a relevant subset of data in a continuous cycle over the course of the study. Sources for discourses were broad, in English language, and were refined as the study moved forward to situate the study within Australia and New Zealand. Additional data were obtained through individual interviews with midwives providing care and women who experienced a complex pregnancy. Participation was voluntary, and early recruitment was undertaken through snowballing techniques. Targeted recruitment as the study advanced took place via a midwifery professional organization newsletter advertisement. The midwives recruited had diverse professional experiences and were located across Australia and New Zealand, working in rural and metropolitan public health services and nongovernment organizations. The women who participated identified as having a pregnancy that required multi-disciplinary support. Interviews were undertaken between May and December 2021 and completed virtually due to travel restrictions during the Covid-19 response. Interview lengths ranged from 45 to 80 minutes. All interviewees were asked an initial question; "Tell me everything about what woman-centered care means to you." From there, interview questioning followed the lead of the participant delving deeper into their thoughts, feelings, experiences, and perspectives. Saturation was reached after interviews with nine midwives and two women.

2.3 | Data analysis

Each dataset was analyzed separately. This approach allowed for comparison across sources, identifying areas of alignment and disconnects. The findings from the public discourse identified the elements of the situation for the next stage of the analysis, the individual interviews. Identifying these elements early in the study enabled the researchers to differentiate between what elements merely surrounded the situation under examination and those that became "part and parcel," and therefore constituting the situation under examination, woman-centered midwifery care. Analysis of individual interviews provided an understanding of those directly involved in complex midwifery care. Situational, positional, social world or arena, and relational maps were used in data analysis to analyze power relations, boundary objects, and human and non-human elements found within the 'real world' of maternity services. Memos were used to document and detail the analysis-in-progress.

The first author conducted the interviews and early data analysis of both subsets of data. Codes and categories leading to the final theory were discussed among all members of the team and agreed. Data triangulation occurred through multiple data sources with data collection, analysis, and memoing, undertaken concurrently. Different perspectives from within the research team supported reflexivity. Sampling ceased when no new concepts were appearing in the data. Evaluating the final product was through actively engaging with reflective questions from the research process to confirm the full research process had been undertaken. When presenting the findings of this study, pseudonyms are used to protect the participants' identity.

3 | RESULTS

The findings from the analysis of publicly available discourses in this study identify that midwifery is constructed discursively in public forums that become social realities. Conversely, contemporary healthcare sees midwives working in a system framed by neoliberal healthcare reform that has followed a lean thinking approach resulting in siloed care, disease-oriented services, sub-optimal communication across specialist services, and thereby fragmented care. This environment makes the woman structurally vulnerable to systems that are rigid and unforgiving, and the provision of individualized maternity care is problematic. The risk averse, technocratic, and litigious environment within which midwives work shapes how midwives approach their role but runs contrary to the rhetoric of an "individualized" woman-centric approach that is supposed to underpin midwifery care. Boundary tensions are created through social discursive labels applied to childbearing women, fetal personhood discourses, and midwifery professional "lines in the sand."

By identifying key elements of WCC, drawn from the discourse analysis of public sources, and the individual interviews undertaken with midwives and women, it is possible to define WCC as the woman being seen, heard, and known as she navigates herself through the childbearing journey and transitions between models of care, health professionals and care paradigms. The key finding from this study is the *midwifery capabilities theory*. The *midwifery capabilities theory* and the categories that comprise it are described in the following section.

3.1 | The midwifery capabilities theory

The *midwifery capabilities theory* (Figure 1.) emerged from the interview data with both cohorts of participants. This

FIGURE 1 The midwifery capabilities theory. It is comprised of three categories and describes the process midwives use to develop a woman's capabilities when experiencing a complex pregnancy, to promote and maintain woman centred care during care transitions. The three categories are creating space, moments in time and equalizing power and positionality. This figure is reproduced from Naughton [23, p. 226].

theory describes the process midwives use for developing women's capabilities when experiencing a complex pregnancy, to promote and maintain woman-centered care during care transitions. This is achieved through the midwifery relationship creating space, moments in time, and equalizing power and positionality. The *midwifery capabilities theory* draws on existing political and economic theories of Justice as Fairness,[20] the capability of persons to achieve their well-being and freedom, rather than on their mere right to do so[21] and capabilities as human dignity[22] to position a respectful, human rights, socially just, and emancipatory trauma-informed framework into healthcare. Extending these existing theories through the *midwifery capabilities theory* posits equality as a baseline within health services that reach those furthest behind, acknowledges human diversity, and provides all women with opportunities to be self-determining and to action this.

The *midwifery capabilities theory* comprises three categories: *Creating space*, *moments in time*, and *equalizing power and positionality*. Each is now discussed in detail below.

3.1.1 | Creating space

The category of *creating space* includes the elements of *holding space for the woman; hearing*; and *free from judgment*, describing the factors that allow the midwife to create space for the woman (Figure 2).

There are individual and systemic factors that limit how, when, and where midwives create space for women. Institutional practices that limit the time midwives spend with women reduce the midwife's ability to fully engage with the woman and actively listen.

The following quote from Carmen represents the common theme in the narratives.

> Carmen (midwife): Through understanding her, and to understand somebody, you actually need to create space and time to have conversations.

Health systems that pressure midwives to prioritize service demands mean a midwife may choose to avoid questioning a woman if it is likely to lead to a discussion requiring extra time. This minimizes opportunities for women to engage in conversations around their individual needs.

> Athena (midwife): Partially because it's a fine line that we walk isn't it, you don't poke the bear. If I can't hear her and hold space for her properly, then let's just leave it alone,

Midwives recognized the importance of the woman feeling that this space was safe from broader social and institutional discrimination or judgments, while also recognizing the challenges of being able to provide the space.

> Diana (midwife): I think it happens more than it should. Yeah. I think that—I do get comments from women saying sometimes that they do feel judged.

Midwives also recognize that when space is created and midwives actively listen, this promotes the woman's capability for decision-making, ensuring centrality to her care.

> Tracey (woman with a complex pregnancy): It was calm, I walked into theater, we had good conversations, it was relaxed. I felt in control. I felt safe and it was exactly what I ended up wanting.

Creating space emerged as the operationalization of "being with woman." Midwives when supported within service settings can create safe spaces for women. Safe spaces are created through the midwifery relationship enacting a woman-centered approach, holding the space free from institutional discrimination and for the time required and genuinely hearing the woman.

3.1.2 | Moments in time

Moments in time (Figure 3) describes the moments required for midwives to actively create environments in which women feel comfortable, trust is built, and relationships through connection can develop.

> Athena (midwife): ..... Remember to look the woman in the eye and smile at her, and if we're not doing that, what's the bloody point?... if I can't connect with women and work out what's important to them and direct them and support them...

Being present requires the midwife to be aware of their own individual bias which can reinforce stereotypes and lead to skewed judgments and assumptions. Through realizing personal triggers or bias, they can be actively managed and mitigated with the goal of listening and building relationships.

> Lucina (midwife): I guess when there's more complex issues it kind of requires me sometimes to put my own personal beliefs to the

FIGURE 2 Creating space. It represents the category of creating space in the *midwifery capabilities theory*. This figure is reproduced from Naughton [23, p. 244].

> side in order to provide that woman-centered care.

Midwives identified that for the woman to be "present" as co-creator of the moment to develop the midwifery/woman relationship, trust is needed.

> Lily (midwife): So, she was very mistrusting of us as a maternity team. She felt that obviously in her first pregnancy that she wasn't listened to, and she wasn't heard.

When continuity or consistency in care is not maintained, midwives identify women feel that they are not known and by default, not cared for, reducing their feelings of significance, and making them feel lost in the system.

> Carmen (midwife): ... because every single time they are showing up they are being asked the same questions and they probably feel like every time they are having to tell their story over and over again to different people. When you're doing that, I guess, you don't feel heard and you don't feel cared for as such.

The value of the woman being seen, heard, and known by midwives within the maternity system was highlighted by women.

> Tracey (woman): I think for the first pregnancy, the ideal care would be to have the midwife in hospital with you as your pregnancy advocate really. Someone who knew me, someone who knew my personality ...
>
> Nita (woman): ... So, she was advocating for me like that .... That just meant so much to me that she cared. ..... She knew me, she knew what I wanted, she knew who we were, et cetera, was there I really feel saved me from PTSD.

Moments in Time is about creating genuine human connections between women and midwives through honest and transparent communication. For midwives, being present, consistency in care, and awareness of and minimizing bias and assumptions during care interactions build trust. The trusting midwifery relationship enables women to be open and honest and provides opportunities for the woman to be seen, heard, and known so the midwife can authentically advocate for the woman where needed.

3.1.3 | Equalizing power and positionality

Equalizing power and positionality, represented in Figure 4 describes what the midwives articulated, in different ways, the way that power shaped their practice on many levels. That is, midwifery practice is bound through differentials in professional knowledge between women and midwives.

> Lily (midwife): I think a lot of women come in and hand over their autonomy and I think we see this all the time in midwifery. Especially when you've got fear involved and I think we do have a power dominance because we are sitting there in a position of we have information that they don't have. So, there is a power difference between that.

There are inescapable power differentials between midwives and other professionals and between midwives and women.

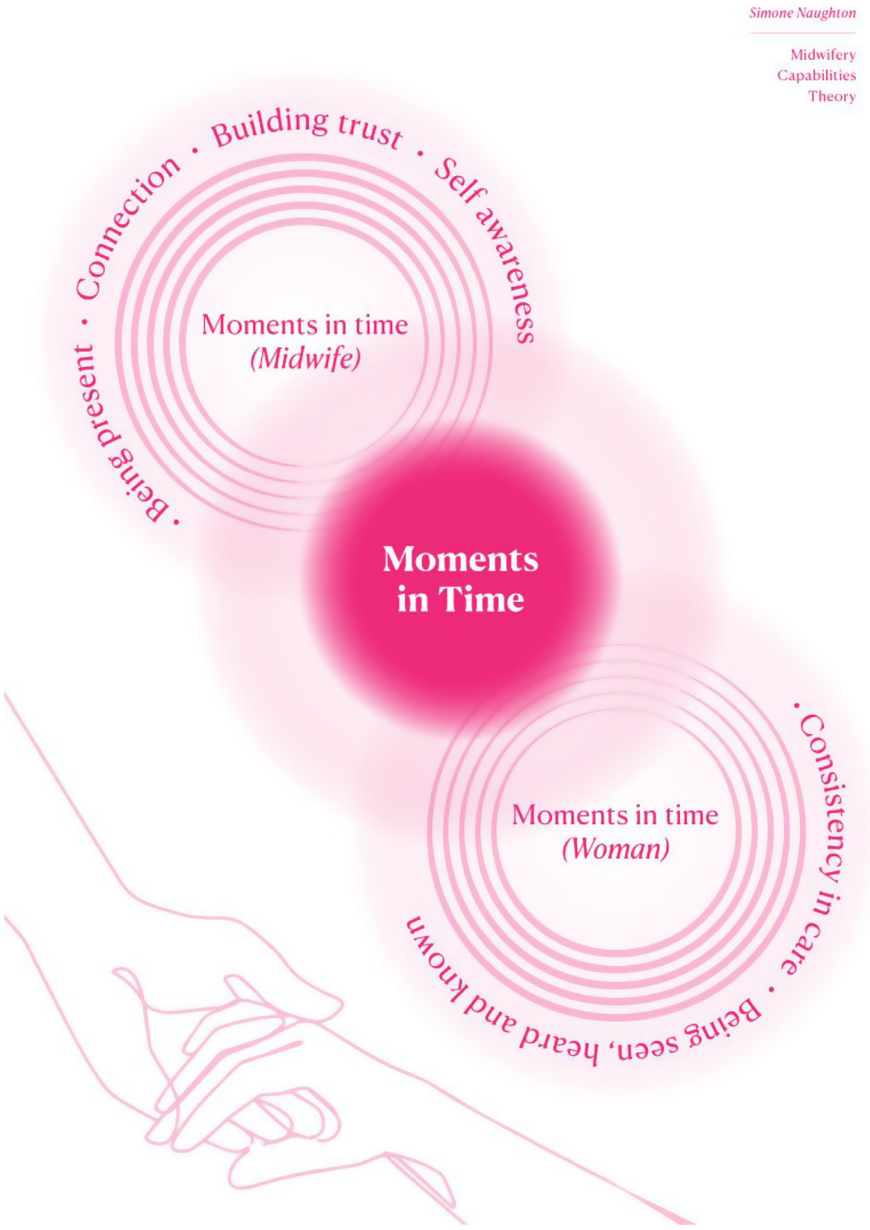

FIGURE 3 Moments in time. It represents the category of moments in time in the *midwifery capabilities theory*. This figure is reproduced from Naughton [23, p. 228].

> Tracey (woman): So, you have a choice, but especially if you've got a good relationship with your midwife, you feel obliged to do what's in their best interests as well.

Balancing power differentials means acknowledging women as 'knowers' who bring personal experiences and knowledge to the relationship. Sharing knowledge enables unbiased discussions focused on the woman. This supports the woman to share decision-making with family members when she identifies this is important from a personal or cultural perspective; and has confidence in voicing her own informed decisions.

Codes of professional conduct and frameworks for scope-of-practice decision-making provide an explicit system of rules and principles for professional self-regulation and denote professional responsibility and accountability to society. There are professional and institutional regulations or "lines in the sand" within which the midwife must act. Fear and boundary tensions encouraged midwives to conform to the established guidelines and accepted norms, often in preference to the woman's wishes.

> Lily (midwife): It feels like we often come from a place that's litigious not necessarily that's woman-centered. So, we offer these things as a routine, and if a woman declines that care, it becomes very much about how we have to protect ourselves.

Systems that silo medical and midwifery models prevent women with complexity from accessing midwifery

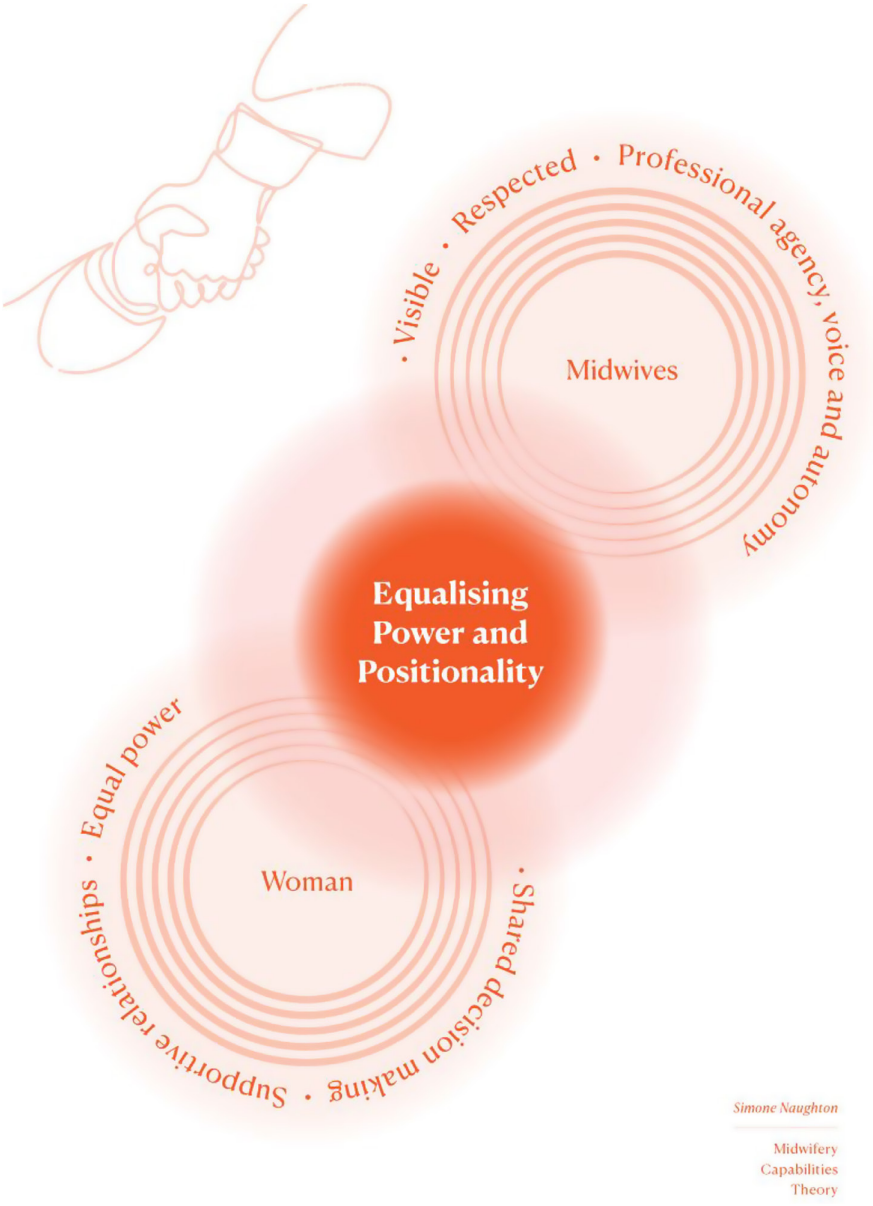

FIGURE 4 Equalizing power and positionality. It represents the category of equalizing power and positionality in the *midwifery capabilities theory*. This figure is reproduced from Naughton [23, p. 249].

relationships across the childbearing continuum. It is within this hierarchical system of control that midwives are prevented from acting out their full role.

> Athena (midwife): Well, the hospital itself needs us to be quick and efficient and get everyone through and out the door as quickly as possible. They (the doctors) get priority over midwives, whether I personally agree with that, sometimes I do, sometimes I don't. It is that political structure.

Equalizing power and positionality means engaging with and balancing existing power relations. Balancing power acknowledges the value of each other, is respectful, and supports the woman's informed decision-making.

4 | DISCUSSION

Capabilities are closely linked to human rights.[22] Human rights are secured to people only when the relevant capabilities to function are present.[23] Adopting a capabilities approach includes focusing on what people are actually able to do and to be and make visible and address inequalities through opportunities to exercise these capabilities.[23] Developing capabilities does not privilege western ideas, because there is no culture in which people do not ask themselves what they are able to do and what opportunities they have for functioning.[22] The language of capabilities communicates the difference between pushing people into functioning in ways you consider valuable and leaving the choice up to them, placing emphasis on people's choice and autonomy.[22] In maternity services, it is the woman's ability to navigate different pathways and action

the steps needed, her capabilities, which support keeping care centered on her individual needs and equity in health outcomes and quality of life.[23]

The language of capabilities is about respect. Within maternity health services, keeping care centered on women, developing a woman's capabilities, and providing opportunities to enact these capabilities demonstrates respect. When care is respectful, care is safe; collaborative; trust is developed; and women have choices and feel empowered, essential to trauma-informed care frameworks. For a woman with complex needs or from disadvantaged backgrounds, actioning the *midwifery capabilities theory* offers one way to move respectful care from theory into practice.

Situational analysis of maternity services discourses within which this study exists suggests a dominant managerial quality and safety perspective where performance, flexibility, cost-effectiveness, and accountability are achieved through increasing health institution protocols, safety checks, and documentation.[24] These narrow understandings of risk, safety, and quality create institutional blind spots that create power imbalances and position clinical midwives as unqualified speakers in the "business" within the organization, able to be ignored.[24] Midwives must find their voice in a complex system and position themselves to enable the woman's voice to be heard. Moral bystanding or remaining silent or inactive on the adverse effects from societal and institutional power hierarchies on the voices of women and midwives creates questions around meeting ethical midwifery responsibilities.[25] Disrespectful care includes coercive treatment; trivializing preferences and personal needs; ineffective communication; lack of supportive care; and loss of autonomy.[26] However, systemic barriers to respectful care are removed when space is created by midwives using a midwifery capabilities approach to elevate the voices of women, acknowledge women as knowers who are to be listened to and authentically advocate for women. When health providers do not get to know the issues that are important to women, fail to listen, ignore, dismiss, or do not believe women, there is a cost. This cost is trauma and conflict.

The *midwifery capabilities theory* identifies that midwives can provide WCC for a woman with a complex pregnancy through developing a woman's capabilities and supporting opportunities for actioning as the woman moves through the health system. The *midwifery capabilities theory* through its relational and contextual approach pushes back against power asymmetries between care providers and receivers to acknowledge women as knowers who are listened to.

Developing capabilities supports confidence in women so they can identify their needs and convey these to their care providers. This requires *moments in time* with the presence of the midwife and the woman being seen, heard, and known; *creating the space*; and *equalizing power and positionality*. Functioning is not evaluated as it is determined by the woman. Women are free to determine their own course. Focus on capabilities as opposed to functioning, protects sensitivities to culture, religious, and power differentials. This foundation is required for a woman to develop and action her capabilities, creates equity in opportunities, is respectful, and is the true essence of WCC for a woman with a complex pregnancy.

5 | CONCLUSION

In the 'real world' of maternity services, midwives, managers, and executive teams will need to work together to move from rhetoric to actioning WCC for all pregnant and birthing women. Midwifery needs to be recognized as a social protective mechanism, instrumental in driving tangible progress toward improving maternal and child outcomes. The *midwifery capabilities theory* provides a framework to do this. Responding to the care women want requires embracing health outcomes measures that are multi-dimensional and value the women's perspective. This requires asking the woman whether care was respectful, choices informed and was she seen, heard, and known during care transitions.

5.1 | Strengths and limitations

This paper has presented a new theory, *the midwifery capabilities theory* which has transferability and applicability across health professions, providing a framework to promote human rights in health. *Creating space*, *moments in time*, and *equalizing power and positionality* promotes a woman's self-determination and minimize vulnerabilities, regardless of level of complexity.

The limitations of this study include the small number of participants that were geographically limited to Australia and New Zealand which may have led to saturation quickly. Additionally, the views of marginalized women may not be fully represented in the interviews. Discourse data were limited to those in English which may not have captured all perspectives.

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CONFLICT OF INTEREST STATEMENT

There are no conflict of interest identified with this manuscript.

DATA AVAILABILITY STATEMENT

Research data are not shared.

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