



NEW ZEALAND  
COLLEGE OF  
MIDWIVES (INC)

# JOURNAL

Handing over the reins – an evolving  
Editorial Board

First-time New Zealand mothers'  
experience of birth: Importance of  
relationship and support

Assessing Quality Care – The  
Beginning of the Journey

Being with women with risk: The  
referral and consultation practices and  
attitudes of New Zealand midwives

The Effects of Childhood Sexual Abuse  
on Labour and Birthing: an Exploration  
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- Promote women's health issues as they relate to childbearing women and their families.
- Promote the view of childbirth as a normal life event for the majority of women, and the midwifery profession's role in effecting this.
- Provoke discussion of midwifery issues.
- Support the development of New Zealand midwifery scholarship and research.
- Support the dissemination of New Zealand and international research into midwifery and maternal and child health.

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For queries regarding submission please contact:  
Lesley Dixon (NZCOM Journal secretariat)  
PO Box 21-106  
Christchurch 8143  
Fax 03 377 5663 or Telephone 03 377 2732

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# Handing over the reins - an evolving Editorial Board

Andrea Gilkison & Lesley Dixon

It is hard to believe that this is the 22nd year and the 45th issue of the Journal of the New Zealand College of Midwives. The first issue (edited by Judy Hedwig and Helen Manoharan of Palmerston North) was published in September 1989, and since then has been under the stewardship of some outstanding midwifery writers and researchers. Joan Skinner took over as Editor of the Journal in April 2008, from the Otago-based Editorial Board of Alison Stewart, Sally Pairman, Deb Davis, Jean Patterson and Rhondda Davies who had collaboratively edited the journal since 2001. Under Joan's guidance, the Journal has continued to grow in the quality of research and writing as she supported and encouraged midwives in practice, education and research to write about what matters to the midwifery profession. Joan has spent considerable time growing midwifery writers and helping authors to craft their research into an article for publication. The role of Journal Editor is an enormous job, and after four years, Joan feels it is time to hand over the reins.

The Journal is still evolving and Joan's resignation has stimulated discussion and further changes. Since 2010 the Journal has had three sub-editors; Jackie Gunn, Ruth Martis and Andrea Gilkison who have supported the Editor. At the beginning of this year Susan Crowther also joined the team as a sub-editor, with Lesley Dixon actively involved as the Journal secretariat, managing papers for review, and getting each issue ready for publication. Earlier this year, the editorial group met with the New Zealand College of Midwives to discuss the challenges of ensuring a quality journal publication and to clarify optimal editorial processes. When the editorial processes of other midwifery journals were reviewed, it was found that the majority have an editorial board comprising six or more members and most journals have more than one editor. It was agreed that we should follow this lead and appoint two editors to work together. The two editors would work with

four sub-editors who would be responsible for working with authors to support them to publication. It was proposed and agreed that the two co-editors would be Andrea Gilkison and Lesley Dixon. Andrea and Lesley would work collaboratively with sub-editors Ruth, Jackie and Susan as an editorial board, with a fourth sub-editor position to be filled in the near future. The Journal Editorial Board will work in a partnership philosophy to ensure consensus building. The board will be responsible for the content and quality of the papers published, robust and efficient publication processes and future strategic direction and planning for the Journal.

We hope that the setting up of an Editorial Board in this way will enhance support for the editors, the sub editors and the authors who are submitting their papers.

We are sorry to be losing Joan, but would like to acknowledge her outstanding contribution as Editor of the Journal for the last four years. Joan has been a wonderful role model for us to follow with considered and measured feedback to authors alongside encouragement and support to improve the quality of writing. She has worked hard to ensure that there were sufficient good quality papers prepared for publication whilst also holding down her own demanding position at Victoria University. We appreciate her time, passion and commitment. She has paved the way for the rest of us to follow, so thank you Joan.

When Joan took over from the Otago Editorial Board in 2008, she wrote that it was "with some trepidation that she took over the reins as editor of this Journal." Joan we know how you felt! Your editorship over the last four years has been outstanding, and your shoes will be very hard to fill. We are extremely grateful for the systems that you have put in place, we are sure that it will make our roles a lot easier.

This issue of the Journal has been a collaborative effort with Joan mentoring and supporting us through to publication. Each of the four papers in this issue has something to offer midwives wherever they work. The first paper presents research exploring the experiences of

first time mothers in New Zealand and has come from outside of the midwifery profession. Reassuringly it points to the importance women place on the supportive relationships they have with midwives in the New Zealand context of continuity of midwifery care. Joan Skinner's paper draws on her doctoral research which examines the referral patterns of LMC midwives. The results indicated that, at that time (2005), midwives provided care to women with a variety of risk factors and continued to provide continuity of care even when clinical responsibility was transferred.

For midwives working in maternity hospital environments, Lesa Freeman and Anna van Uden have provided a summary of an audit undertaken in their primary maternity unit. The audit was a collaborative affair with all the staff involved and demonstrates how midwives can become involved in quality improvements and motivate changes to support good practice. Lastly, Ellen Clark and Liz Smythe have explored some of the key themes and issues related to identifying women who have experienced childhood sexual abuse and the effects this may have during labour and birth. They have set out some 'universal precautions' that can be used by core midwives who have not previously met women to ensure sensitive and appropriate care for all women but which may also reduce any additional trauma for women who may have been affected by childhood sexual abuse.

Before introducing the Editorial Board in the following biographies, we would like to take this opportunity to thank Rhondda Davies for her proof reading of each issue, all our wonderful skilled reviewers, and of course the authors who work so hard to write and re-write their articles without whom this journal would not exist. We should be so proud of the growing number of midwife writers and researchers in Aotearoa/New Zealand. Talking of good writers and researchers, we were very impressed by the caliber of presentations at the Joan Donley Research Forum in Taranaki in August. We welcome submissions to the Journal from everybody but especially from each and every one of those midwife presenters.

# Introducing the Journal's Editorial Board



## Andrea Gilkison

Andrea has been a midwife in New Zealand since 1985. Andrea went to Wellington Polytechnic for her midwifery education (as a part of the Advanced Diploma of Nursing), and

has practised in various areas of midwifery at Wanganui Base hospital, Wellington Women's Hospital and Palmerston North Hospital.

During the 1990s, Andrea worked in the Manawatu region as a self-employed midwife. Her passion has been supporting women who choose to birth at home or in primary birthing units. Andrea has had a long involvement with the New Zealand College of Midwives and was a regional chairperson of the Manawatu region and on the editorial committee for the College Journal in the early 1990s.

In 1998, Andrea's focus turned to education. She lived and worked in the United Kingdom (UK), and completed her Masters degree in education there. Her Masters research explored the facilitation of Problem-Based learning tutorials. Returning to Auckland, New Zealand in 2001, Andrea was able to combine midwifery with education, when she commenced teaching in the undergraduate midwifery programme at Auckland University of Technology (AUT). Andrea is now a senior lecturer and programme leader for the midwifery programme, and also teaches in the postgraduate midwifery programme. She has gained her PhD this year which explored the experience of implementing a narrative-centred curriculum in an undergraduate midwifery programme.



## Lesley Dixon

Lesley is a Midwifery Advisor with the New Zealand College of Midwives, providing practice advice for midwives and developing a research framework for the College to support midwifery knowledge and practice. During

her 25 years working as a midwife Lesley has practised midwifery across a variety of work settings. Her first years were as a community midwife in the UK followed by several years working in Germany and a final move to New Zealand 12 years ago, where she has worked as a Lead Maternity Care midwife and a Charge

Midwife of a primary birthing unit. Whilst working Lesley has also undertaken an academic journey starting with an Honours degree awarded in the UK, a Masters in Midwifery from Otago, New Zealand and a PhD completed this year with Victoria University of Wellington. Her doctoral research has explored women's perspectives and understanding of labour as it moves towards birth.



## Jackie Gunn

Jackie is the Head of Midwifery at AUT University and has worked in Midwifery Education for more than 20 years.

During that time she has led curriculum development and

implementation of the BHSc (Midwifery) and the development of postgraduate midwifery papers. Jackie has been a midwife for more than 30 years. During this time she practised as a Lead Maternity Care midwife for over ten years and as a core midwife prior to 1991 and again more recently to maintain her midwifery practice. Jackie is the National Education Consultant for NZ College of Midwives and a member of the Health Practitioners' Disciplinary Tribunal. She was recently made a life member of NZ College of Midwives.



## Ruth Martis

Ruth has practised as a midwife for nearly 30 years in a variety of settings, mainly attending homebirths or working in primary units. She has worked across a number of countries, mostly in South-East Asia, but recently has had the

privilege of spending some time with the Hamlin Fistula Trust in Ethiopia. Ruth is currently a senior midwifery lecturer at the CPIT Midwifery School, Christchurch. She has been involved in a number of research projects and clinical practice guideline developments. Her Master's thesis researched the antenatal education needs of young pregnant women and she has recently been invited to be on the trust for Rachel's House working with young parents, as well being part of Waipuna St. Johns professional development team. Her main research and midwifery interests are how to keep birth normal, oxytocin, breastfeeding/lactation, issues surrounding teenage pregnancies and the implementation of

evidence-based care. Ruth was a regular feature author for five years of 'Teen Talk' for the Kiwi Parent magazine. She has published a number of research articles and a chapter for the recent book by Davies, Daellenbach and Kensington called 'Sustainability, midwifery and birth'. She is a fledging Cochrane review author, having co-authored and published three reviews before embarking on becoming a first Cochrane review author. Ruth is also a New Zealand College of Midwives foundation member and held a variety of positions with the College over the years. Currently she is a member of the NZCOM governance committee.



## Susan Crowther

Susan has worked in health care practice since 1983. For the last 20 years she has practised as a midwife in a variety of settings, home, birth centres and hospitals in several countries such as UK, Ghana, Burkina Faso, Armenia, NZ

and France. As a NHS consultant midwife in England she set up a birth centre and organised the provision for a water birth service in Cambridge in the UK before coming to NZ with her NZ husband. Once in NZ she set up a remote rural self-employed midwifery service on the Kaipara, Northland. In early 2010 she joined AUT as a midwife lecturer and occasionally still provides a rural locum service for colleagues. She writes and publishes regularly in midwifery journals and has been on the editorial board for the UK Practising Midwife for the past decade. She is a PhD candidate examining the often hidden spiritual sacred aspects of birth that remain concealed within contemporary metanarratives that inform the way we speak and research childbirth in the 21st century. Susan is passionate about primary midwifery provision and family focussed maternity care. She loves nature and lives on a biodynamic lifestyle block 100 km north of Auckland.

# First-time New Zealand mothers' experience of birth: Importance of relationship and support

### Authors:

- Anne Howarth, MSc,  
Department of Psychological Medicine  
Dunedin School of Medicine  
Department of Psychology  
University of Otago
- Nicola Swain, PhD  
Corresponding author  
Department of Psychological Medicine  
Dunedin School of Medicine  
PO Box 913  
Dunedin 9054  
Email: [nicola.swain@otago.ac.nz](mailto:nicola.swain@otago.ac.nz)
- Gareth J. Treharne, PhD  
Department of Psychology  
University of Otago

### ABSTRACT:

**Background:** Becoming a mother is a major developmental life event. The new mother may need to reorganize her priorities, behaviours, and goals to meet this new challenge while at the same time sustaining her sense of self. Support from others contextualises these adjustments, but little is known about mothers' experience of support received from the range of people they interact with, in the build up to and during birthing.

**Method:** A qualitative methodology was employed to obtain an in-depth insight into the birth experience of first-time New Zealand mothers. Ten participants aged 24 to 38 years (median 31.5 years) were interviewed face-to-face within 11 days to 16 weeks of giving birth (median 13.5 weeks). The semi-structured interviews were audio-recorded, transcribed verbatim and analysed using a phenomenological form of thematic analysis.

**Results:** A core theme identified as common across transcripts was relationship issues. Four subthemes were differentiated: midwife relationships; partner involvement; family and friend support; and continuous support. The midwife relationship was notably important to all participants. Partners were considered

the primary providers of continuous support, along with family, friends and midwives. Participants wanted their partners fully involved for the support partners gave and as an acknowledgement of the changes occurring in their relationships, from couple-hood to family.

**Conclusions:** The present findings reflect the importance new mothers in New Zealand attribute to relationships. Acknowledging the importance of relationships and encouraging relationship development are likely to enhance the sense of birth satisfaction felt by New Zealand first-time mothers.

### KEY WORDS

Birth satisfaction, relationship issues, childbirth, midwives, support, first-time mother

### NOTE

This research formed part of a Masters degree for Anne Howarth.

### INTRODUCTION

A significant change occurs when a woman becomes pregnant and gives birth to a baby (Fowles & Horowitz, 2006; Howarth, Swain, & Treharne, 2010; Mercer, 2004). New mothers' self-concepts undergo radical changes in order to incorporate this new role, the 'maternal identity', into an already established sense of self (Rogan, Shmied, Barclay, Everitt, & Wyllie, 1997; Rubin, 1984). One of the issues that affect a woman's sense of herself as a competent mother is the extent of her satisfaction with her birthing experience (Bradley, 1996; Klaus, 1998; Rubin, 1984; van Teijlingen, Hundley, Rennie, Graham, & Fitzmaurice, 2003). Indeed, "it is the birth that provides a crucial turning point" (Miller, 2002, p. 17).

Research has established that a negative birthing experience can affect a mother's early interaction with her infant (Koniak-Griffin, 1993; Waldenstrom, Hildingsson, Rubertsson, & Radestad, 2004). The new mother may be left experiencing a lack of control. She may feel bewildered by the realisation of changes to her lifestyle, and thus have difficulty establishing her maternal identity (Miller, 2002). This has

potential long term psychosocial implications since a mother's sense of maternal identity has the capacity to either facilitate or impede her ability to develop a secure attachment with her infant (Nelson, 2004).

It is therefore crucially important that birth satisfaction is considered for every woman giving birth. One factor contributing towards birth satisfaction is experiencing personal and caring support (Common Knowledge Trust [CKT], 2001; Koniak-Griffin, 1993; Rubin, 1984; van Teijlingen et al., 2003). Using self-report data from women at a mean 24 weeks gestation, Glazier, Elgar, Goel, and Holzapfel (2004) confirmed that good social support predicted positive consequences for both the birthing process and later as the woman adjusted to her new role as mother. Similarly, the women in studies conducted by Halldorsdottir and Karlsdottir (1996) and Gibbins and Thomson (2001) expressed a strong need for understanding and caring from those who were a part of their birth journeys. Positive social support from midwives, partners and significant others assisted women to cope with the changes and challenges experienced throughout their pregnancies and birthing processes. Howarth, Swain and Treharne (2011) reported that taking personal responsibility to be well-informed and well-prepared also had a positive impact on birth satisfaction for New Zealand women.

Of particular importance is continuous support throughout the birthing process (Hodnett, Gates, Hofmeyr, & Sakala, 2005). For example, a consistent finding is that such continuous one-to-one support can reduce a woman's perception of pain and hence her need for analgesia (ibid). While a midwife may offer this continuous support once labour is well established (Vincent, 2008), an expectant woman relies on others for continuous support from the first twinges that indicate the commencement of labour (Bradley, 1996; CKT, 2001). Bradley (1996) felt the father of the child was most qualified to do this because of the emotional connection he usually has with the mother.

The father's continuous presence has been found to increase his partner's feeling of satisfaction with her birthing process. Icelandic

women described their vulnerability while in labour and their need for support and caring from those close to them in words such as “He didn’t have to do anything or say anything, just that he was present ... that he was there to experience this with me. That was extremely important” (Jean, 33, mother of four, Halldorsdottir & Karlsdottir, 1996, p.54). Gungor and Beji (2007) established that Turkish women felt supported and better able to cope when each was encouraged and reassured by her partner; when her partner tried to understand and showed his love for her; when he was able to communicate well with her; when he facilitated decision-making between her and medical personnel; and when his support made her feel she was not alone. Such continuous one-to-one support during labour and birth contributed towards a woman’s sense of birth satisfaction thus positively introducing her into the role of motherhood.

In a review of relevant literature, Howarth, Swain, and Treharne (2010) identified a lack of studies examining the New Zealand birth experience. As it could not be assumed that issues related to social support throughout pregnancy and birth and continuous support throughout labour and birth identified in other cultures would automatically reflect New Zealand birthing traditions and concerns, an interpretive phenomenological approach was used to examine the birthing experiences of first-time mothers in New Zealand (Smith, 1995). Traditional hypotheses were precluded, as the data themselves shaped how the research question was answered (Braun & Clarke, 2006). The broad research question was: What issues are evident in the birthing experiences of first-time mothers in New Zealand, and how do they feel about these experiences in the months after birth? This article focuses on the ways in which relationship issues and support were raised as central to the New Zealand birthing experience of ten first-time mothers.

## METHOD

### Participants

The inclusion criteria were: 1) first-time mothers (with singleton pregnancies) who had given birth to a healthy baby within the 4 months prior to the interview; 2) being aged between 18 years and 42 years; 3) having been registered with and received care during pregnancy from a midwife; and 4) living with the father of the baby. Participants were sufficiently literate to be able to speak and read English to the level required by the study.

The ten participants were aged 24 to 38 years (mean/median age 31.5 years). The mean age for women giving birth to their first child in New Zealand was 28 years for the year ending March 2008 (Statistics New Zealand, 2008). Educationally, participants varied from school leavers who sought practical qualifications through to university graduates,

with one participant holding a PhD degree. All participants had studied and/or worked before having their babies in a range of subjects and career options.

### Procedure

Participants self-selected by contacting the interviewer (AH). A newspaper advertisement was placed in a local community newspaper. Posters were placed in areas frequented by new mothers and a snowballing technique was used. All interviews were face-to-face. Of the ten participants, seven elected to meet in their own homes, two elected to meet in the house of one of the researchers (NS), and one elected to meet at her place of work. Information sheets and study questions were emailed to participants prior to the interview.

Consent forms were completed prior to the commencement of the interviews at which time participants were asked if they had any questions or concerns. The interviews lasted between 57 minutes and 106 minutes (mean 76 minutes). Three interviews had two researchers present (AH with NS). Each participant was assigned a pseudonym and other identifying material was removed or altered to protect the anonymity of individuals and organizations. Participants were gifted a \$20 petrol voucher for taking part in the study.

Ethical approval from the New Zealand Lower South Regional Ethics Committee was gained for this study reference number: LRS/08/22/EXP).

### Data Analysis

A form of thematic analysis informed by Interpretive Phenomenological Analysis (IPA) (Smith, 1995, 1996; Smith, Flowers, & Larkin, 2009; Smith, Jarman, & Osborn, 1999) was used in order to obtain a more complete and detailed description of the experiences of birth encountered by the local women (Trochim, 2006) than a standard quantitative instrument was likely to provide (Reid, Flowers, & Larkin, 2005). This analysis is both descriptive and interpretive.

Once participants had confirmed the verbatim transcriptions of interviews accurately expressed their perceptions of their birth experiences, data analysis was commenced. Patterns within the qualitative data were identified using information coded across the data corpus (Braun & Clarke, 2006). Data were then organised into meaningful groups. Data from the transcript that supported each code were briefly summarized. This interview summary detailed the designated codes and supporting data in the order they arose in the interview. Next, to ensure each woman’s experience of pregnancy, labour and birth had been accurately interpreted. A ‘Birth Story’ reflecting these individual interview summaries was written and sent to individual participants with a request for any feedback to be sent via email (their preferred method of communication).

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The father's continuous presence has been found to increase his partner's feeling of satisfaction with her birthing process.

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Connections between the initial themes were identified and organised into broader themes across participants. Core themes were identified along with related sub-themes. It was found that some initial themes were more realistically sub-themes of larger themes, and thus a pattern of hierarchy became apparent. This process continued until the primary analyst (AH, with ongoing feedback from NS and GT) felt the themes provided a good overview of the data corpus and the relationships between the themes that were emerging. By the end of this phase, four core themes were identified and named. These consisted of: 1) taking personal responsibility; 2) relationship and support issues; 3) midwife and doctor relationships; and 4) safety net. This article will focus on four of the implications of *relationship and support issues*, namely: 1) midwife relationships; 2) partner involvement; 3) family and friend support; and 4) continuous support during labour and birth. In the following presentation of results, participants are referred to by their pseudonyms; editing is marked as [...] and additional clarifications within quotes are also noted in square brackets.

## RESULTS

### Birthing characteristics

Three babies were born at home; the remaining seven were born in hospital. All babies were vaginal births. Further details of participants’ birth experiences can be found in Howarth, Swain and Treharne (in press).

### RELATIONSHIP ISSUES

Relationship issues with those people who were involved with these participants’ pregnancy, labour and birth support and care were described as being of great importance. 1) Midwife relationships; 2) partner involvement;

3) family and friend support; and 4) continuous support during labour and birth were four of the sub-themes identified in the core theme relationship issues.

### **The midwife relationship**

Self-employed midwives were the Lead Maternity Carers (LMCs) for all participants. For some participants it was quite an issue finding the right midwife, in part owing to a shortage of midwives, particularly midwives who care for a particular cultural niche:

*So I, um, decided that I wanted a Māori midwife, so I rung round and there aren't really any in [town]. There's like one that I found listed and I rung her up and she said she was overbooked, too booked. (Ngairi)*

While she was unable to find an available midwife from her own culture, Ngairi eventually engaged a midwife who came from a minority cultural background that Ngairi could relate to. Her midwife related to, and understood, Ngairi's cultural needs. The midwife was also able to demonstrate her professionalism to an extent that Ngairi's partner felt reassured that Ngairi would be safe to attempt a homebirth.

The trust women placed in their midwives gave them a sense of security and reassurance, and so the support from their midwives was very important, especially once labour really got going. Anita describes her distress when her midwife had to go to an appointment and leave her for a short time as her labour started to escalate:

*The last time she went away I felt a bit stressed out by it [...] coz she came in and sort of stopped and had her lunch and she had one more appointment to go and I felt like things were sorta escalating a little bit and she's like... "It's 5 minutes down the road". [...] It was just like, you know, this woman really needs me, I need to get this one in, coz I think she might be going into labour. It was like "Okay, I can give you the half hour to go". [...] But she was really good about why she was needing to go, but still I would have liked her to have stayed if she could. (Anita)*

Participants in this study were looking for a close and personal relationship with their midwives in which they felt comfortable with each other:

*We just phoned [midwife's name][...] and just, you know, talked to her on the phone a few times before we met her, but we could feel right away, you know, she was really warm and friendly and lovely, without meeting her we knew she was the right person, you know, it just felt right. (Beth)*

It was important to participants that their midwives demonstrated their understanding of the uniqueness of the pregnancy and birth

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## The trust women placed in their midwives gave them a sense of security and reassurance.

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experience for each woman and that they responded accordingly:

*Because she [her midwife] came in and, um, and washed me in the shower, which was really lovely and I didn't know I needed help and I'd never been washed by anyone else [laughs] in my life, you know, it was actually really lovely.[...] Um, you know, there was a lot of blood and [she] washed it all off. And I guess that was quite nice that, even though he was born, the focus didn't immediately all shift onto him, you know, [...] and that was quite a nice completion of the process for her to be there with me then. [...] Um, yeah, I felt very supported by her doing that. (Beth)*

Midwives had encouraged participants to take personal responsibility for their own birthing processes and they guided without pushing:

*Yeah, yeah, really, yeah, really wise and very gentle as well and nice. [...] Yeah, yeah, yeah she was really good. Yeah, and also, um, quite respectful of our wishes and wants with different things, like she would often, she was slow to offer advice but very quick to offer sort of information or resources um, but with perhaps a heavy emphasis on us making the decision or us trusting our intuition, or um, or reading up and finding out, but she would, she would be there to offer information and I, I don't think she ever would've made a decision on our behalf. (Kim)*

If medical intervention was required, women wanted their midwives, who were aware of their personal wishes and needs, to be knowledgeable about their situations and, if necessary, to advocate for them:

*She [her midwife] was very good at making it very clear to the doctors that we were, we had really wanted a home birth and that we were only there because things were going wrong, like, you know, she, she made that clear to them because she said, "If they know that, they're often more", um, "respectful of your wishes, [...] because you are, you're already out of the environment you wanted to be in". (Beth)*

### **Partner inclusion and involvement**

In talking about the importance of her partner's inclusion and involvement in her pregnancy care, labour and birth processes, Anita said:

*They're half the whole process [laughs] you know. (Anita)*

Anita went on to explain how her husband came to her antenatal visits with the midwife. He was determined to be a part of this new journey their relationship was taking:

*My husband, came with me 99% of the time, um, cos he's a teacher so he's quite a curious beast [laughs]. [...] So he really wanted to know what was going on and he wanted to be able to ask the questions about what was happening for me as well. [...] [He] really was very determined to be involved with the process. (Anita)*

When asked if her midwife made her partner welcome, Anita replied:

*Yes completely, yep. It was one of the provisos that I put on when I asked her if she wanted to be my midwife. I said my husband will be there a lot. He will ask lots of questions. (Anita)*

Women felt the need of the closeness their relationships with their partners entailed, as well as the emotional and practical support. Partners offered this caring assistance in a number of ways:

*He'd come home and he'd cook and he'd clean and, yeah, he was just really good, [...] really helpful, ran me baths and all of that sort of thing. [Emotionally] he was really good. [...] We did freak out a wee bit when they were saying [baby's name]'s small and he's just saying, look, you know, it doesn't matter, she'll be alright, she's healthy, you know. We knew she was kicking and he just, he was very reassuring. (Rae)*

All of the women in this study wanted and expected their partners to be present at the birth. Wendy, who was concerned her partner's career might see him out of town when she gave birth, remarked:

*I was very pleased to have him there, yeah, it was really good. [...] Oh, yeah, I would've been really gutted, I said, "I didn't know if I'd forgive him if he wasn't there". [...] Yeah, so he had to be, so I was very pleased he was there. (Wendy)*

However, once the baby was born, not all new fathers took to baby care without some encouragement, because they felt they lacked the necessary skills:

*I didn't give him a choice. I think if I'd given him a choice he would've opted out and "I don't know what to do, so I won't." (Anita)*

The women who took part in this study were aware that bringing a baby into their couplehood entailed changes for their partners as well



as themselves. Their partners would also be facing major relationship and lifestyle changes along with new responsibilities. To ease the incorporation of a family relationship into an already established couple relationship, Anita aptly commented:

*He needs to be part of this process.* (Anita)

Several participants noted that it was stressful for both partners when hospital policy dictated the new father must leave the hospital at night after a birth, especially as in these cases, medical interventions had occurred. Both partners wanted to experience together those first hours in the new family relationship the birth of their child had created:

*It wasn't like, I mean he was just sort of sitting there and so was I, so it wasn't like he was being noisy or anything but, yeah, they said, "No, he had to [leave]". [...] I was actually quite upset. [...] I didn't want, I didn't want him to leave, I sort of thought he'd be with us the whole time. [...] I mean we hadn't really had much of a chance to talk, because I was being monitored and we always had other people in the room and I just would've like some time on my own with him.* (Rae)

Partners took this journey together, recognising that each had needs to be met and working to meet those needs for each other:

*My partner and I were at pains to ensure that the early stages of labour were restful and fun! Seems funny to say it, but the first couple of hours were fun; very exciting for both of us. We put the music on and danced around the living room (well I waddled more than danced!). We both look back on that with fond memories!* (Kim)

### **Family and other support people**

Families and friends were also important providers of the social support participants desired so that they felt encouraged and cared for throughout their pregnancies:

*I don't have family around but his family's around and would do things, like always drop off lots of firewood and lots of friends who were interested in the pregnancy and supportive and wanting to talk about it and stuff like that.* (Wendy)

Kim, whose family lives overseas, discussed the practical support she and her partner received from the community they were a part of:

*We had good support from when we lived in [suburb]. There's a lot of young families there and so we were on, um, yeah, a lot of friends came out and helped.* (Kim)

This support continued after the birth of the child:

*Actually there's, between that friendship group, there's a roster of the domestic goddesses; so for the first 2 weeks, we had, um, evening meals*

*dropped off, which was really nice, and that's been something that we've all done for each other [...] as the children come along. So we had 2 weeks of evening meals which was lovely.* (Kim)

### **Continuous support throughout labour and birth**

The participants in this study found continuous support during labour and birth to be an issue of importance. When it came to the birth, the participants had thought carefully about who they did and did not want to be present:

*My mother would not have been helpful. [...] I had a first year [midwifery] student follow me through [...] And she was great! [...] It was fabulous, especially on the day of the birth. [...] Because of course [husband's name] was sort of my main support person but of course he needs to pee and eat [laughs]. [...] And, and he needs a break. [...] As much as I can't stop what I'm doing; it's an escalating process that started and I can't stop it. He needs to stop and she was just incredible. She was so good. [...] I have some close friends that were sort of on that list of [...] extra people if we needed more people if people needed to sleep and rest and stuff.* (Anita)

Anita had put a lot of energy into organising her home birth so that when her partner, whom she considered her main support person, needed to take a rest or have a meal or visit the toilet, there would always be someone there to hold her hand. When asked how important she felt it was to have a support person other than her husband and midwife for her home birth, Anita answered:

*Extremely important. I think, I think even if I had have been in the hospital I would've felt a bit lost without her.* (Anita)

Cath also expressed the importance she put on having family members present to support her through labour and birth:

*They were, they were just, you know, every time one of them hold my hands.* (Cath)

The women felt that having somebody always present was important. They were advocating for continuous support throughout their labour and birth process.

## **DISCUSSION**

In the present study, participants agreed with previous New Zealand research (Ministry of Health, 2007) that a warm and caring relationship with professional maternity carers was desirable. Lack of satisfactory relationships contributed to a sense of vulnerability and associated anxiety. The present study also provides evidence for the ways in which first-time New Zealand mothers' birth satisfaction is affected by the social support received from partner, family and friends. Social support

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throughout pregnancy, and continuous support throughout labour and birth, were very important for these New Zealand mothers. The sense that they were not alone on the journey of birth enhanced the participants' belief in themselves and positively introduced them to motherhood.

Participants in the present study favoured the current New Zealand midwife-driven maternity system, also supporting previous research (ibid). However, unlike some women who completed the New Zealand *Maternity Services Consumer Satisfaction Survey* (ibid), all of the participants in the present study were able to register with a midwife. Some participants experienced initial difficulty finding a midwife suitable for their needs. For example, Ngaire was unable to register with the midwife who shared her Māori cultural background as this midwife was fully booked for the month. But even when women had registered with a suitable midwife, they had no guarantee that their familiar midwife would be available when they eventually went into labour.

In support of previous research (Halldorsdottir & Karlsdottir, 1996; Lundgren & Dahlberg, 2002; Ministry of Health, 2007), this study identified the importance the participant placed on her relationship with her midwife. Lundgren's and Dahlberg (2002) commented that "the quality of the relationship between the woman and the midwife is a key factor for good support during childbirth" (p. 155). The relationship a participant had with her midwife built over time, as the woman and her midwife came to know each other and trust developed. Having midwife continuity of care was important to participants. Each woman wanted to give birth at a time when her own midwife would be on call/available. Even if a woman required medical intervention she felt reassured if her midwife was present, especially when the midwife advocated for her.

Each participant wanted her midwife to demonstrate her understanding of the uniqueness of each birth and to individualise care given. Participants expected that their midwives had the capacity to work with pregnant and birthing women, supporting

their birth desires in a realistic manner. The midwives who were most successful guided without dictating, and encouraged their clients to be proactive in managing their own labour and birth processes. Only Rae felt any disappointment in her midwife, largely owing to the midwife's lack of advocacy and lack of awareness of the trauma Rae had experienced during the medical intervention that became necessary. Despite this Rae still felt that she could work with this midwife again for a subsequent pregnancy, highlighting that situational factors and communication were pertinent. Issues between midwives and doctors which arose in this study are discussed elsewhere (Howarth, Swain and Treharne, in press). Overall, the relationship participants developed with their midwife had the potential to greatly enhance the satisfaction a woman experienced with her birth experience. For example, Beth talked about the warm sense of completion she experienced when her midwife washed her in the shower after she had given birth.

In particular, continuous support throughout labour and birth was an issue for all of the present participants. The importance of continuous support during labour and birth has been well documented since Sosa, Kennell, Klaus, Robertson, and Urrutia, (1980) paper on the topic (see also Howarth, Swain, & Treharne, 2010). Researchers such as Klaus (1998), Klaus and Kennell (1997), Hodnett (2005) and others have examined this concept thoroughly and supported Sosa et al.'s (1980) findings that continuous support gives comfort and enhances a woman's experience of birth. It has also been shown to decrease the length of and difficulty of labour, reducing the need for medical interventions (Sosa et al., 1980). The reports of the women in this study provide further evidence of the importance of continuous support.

As well as the support of midwives, all of the women in the present study wanted and expected their partners to be present during labour and at the birth. Participants found continuous emotional, physical and informational support from their partners added to the intimacy and specialness of the birth thus supporting work by Bradley (1996), Gungor and Beji (2007), and Halldorsdottir and Karlsdottir (1996).

Developing team skills was discussed as an important aspect of birth preparation for the pregnant woman and her partner. Both partners recognised that each partner was facing major lifestyle changes, and the father-to-be was encouraged to gain knowledge and skills to assist during labour and birth. Participants worked together to adjust to their changing relationships and lifestyles, moving from couple-hood to a family relationship. Participants made the point that parenthood was a new journey for their partners as well. A partner had needs to be addressed

as new responsibilities were taken on board (Friedewald, Fletcher, & Fairbairn, 2005; Turan, Nalbant, Bulut, & Sahip, 2001). This supported findings by Friedewald (2007) who wrote about the need expressed by fathers to be a part of the process of giving birth to their child.

Concern was expressed by participants that there were few resources available for the soon-to-be father to help him adjust to his new role. For the present participants, being pregnant and giving birth was a family event and one in which their partners had major roles to play. This attitude reflects a change in the perceived role of the father which initially saw the father as the provider but now sees him as taking a more active part in childcare (Castle, Slade, Barranco-Wadlow, & Rogers, 2008).

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## The midwives who were most successful guided without dictating, and encouraged their clients to be proactive in managing their own labour and birth processes.

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Participants felt that those partners, who had had no previous experience of infants, were concerned about their abilities to care for a newborn. This apprehension was supported in a study conducted by Castle et al. (2008). They also found that men were concerned about the transition from a couple to a family with a child (Castle et al., 2008). Boyce, Condon, Barton, and Corkindale (2007) concluded that providing men with more information regarding pregnancy, childbirth and parenting would be a positive step in assisting these men to overcome their anxieties, a step which present participants would support.

Participants in the present study also commented on how difficult partners found witnessing their labour pain, particularly when partners did not know what they could do to help. Chapman (2000) found that men

tend to find it very difficult to cope with the pain the birthing mother may endure. He suggested that the father felt frustrated and helpless when his partner was experiencing difficulty in coping with labour pain. This finding is supported by Greenhalgh (2000) who found that how the father experiences his partner's labour and subsequent birth may actually affect his later psychosocial well-being. Vinnie and Rae described how their partners were distressed as a result of witnessing their difficult birth experiences. In the present study, for those partners who had witnessed difficult births, the local hospital policy which insisted new fathers leave even in the middle of the night after the birth, exacerbated this distress. This policy, imposed by the necessity of shared accommodation for mothers, also created distress for the new mothers, Vinnie and Rae. After a difficult birth they felt a great need to be close to their partners. The women were also aware of their partner's distress and were left feeling anxious about their partner's well-being at a time when their energies could have been better directed towards bonding with their baby.

Limitations of this research include that the project drew upon the birth stories of ten women who self-selected to participate, perhaps because they felt they had a story to tell or were seeking reassurance that their story was not out of the ordinary. The present study necessarily took a retrospective approach and it may be that in coming to terms with their experiences, some issues of potential importance were re-evaluated by the participants. Also birth can be a difficult experience and several participants acknowledged that there were some areas of their birth experience about which they were unsure as their memories were not clear.

Despite the issues raised by a retrospective approach, the present study has a major strength in that the methodology allowed for a deep exploration of what these women experienced and how they perceived their experiences. The result is an interpretive and descriptive picture of what did and what did not work for these particular women. It cannot be assumed that all women giving birth will come from such backgrounds, nor that they will have the personal skills that these well educated New Zealand women had. As a result, it can be expected that there are many first-time mothers who will have had very different experiences of pregnancy, labour and birth that this study did not attract or reach. Also women who are giving birth for a second, third or later time may have different perspectives of the birth experience that merits further exploration in relation to the themes described in the present study. Future studies would benefit from recruitment methods that make them more attractive to other demographic groups, and might use a stratified approach for inclusion of a range of participants. Women who are younger, for example teenage mothers,

and women who are older, for example women giving birth for the first time in their 40s, will have different stories to tell from which different themes may emerge.

While this report includes cases of women who had both satisfying home and hospital births, it does not include a homebirth that did not go as planned as a counterbalance to the hospital births that required intervention. It also does not include any women who required caesarean sections, or who had a baby with detrimental outcomes from complications, so another potentially important part of the broader picture requires further investigation.

It must also be remembered that these stories portray only one perspective, that of the woman giving birth. It may be that other stakeholders, such as the fathers, the midwives, both independent and hospital midwives, and others who comprise the maternity health professional teams, perceive their roles in quite different ways. Their perspectives on the births in this study, should they have been involved, could have been different to the perceptions of the births as described by the women themselves.

## CONCLUSIONS

Positive relationships were important to the participants and contributed to an increased sense of satisfaction with their birthing process. The midwife relationship was extremely important to all participants. Continuous support was an expectation of these participants and was provided by family, friends, and midwives. Partners were considered the primary provider of continuous support. Participants wanted their partners involved in their pregnancies, labours and birth for the support partners gave and as an acknowledged part of the changes occurring in their relationships, from couple-hood to family. Acknowledging the importance of relationships and encouraging relationship development is likely to enhance the sense of birth satisfaction felt by New Zealand mothers.

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# Assessing Quality Care – The Beginning of the Journey

### Authors:

- Anna van Uden, MMid, BN, RM, RGON.  
Charge Midwife  
St George's Hospital  
Christchurch  
Email: anna.vanuden@stgeorges.org.nz
- Lesa Freeman, PhD, MA(Hons), Grad Cert  
(Higher Ed), BA, RM, RGON.  
Midwife  
St George's Hospital  
Christchurch

## ABSTRACT

**Background:** When an institution is providing a maternity service it is of utmost importance that the service meets the needs of its consumers. During 2008 a number of reports were published highlighting the necessity of achieving this level of quality outcome. St George's Maternity service, in providing primary level care to women, was motivated to assess the level of care within the unit and provide data to demonstrate quality delivery of care.

### Objectives:

- To determine an appropriate set of standards to measure maternity care provision in a primary birthing unit.
- To develop an assessment template to present the evidence against the identified standards.
- To conduct an audit to measure and evaluate care provision at St George's Maternity against the identified standards and criteria.
- To invite similar primary maternity units to benchmark practice against St George's Maternity services.

**Method:** Care provision at St George's Maternity was audited, in 2009, against 23 of the 30 Royal College of Obstetricians and Gynaecologists 'Standards for Maternity Care' (RCOG, 2008).

**Results:** All criteria were met for 21 of the 23 Standards reviewed.

**Conclusion:** The Royal College of Obstetricians and Gynaecologists' *Standards for Maternity Care* (ibid) was found to be an invaluable initial tool to audit practice at St George's Maternity, and quantitatively acquire evidence that reflects a commitment

to excellence in service provision and ensure continuous quality improvement. An ultimate goal, however, will be to access standards that will measure quality and safety within maternity services, which are designed specifically for the New Zealand context.

### KEY WORDS:

Primary birthing unit, maternity services, Standards for Maternity Care, audit, quality care.

## INTRODUCTION

When providing a maternity service it is of utmost importance that the service reflects the needs of its consumers. Currently within the New Zealand context, the Ministry of Health is leading a project entitled 'The Maternity Quality Initiative' with the aim of developing, by July 2011, New Zealand Maternity Standards, with associated audit criteria and measurement tools (Ministry of Health, 2008a).

Ball and Hughes (1993) contend that standards are a way of defining specific methods and actions to produce a service, or quality of care, that can be measured in some way. The aim of all providers of maternity care will be to meet the standards by formally engaging with the process and demonstrating quality improvements, thus fostering consumer confidence and satisfaction with service provision.

During 2008 a number of reports were published both nationally and internationally, highlighting the necessity to present a quality delivery of maternity services. These were:

1. Ministry of Health, New Zealand. *Maternity Action Plan, 2008-2012, Draft for Consultation* (MOH, 2008a).
2. The Royal College of Obstetricians and Gynaecologists, United Kingdom. (June) *Standards for Maternity Care* (RCOG, 2008).
3. Queensland, Ministry of Health, (August). *Policy Directive - Clinical Governance for Midwifery Models of Care* (2008).
4. Ministry of Health, New Zealand. (October) Review of the Quality, Safety and Management of Maternity Services in the Wellington Area (MOH, 2008b).

One common theme identified within these reports was the need for a national set of maternity standards to ensure quality service with the ultimate goal of ensuring public satisfaction and confidence.

## SETTING

St George's Maternity service in Christchurch, New Zealand, comprises a 21-bed birthing unit providing primary level care to women.

Facilities include: four birthing rooms (one containing a birthing pool), 17 postnatal rooms, and two antenatal clinic rooms. In 2010, 330 women had normal births in the unit, and postnatal care was provided to an additional 1433 women.

As the unit is situated within a modern surgical hospital, maternity staff enjoy the privilege of accessing additional supports available, for example: a quality assurance co-ordinator, infection control nurse, on site cardio-pulmonary resuscitation training, and in-service education. This access is an asset that enhances quality of care.

St George's Maternity service has a contract with the Canterbury District Health Board (CDHB) to provide care for healthy women experiencing a normal pregnancy, birth and in-patient postnatal stay (primary care). Women and babies experiencing significant deviations from normal (deemed secondary care), are referred by their Lead Maternity Carer (LMC) to the services of Women's Health Division (CDHB) and are therefore not cared for at St George's Maternity unit. St George's midwives have the opportunity to practise across the scope of midwifery practice by providing antenatal care through to the birth, and care in the postnatal period for a small cohort of women, while also supporting LMCs and the larger number of their clients who utilise the unit.

Primary maternity facilities promote birth as a normal life event and aim to enhance the mother and baby relationship (CDHB, 2005). A strength of St George's Maternity unit is the staff's belief in promoting safe, flexible and supportive care. The maternity staff were therefore motivated to assess the quality of care within the unit and contribute by providing data that would demonstrate a commitment to quality delivery of care.

As an organisation, St George's Hospital has been accredited with Quality Health New Zealand since 1996, and in 2009 achieved the Telarc Quality Health New Zealand's Evaluation and Quality Improvement Programme (EQuIP 4) requirement for accreditation status. This EQuIP 4 accreditation programme is based on The Australian Council of Healthcare Standards (TACHS) EQuIP 4 model (2008) and adapted to fit the New Zealand health care environment. St George's Hospital in 2009 also continued to meet the Ministry of Health's, Health and Disability Services Certification requirements.

EQuIP 4 Standards (TACHS, 2008) and the NZS8134 Health and Disability Services Standards (Standards New Zealand, 2008) are, however, both generic in nature and apply across a wide range of service settings within the health

and disability service sector. It is acknowledged that there are differences with the provision of maternity services in Australia and New Zealand owing to the 1990 Amendment of the New Zealand Nurses Act whereby midwives were enabled to practise as autonomous practitioners. Therefore using these frameworks solely will not capture the unique provision and features of New Zealand's maternity service that are underpinned by Section 88 of the New Zealand Public Health and Disability Act 2000 (MOH, 2007).

Reviewing the Ministry of Health's Maternity Action Plan (MOH, 2008a) also strengthened their resolve to provide quantitative data, specifically principle four of the plan that states, "Maternity services provide safe, high quality services that are nationally consistent and continuously improve" (ibid, p 8). This principle supported the recommendation from the EQUiP 4, 2009 survey regarding demonstrating quality improvements in the provision of care. The question was whether there were the resources within the maternity unit to undertake such an audit. In reviewing the staffing and time commitment it became apparent that there was the expertise to begin such a project; the issue was which tool best reflected the context of our practice. As noted in the Maternity Action Plan there are currently in New Zealand no national principles and standards to guide all maternity services (MOH, 2008a, p 3).

## METHOD

One of the first objectives of this initiative at St George's Maternity was to locate a tool to measure the level of care provided in a primary maternity unit. The answer appeared in the form of The Royal College of Obstetricians and Gynaecologists' (RCOG's) *Standards for Maternity Care* (RCOG, 2008). These Standards were formulated from a report by a working party comprising the Royal College of Obstetricians and Gynaecologists, the Royal College of Midwives, the Royal College of Anaesthetists, and the Royal College of Paediatrics and Child Health, United Kingdom. This report listed thirty standards that cover pre-conception care through to the transition into parenthood, and included audit indicators to guide the user in providing the necessary evidence to meet each standard. The Royal College of Obstetricians and Gynaecologists envisaged that "maternity services should be working towards achieving the standards identified to ensure a contemporary safe service meeting the needs of women and families" (ibid, p 10). It was also stated that clinicians may use the standards and audit indicators to inform their own practice and service development and as a benchmark for improvement (ibid). As this tool provided the necessary framework, and the standards covered all aspects of maternity service provision from primary through to tertiary facilities, permission was sought and obtained from the Head of Publications, RCOG to use their material.

Of the 30 *Standards for Maternity Care* (ibid), 23 were deemed appropriate for reviewing St George's primary facility. The standards pertaining to pre-pregnancy, preterm infants and in-patient antenatal services (Standards

1, 2, 4, 6, 11, 17, 26) were excluded, as they were not pertinent to care provided by the St George's Maternity service (see Table 1).

## PROCESS

At a ward meeting in November 2008, a proposal was introduced to staff to consider conducting an audit to measure the maternity services provided at St George's against RCOG's *Standards for Maternity Care* (2008). It was determined that it would be beneficial to the unit if data could be presented in a structured format, therefore an assessment template was developed to present the evidence against the identified standards (see Figure 1 for exemplar of the template using Standard 3). A completion date of September 2009 was set to correspond with EQUiP 4's mid-cycle periodic review.

Each staff member was requested to choose one of the 23 selected standards, document current practice against that standard's criteria, and determine whether the standard had

been met or not. Following this procedure each standard was peer reviewed prior to formatting. The documentation was further reviewed by the Charge Midwife, and the Manager of Maternity Services to ensure no information had been omitted. Initially it was anticipated that this process would take a few weeks but it took six months to review and provide comment to the Standards. Twelve of the 23 standards were further cross-referenced against the specific audit indicators providing examples of evidence that included: policies, information sheets, previous audits, booking forms, and records of staff participation in education sessions (see Table 1).

## RESULTS

All criteria were met for 21 of the 23 Standards reviewed. Standard 3, *Access to maternity care* was not met as the Standard recommends a plan of care is established prior to 12 weeks gestation. However, antenatal care provided by St George's Maternity midwives as the LMC was generally

**Table 1:** Standards of Midwifery Care (RCOG, 2008) and Whether Included or Excluded in the Audit Process

STANDARD	DESCRIPTION	INCLUDED IN AUDIT	FURTHER EVIDENCE CROSS-REFERENCED
1	Looking forward to pregnancy.	NO	
2	Pre-pregnancy care for women with existing medical conditions or significant family or obstetric history.	NO	
3	Access to maternity care.	YES	
4	Early pregnancy services.	NO	
5	Maternity booking and planning of care.	YES	
6	Pre-existing medical conditions in pregnancy.	NO	
7	Women with social needs.	YES	
8	Pre-existing and developing mental health conditions in pregnancy.	YES	
9	Antenatal screening.	YES	
10	Routine antenatal care.	YES	
11	Pregnancy-related conditions.	NO	
12	Intrapartum care.	YES	YES
13	Neonatal care and assessment.	YES	YES
14	Postnatal assessment and care of the mother.	YES	YES
15	Supporting infant feeding.	YES	YES
16	Care of babies requiring additional support.	YES	YES
17	Care of babies born prematurely.	NO	
18	Promotion of healthy parent-infant relationships.	YES	YES
19	Transition to parenthood.	YES	YES
20	Supporting families who experience bereavement, pregnancy loss, stillbirth, or early neonatal death.	YES	
21	Choice and appropriate care.	YES	
22	Communication.	YES	YES
23	Training and professional competence.	YES	YES
24	Documentation and confidentiality.	YES	YES
25	Clinical governance.	YES	
26	Development, implementation and review of local maternity services strategy.	NO	
27	Maternity and neonatal networks.	YES	
28	Child protection and safeguarding babies.	YES	YES
29	Infection prevention and control.	YES	YES
30	Staffing.	YES	YES

as the result of women who self-referred and these were more commonly in the second trimester or after (i.e. 14-20 weeks gestation).

Two criteria within Standard 7, 'Women with social needs': 7.6 (women with drug and alcohol issues), and 7.8 (teenage specialist services) were not met, as although every effort is made in the unit to accommodate specific requests, these specially developed services, documented in the audit criteria, are generally provided by the secondary service (i.e CDHB) where the contracted funding is held (see Table 2).

## DISCUSSION

The development of an assessment template to present the evidence against the 23 identified standards has produced a document whereby

staff can locate and use the information as a resource to aid them with their daily practice. Five key discussion points arose from the data:

### 1. A thorough review of the maternity services provided by the unit was documented.

The data revealed that, as a primary service, St George's Maternity can provide care that meets robust standards of quality. The staff were well qualified and confident in their assessment and decision-making skills. Women and their families were the central focus of care provision and each woman was cared for within her cultural needs. This was supported through communication, documentation and maternity satisfaction surveys. An ongoing challenge for staff is to maintain and enhance their

clinical and theoretical skills in accordance with evidence-based practice. While targets were met during this time period, St George's Maternity is committed to providing further education and clinical experience opportunities for staff, undertaking further audits to demonstrate quality improvements, and gathering additional styles of feedback from consumers of the unit's service.

### 2. Identifying and developing relationships with providers that can further support women and families in the antenatal, birth and postnatal periods.

The majority of standards called for evidence that demonstrated that the woman and her family were offered the services of the

Figure 2: Exemplar of Assessment Audit - Standard 3

Standard 3 ACCESS TO MATERNITY CARE Early access to engagement with Maternity Services enables a plan of care to be established before the 12th completed week of pregnancy. The plan is tailored to suit the individual health and social care needs of the woman and her partner throughout pregnancy and the transition to parenthood. Late booking is associated with poorer outcomes			
CRITERIA	YES	NO	EVIDENCE
3.1 Antenatal care is accessible to all women and should be sensitive to the needs of the individual women and the local community			St George's Maternity Services provides midwifery led care for women who present with normal pregnancy and are suitable to birth at a primary birthing unit. The care is titled <i>Supportive Care</i> whereby the woman will attend antenatal visits in the maternity unit and be seen by midwives working there. As a means of continuity the Obstetric Manager and/or Charge Midwife will ensure that they assess the woman at alternate visits. The majority of women who access this care usually have presented later in pregnancy having found they were unable to access a lead maternity carer. For example: women returning from overseas during their pregnancy, women wishing to change LMC and women who have used a general practitioner for the first trimester.
3.2 The option for all women to access a midwife.			Women may attend an antenatal visit at the maternity unit seven days a week between the times of 0900-1600. There is midwifery care and advice available 24 hours a day if the woman needs to access birth and or emergency care outside these times. Women are encouraged to bring a support person with them to the visits. St George's Maternity Services acts as an agent of Christchurch Blood Bank and can supply women with anti-D as prescribed from their LMC on a seven day per week service.
3.3 Antenatal care should be provided in a variety of local settings and at times that take into account of the demands of the woman's working life and family.			St George's Maternity Services are advertised bi-weekly in community newspapers and on the Internet. Brochures detailing services are also available at doctors' surgeries and through LMCs.
3.4 All commissioners and providers of maternity care and local authorities should ensure that campaigns and materials are targeted towards women in groups and communities who under-use maternity services or who are at greater risk of poor outcomes.			St George's Maternity Services provides care for all women provided they are suitable to birth in a primary unit, and/or following birth. Women are referred to Christchurch Women's Hospital, Young Parents Group CWH, Parent centre, Early Start Project. Community Network Antenatal Classes, St George's Maternity Services provides classes specific for breastfeeding, involving a two-hour session and offers monthly tours of the unit to consumers wishing to use the facility.
3.5 Maternity services should be proactive in engaging all women, particularly women from disadvantaged and minority groups and communities, early in their pregnancy and maintain contact before and after birth.			For women accessing supportive care services at St George's Maternity Services, they are given information and encouraged to attend and book into antenatal classes relevant to their situation e.g. Christchurch Women's Hospital, Rookies (Waipuna Youth and Community Trust) and Early Start Programme.
3.6 Specialist services should be provided for pregnant teenagers.			Every individual has the legal right to an interpreter when dealing with a health service provider. This service is arranged through the Maternity manager and is organised via telephone conference, or community interpreter services. See policy
3.7 There should be provision for translation, interpreting and advocacy service.			
3.8 Services should be flexible enough to meet the needs of all women, in caring for the vulnerable and hard to reach groups.			
3.9 Local maternity services should ensure that they are inclusive for women with learning and physical disability and take in to account their communication equipment and support needs.			Women with intellectual and physical disability or sensory impairment or health issues usually present as secondary e.g. hearing difficulty, sight impairment. These clients may need to be referred to Christchurch Women's Hospital so that they can access the appropriate service and support. Otherwise the LMC will contact the hospital prior to admission to co-ordinate a specific care plan.

wider community of health providers. These ranged from interpreting services through to advanced medical care. This project motivated the staff to seek out and document what supporting services were utilised and then identify the services that could be targeted to advance stronger relationships. This was achieved by facilitating teaching sessions by the nominated care providers, for example; Pacific Island Trust, the hospital Kaumatua, and by utilising the skills of interpreter services and representatives of other ethnic communities.

As a means of enhancing professional development through activities, regular attendance at both internal and external meetings by staff was also encouraged. This provides opportunities for information sharing, education updates and networking, for example: New Zealand College of Midwives (NZCOM) meetings, St George's Midwives Network, training opportunities at Women's Health Division, CDHB, Canterbury Breastfeeding Network, and Plunket meetings.

3. *A review of the standards pertaining to maternity services and supporting documents that already exist in New Zealand.*

There was acceptance that the Standards for Maternity Care (2008), although of United Kingdom (UK) origin, are not dissimilar to standards that would be expected in the New Zealand context. The staff were encouraged to source comparable data already available in New Zealand as evidence. This included references to: the NZCOM Midwives Handbook for Practice (NZCOM, 2008); The Midwifery Council of New Zealand's Competencies for Entry to the Register of Midwives (MCNZ, 2008); Notice Pursuant to Section 88 of the New Zealand Public Health and Disability Act (MOH, 2007); the New Zealand Primary Maternity Services Notice, (MOH, 2007); Code of Health and Disability Services Consumer's Rights (Health and Disability Commissioner, 1996); the New Zealand Standards Health Records (SNZ, 2002); and The Treaty of Waitangi (Ministry for Culture and Heritage, 2010). This again demonstrates that whilst there is a need for a framework to be developed by a multi-disciplinary group with specific reference to the New Zealand context, a lot of complementary tools are already accessible to support the goals

of the Maternity Action Plan (MOH, 2008).

4. *The importance of communication and documentation.*

Standard 12 'Intrapartum Care', Criterion 12.3, notes that 'communication is a keystone of good clinical practice' (RCOG, 2008, p 32). This project exposed the vast array of communication and documentation methods used in the maternity unit. It challenged the staff to develop initiatives that could result in streamlining the process to ensure that there was a fluid and ongoing dissemination of information for staff, providers and clients. Initiatives that have since been introduced in the maternity unit include: re-developed care plans and care pathways, communication to staff and LMCs through electronic media, and the hospital initiative of a web page with a specific reference to the maternity unit. A further challenge is to make more efficient the information presented on notice boards, communication books and unit meeting minutes, through the development of an integrated communication portal.

5. *A list of education development required for staff arising from the data.*

**Table 2:** Audit of Care against RCOG's Standards for Maternity Care (2008)

STANDARD	DESCRIPTION	EVIDENCE
3	Access to maternity care	<b>Not Met:</b> 'Plan of care is to be established prior to 12 weeks gestation'. The Standard was not met, however, the criteria were met once the woman had initiated a self-referral. Midwifery care provided from St George's Maternity was generally gained from self-referral of a woman who was of greater gestation (i.e. 14-20 weeks).
5	Maternity booking and planning of care	<b>Standard Met:</b>
7	Women with social needs	'Some women and their families require specially developed services to ensure access.' <b>Not Met:</b> Criteria 7.6 women with drug and alcohol issues and Criteria 7.8 teenage specialist services. While every effort is made to accommodate specific requests the specially developed services that are documented in the audit criteria are generally provided by the secondary service as that is where the contracted funding is held, e.g. social work referral.
8	Pre-existing and developing mental health conditions in pregnancy	<b>Standard Met:</b> relationships with general practitioner, Lead Maternity Carer and Mother and Baby Unit in place to ensure continuity of information and consistency of care.
9	Antenatal screening	<b>Standard Met:</b> contracts in place with local radiology and community laboratories to enable this testing to be undertaken. Further testing is undertaken by Fetal Maternal Unit WHD
10	Routine antenatal care	<b>Standard Met:</b>
12	Intrapartum care	<b>Standard Met:</b>
13	Neonatal care and assessment	<b>Standard Met:</b>
14	Postnatal assessment and care of the mother	<b>Standard Met:</b>
15	Supporting infant feeding	<b>Standard Met:</b>
16	Care of babies requiring additional support	<b>Standard Met:</b>
18	Promotion of healthy parent-infant relationships	<b>Standard Met:</b>
19	Transition to parenthood	<b>Standard Met:</b>
20	Supporting families who experience bereavement, pregnancy loss, stillbirth, or early neonatal death	<b>Standard Met:</b>
21	Choice and appropriate care	<b>Standard Met:</b>
22	Communication	<b>Standard Met:</b>
23	Training and professional competence	<b>Standard Met:</b>
24	Documentation and confidentiality	<b>Standard Met:</b>
25	Clinical governance	<b>Standard Met:</b>
27	Maternity and neonatal networks	<b>Standard Met:</b>
28	Child protection and safeguarding babies	<b>Standard Met:</b>
29	Infection prevention and control	<b>Standard Met:</b>
30	Staffing	<b>Standard Met:</b>

The Health Practitioners Competence Assurance Act (MOH, 2003) requires that midwives and nurses are engaged in programmes that seek to continually update and improve their skills. In the maternity unit the majority of staff are engaged in the Midwifery Council of New Zealand's Re-certification Programme for Registered Midwives. The *Standards for Maternity Care* (RCOG, 2008) also provide specific suggestions for education programmes for those health professionals providing maternity care, for example: increased focus on child protection, family violence issues, and opportunities for staff to improve clinical skills such as, intravenous cannulation and suturing. The evidence documented within the assessment template provides rich information that can be used as a benchmark when staff undertake further audits to ascertain if the *Standards for Maternity Care* (ibid) have been maintained or if quality improvements were achieved. This information will also be used to identify further areas of policy development, targeting pregnancy, labour, birth and postnatal care of women and their babies and maintaining Baby Friendly Health Initiative accreditation<sup>1</sup>.

## CONSUMER COLLABORATION

The *Standards for Maternity Care* (ibid) provide scope for addressing relationships and are therefore equally appropriate when used to measure quality issues in a small maternity unit, as well as in a larger health facility that plans and administers maternity services. Over the years strong relationships and partnerships have been established between St George's Maternity service and other health professionals, for example: midwife and GP LMCs, colleagues at Women's Health Division CDHB, Christchurch Polytechnic Institute of Technology lecturers and midwifery students, NZCOM regional members, immunisation co-ordinators, well child providers, and other community agencies. Policy development within St George's Maternity unit has therefore been enhanced by the sharing of information amongst these health professionals that in turn aims to foster consistency of information and evidence-based care for women within the Canterbury region.

A key outcome noted in the document is that a great proportion of women using the unit are cared for collaboratively by a variety of health care providers. These providers include: midwife LMCs, core midwives, obstetricians, paediatricians, physiotherapist, laboratory and radiology staff, and other allied health professionals such as: lactation consultant, dietician, and social worker. All these interactions influence the woman's perceptions with regards to the quality of care received.

Presently in St George's Maternity unit, consumer feedback is gathered from the maternity satisfaction questionnaire provided to women on admission. However, this satisfaction questionnaire centres on the 48-to-56 hour postnatal stay and does not collect data that would gauge a woman's satisfaction

with the entire maternity episode. A challenge to the staff is to identify other opportunities for consumer feedback when planning, or auditing current practice.

Participants who contributed comments on the Maternity Action Plan (MOH, 2008) at a regional Ministry of Health discussion day (March 2010) also challenged providers to consider other opportunities to collect consumer feedback that may include the use of consumer focus groups, or other forms of survey that can be standardised and accessible by all users of the maternity services. This has also been addressed at a national level with consumers participating in sector workshops to discuss the proposed Ministry of Health – Quality and Safety Programme for Maternity Services.

## PROFESSIONAL DEVELOPMENT

This project has enabled St George's midwives to specify an area of interest that they may wish to take responsibility for, or further investigate. The document created by the staff in 2009, however, is already dated. For example, the National Screening Unit's introduction of funding for antenatal women to undertake screening for Down syndrome has been a significant amendment to the antenatal screening regime in 2010. The maternity unit staff may use this experience as a motivation to ensure that their maternity service is always reflective and responsive to the needs of its consumers. The participation of the staff in this project will also provide evidence of professional development as a component of the Midwifery Council of New Zealand's Re-certification Programme for Midwives and, if they wish, the Quality Leadership Programme for Midwives developed for core midwives by the District Health Boards and NZCOM.

## CONCLUSION

The use of RCOG's *Standards for Maternity Care* (RCOG, 2008) has been invaluable as an initial tool to audit practice at St George's Maternity, and to quantitatively acquire evidence that shows a commitment to excellence in service provision and ensuring continuous quality improvement.

The project gave staff the opportunity to participate by reflecting on, reviewing and articulating the care delivered in the unit, and to undertake audits to demonstrate quality improvements or motivate change. Participation in the project has offered professional opportunities for staff by developing leaders in the provision of primary care in maternity services.

One factor that was not considered was the time this process would take. Future projects that utilise the whole staff will have a more fixed timeframe commensurate with the demands of a busy workplace. A challenge to the staff of the St George's Maternity service will be for them all to engage in some form of quality assurance activity which will result in a continuous cycle of reflection, consideration, measurement and action.

It is clear that the ultimate goal will be a tool designed specifically for the New Zealand context and culture that measures quality and safety within maternity services. An invitation is extended to similar primary units

to benchmark their practice against that of the staff at St George's Maternity.

## ACKNOWLEDGEMENT

The authors would like to acknowledge the work of all of the staff of St George's Maternity in undertaking this project.

## POST EARTHQUAKE UPDATE

St George's Maternity has provided maternity services to Canterbury women since 1943. The magnitude 6.3 earthquake on 22 February 2011 badly damaged the Heritage building that housed the 21 bed maternity unit. As a consequence maternity services cannot be provided meantime, but alternative sites are being sought. Antenatal breastfeeding classes are still available and breastfeeding support continues in the 'Drop In' clinic that operates during the week. Maternity staff have been relocated elsewhere in the hospital.

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<sup>1</sup> The Baby Friendly Hospital Initiative was launched by the World Health Organisation and the United Nations Children's Fund in 1991 following the Innocenti Declaration of 1990. The initiative is undertaken on a global basis to implement practices that protect, promote and support breastfeeding.



# Being with women with risk: The referral and consultation practices and attitudes of New Zealand midwives

### Author:

- Joan Skinner, PhD, MA (Applied), RM  
Senior Lecturer  
Graduate School of Nursing, Midwifery  
and Health  
Victoria University of Wellington

### ABSTRACT

Managing risk is an important part of a midwife's work and the decision to refer for an obstetric consultation is one way that this is expressed in practice. The research that this paper presents took a mixed method approach and describes the referral for obstetric consultation practices and attitudes of New Zealand midwives. It found that the consultation referral rate was 35%, that there were a large number of reasons for referral, and that midwives usually continued to provide some midwifery care even when risk had been identified. Midwives spoke of the centrality of the woman despite her level of risk.

### KEY WORDS

Midwifery, risk, consultation, referral, with women,

### BACKGROUND

The management of risk continues to be a critical part of contemporary midwives' work and there are certainly challenges as midwives attempt to work a 'birth is normal' paradigm within a 'birth is risky' social and political context (Skinner, 2003). Risk, as it is currently expressed, has been seen by some as a social construct to increase surveillance (Heyman, 1998). In the case of maternity care this relates to the surveillance of midwives and by midwives. Others have seen the risk environment as a product of the anxiety related to late modernity, and to the not-always-positive effects of technology (Beck, 1999; Douglas, 1992; Lupton, 1999). However it is understood, midwives and consumers of midwifery care are both influenced by global and local anxieties associated with the management of risk. Midwives have the double-edged task of identifying and managing risk, while at the same time supporting the normal and promoting anxiety-free birth (Scamell, 2011).

The place where risk in practice is most apparent is in the referral for obstetric consultation. It is

here where risk is most clearly identified and where the midwives' actions and attitudes to risk can be made explicit. This paper presents part of a piece of research that looked at how midwives managed or made sense of risk by exploring their referral for obstetric consultation practices and attitudes. Other findings are reported elsewhere (Skinner, 2010; Skinner & Foureur, 2010). This research is particularly pertinent in New Zealand where 85% of New Zealand women have midwifery-led care. It also has current relevance as the New Zealand Government is in the process of a Maternity Quality Initiative (Ministry of Health, 2011a). Part of this initiative has been a review of the referral for obstetric consultation guidelines. Interestingly, the new reviewed guidelines, now called Guidelines for Consultation with Obstetric and Related Medical Services (Ministry of Health, 2011b) have not been changed significantly. They reiterate the centrality of women in the decisions regarding referral and the importance of three-way communication between woman, midwife and obstetrician. They also contain updated information related to conditions requiring referral and introduce a change in referral categories to clarify process. The guidelines remain fundamentally the same, reflecting an opinion that they have provided a useful tool that has served the maternity sector well, since their introduction in 1996.

This research sought to examine how midwives referred when using the referral guidelines. It asked firstly what the referral practices were, and then asked midwives about how they experienced the referral guidelines. Did they, in fact, provide useful guidance and what impact did they have on the 'with women'-ness of midwifery?

### METHODS

The research took a mixed method approach. Firstly, a total population survey of Lead Maternity Carer (LMC) midwives was undertaken. The midwives were identified from data obtained from the New Zealand College of Midwives database, District Health Boards, telephone books, websites and local contacts. The postal questionnaire was extensive and asked for: demographic data of the midwives, and the numbers of, and reasons for, obstetric consultations over a 4 month period. The questionnaire asked the midwives to state whether they had continued to provide care when transfer of clinical responsibility had occurred. It also contained ten Likert-scaled, attitudinal measures which included questions about the

midwives' attitudes to the referral guidelines, to the nature of the collaborative relationships, and to the risk environment. The survey population included both LMC midwives who were self employed and those midwives working in LMC models but employed by District Health Boards or in primary health care services. After it was pretested, the questionnaire was sent to 649 midwives. There was a 56.5% response rate. Those midwives who responded were identified as being representative of New Zealand LMC midwives by demographic characteristics and by regional distribution when compared with data from the New Zealand workforce statistics (Health Information Service, 2001). The data were entered into SPSS and analysed using descriptive and co relational statistics.

Once preliminary analysis of the survey data had occurred, six focus groups were conducted in a variety of New Zealand settings. Two were held in rural and four in urban settings. Four groups were in the North Island and two in the South. The locations were also chosen to reflect difference in the quality of the collaborative relationships, according to the preliminary analysis of the survey data. Midwives volunteered to participate in the focus groups either by indicating their interest on the returned questionnaire, or by invitation from local contacts. In total 32 midwives participated in the discussions. The point of the group discussions was to gain a more in-depth understanding of the midwives' experiences of the interface between primary and secondary maternity care, and thus to reveal how midwives managed risk in their practice, both the women's risk and their own risk. The focus group data were analysed thematically, taking a content analysis approach. The research was completed in 2005. Ethical approval was granted by the New Zealand National Health Ethics Committee and the Human Ethics Committee of Victoria University of Wellington.

### FINDINGS

#### The survey

Over the 4 month period in which the data were collected, the 311 midwives who completed the questionnaire cared for 4,251 women. Thirty five percent (1,477) of these women had a consultation with an obstetrician at some stage during their childbearing process. The ages of the referred women ranged from 14 to 46 years. Most were European but 16.7% were Māori. Approximately one-third of the women were having their first baby and one-third, their second

(Table 1). In general, the women who required a consultation were representative of the total childbearing population.

Data on episode of referral were obtained from 1408 women. The episodes for which referral was identified were divided up into antenatal, labour/birth (intrapartum) and postnatal. Two thirds were one off referrals, referred in only one episode and a third had referrals in more than one episode. Two and a half percent were referred for obstetric consultation in all three episodes. The most common stage of pregnancy in which a referral for obstetric consultation took place was in the antenatal period. When all referrals were considered 70% (986) of referred women had an antenatal consultation (Table 2). Women who had obstetric consultations in more than one period, had them mostly in the antenatal and intrapartum periods (29.4%).

Where there was an antenatal consultation, the midwife accompanied the woman to the first consultation in 40% of cases. This was most likely to happen where the referral was made to an obstetric team, rather than to a known obstetrician, and least likely where the visit was to a private obstetrician.

The reasons for antenatal referrals were numerous (Figure 1). The question of 'reason for referral' was a multiple response question so the midwives were asked to provide as many reasons as they felt were appropriate. In the antenatal period no reason for referral was provided in 20 cases and thus was classified as missing data. Ten of the referrals had two reasons, and in six cases of referral there were three reasons provided.

The most common reasons for antenatal referral were pre-existing medical conditions and 'other'. There were also many referrals for prolonged pregnancy. The large number of referrals for 'other' was expected, as most existing referral and admission databases have a very high rate in this category, reflecting the variety of possible complications of pregnancy that can occur (New Zealand Health Information Service, 2003; Wallace et al., 1995).

Eight hundred and eleven (57%) of the referrals occurred in the intrapartum period. As with the antenatal period, the reasons for referral were numerous and there was also a large number of referrals for 'other' (Figure 2). There was a significant number of referrals for fetal distress. However, most intrapartum referrals were made for lack of progress.

Of the 1477 women who had a consultation in any period, 43% (608) had the clinical responsibility for their care transferred to the obstetrician. Once transfer of clinical responsibility had occurred, 74% (415) of these 'transferred' women continued to have some midwifery care provided by their LMC midwife (Figure 3). In 26% (108) of cases the midwives who continued care received no payment. One hundred and forty nine women had no ongoing care with their midwife. This represents 10.4% (147) of all the women who had referrals for obstetric consultation and 3.5% of the total caseload of the midwives. Ninety six percent of women cared for by this group of midwives therefore, maintained contact with, and received some midwifery care from, their original LMC midwife through the childbearing process, regardless of their level of risk (Skinner, 2010).

	N*	%	Mean	SD	Range	95%CI
Age	1387	100.0	28.8	6.0	14-46	28.5, 29.1
European	1012	71.7				69.3, 74.1
Maori	236	16.7				14.7, 18.7
Pacific	70	5.0				3.8, 6.2
Asian	56	4.0				3, 5
Other	22	1.6				0.9, 3.3
Parity						
0	474	34.1				31.6, 36.6
1	466	33.5				31, 36
2	270	19.4				17.3, 21.5
3	98	7.1				5.7, 8.5
>3	82	5.9				4.6, 7.2

Table 1: Demographic data of women referred to obstetric consultation.

When asked about the usefulness of the referral guidelines most midwives responded that they were a useful tool (Figure 4).

This practice of staying 'with women' despite the level of risk was reflected in the answer to the attitudinal question which asked whether LMC midwives should care only for low risk women. Seventy percent of the midwives disagreed with this statement (Figure 5). Thirteen percent neither agreed nor disagreed.

The survey revealed that midwives, despite there being identified risk factors in women and

transfer of clinical responsibility, continued to have a strong commitment to being with women. They were frequently present at the first antenatal consultation, and continued the midwifery component of care once obstetric care was required. They overwhelmingly disagreed with the statement that LMC midwives should care only for low risk women.

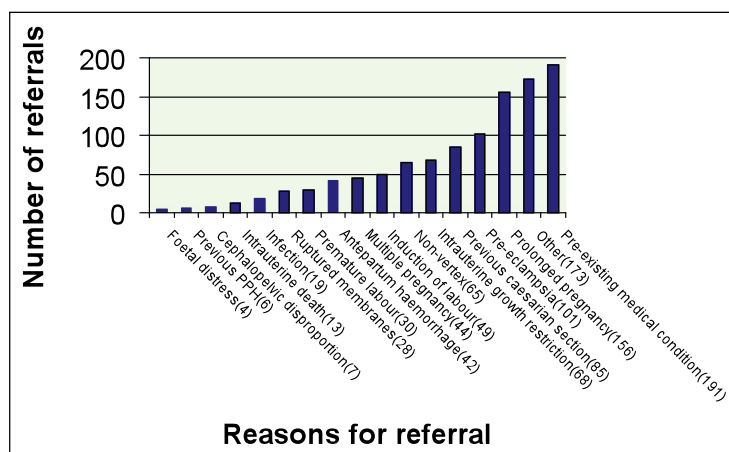
### The focus groups

The focus group data confirmed this finding. Throughout the conversations the woman was seen as central in the provision of care. Of the

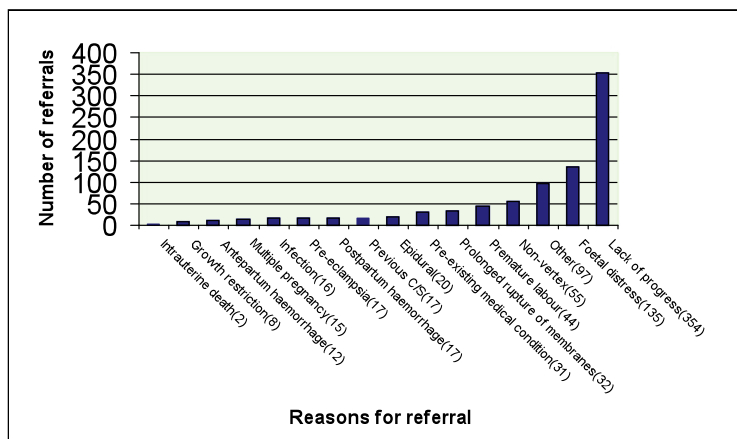
Childbearing episodes in which women were referred	Number	% (95%CI)
Antenatal only	516	36.6% (43,39.2)
Intrapartum only	383	27.3% (24.5,30.1)
Postpartum only	22	1.5% (0.9, 2.1)
Antenatal and intrapartum	411	29.4% (27,31.8)
Antenatal and postpartum	23	1.5% (0.9, 22.1)
Intrapartum and postpartum	17	1.2% (0.6, 1.8)
All three episodes	36	2.5% (1.7, 3.3)
Total	1408	

Table 2: Numbers of women referred according to childbearing episode.

Figure 1: Reasons for antenatal referrals



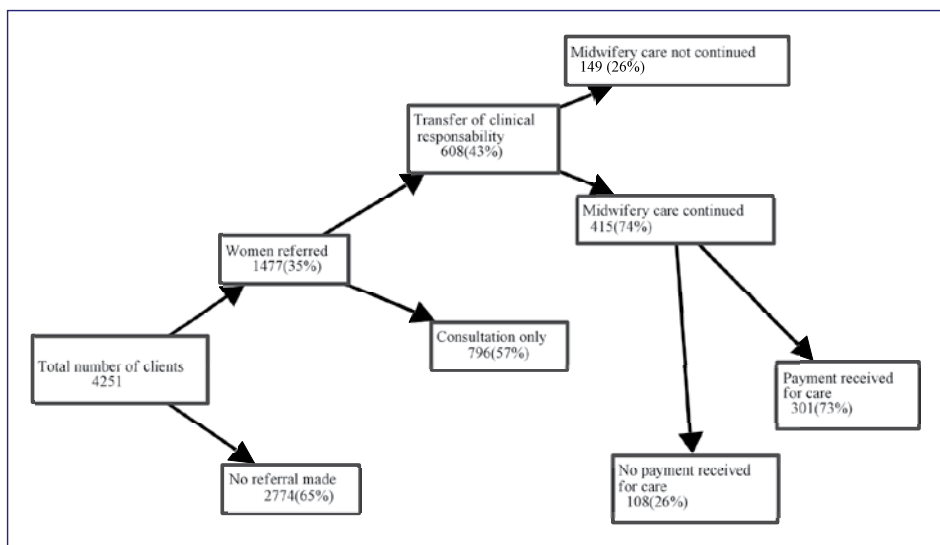
**Figure 2:** Reasons for intrapartum referrals



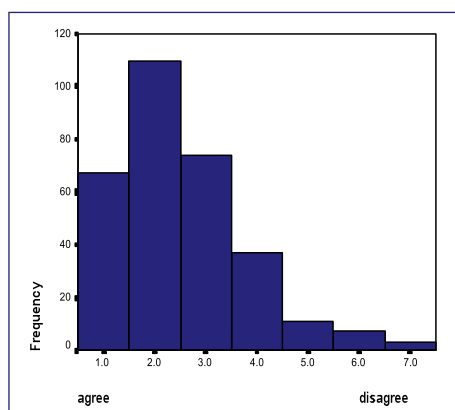
four core themes that emerged, the central theme—from which the others emanated—was named ‘being with women’. The other three themes provided support for the midwives as they focused on meeting women’s needs. They are named ‘working as a professional’, ‘working the system’ and ‘working with complexity’. An in-depth discussion of these three themes is reported elsewhere (Skinner, 2010). Being ‘with

women’ then remained the focus of the midwives’ work and they went to some effort in order to support and be alongside her on the journey into motherhood, whether or not she required obstetric assistance. The discussions were heavily laden with stories from practice, connecting the midwives with the women for whom they cared. The real, complex, and challenging work of meeting the needs of the women was seen as paramount.

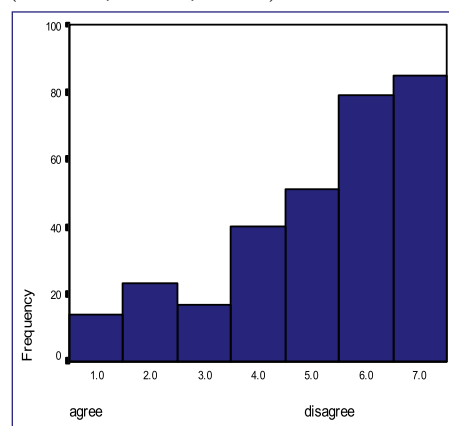
**Figure 3:** Numbers of midwifery referrals for obstetric consultation, transfer of clinical responsibility, and midwifery care continued (Skinner & Foureur, 2010)



**Figure 4:** The referral guidelines are a useful tool when I consider the need for referral



**Figure 5:** LMC midwives should care only for low risk women (Median 6, Mode 7, N=309)



Many women were seen as having some degree of complexity where attention to risk was needed, whether or not a referral was required.

This central theme was broken down into three subthemes: ‘holistic care – being their anchor’, ‘having a relationship – continuity and trust’ and ‘informing choice and communicating risk – things can change’.

**Holistic care – ‘being their anchor’**

The midwives had an holistic view of the woman rather than compartmentalising her into a low risk or high risk ‘case’. As these discussions proceeded, the issues that the midwives raised were often pertinent to all women no matter how their risk status might have been identified. However, when women developed risk characteristics, rather than seeing this as an impediment to their continued participation, most of the midwives saw that their input was even more important.

*My suspicion is that for the woman to have the midwives with them, there’s still aspects of their care that are normal for them and so those things in a crisis situation can get lost. That there’s someone there who, even though decisions have to be made really quickly, that person is still capable of what they can decide. And I think if the midwife’s there, then for the woman there’s more of a ‘well how can we do this that it’s best for the woman?’ (Mary)*

**Having a relationship – ‘continuity and trust’**

For many of the midwives trust was a central part of the relationship that they established with the women over the time they got to know them. This relationship was seen as even more important when risks were identified

*I would also say that in high-risk women, often the risk is minimised by that continuity and trust and they are so much more relaxed. So you actually can often alleviate some of the symptoms and side effects. (Fran)*

*Yeah, and it can be that emergency response or it can be that anticipation of guiding them in a different direction and helping them to make those decisions. And they trust you to do that because we’ve worked with them through their pregnancy. (Patti)*

The midwives valued the relationships that they developed with the women. They did see, however, that the risk environment threatened the development of the trusting relationship and distanced them from the woman.

*And I was saying at a meeting the other day, my midwifery’s changed from the early nineties to now. I see myself as in a much more risk situation in the relationship with the client than I did when I first started going to home births, where that relationship was really close and trusting and very friendly and warm. And now I feel like I’m removed because I’m protecting myself really with more documentation, more knowledge of what can go wrong and what has gone wrong for other midwives. (Fran)*

Within practice, apart from being affected by the risk environment, midwives also had to establish relationships knowing that partnership, where it existed, was tentative and where trust did not exist, risk was increased.

## Informing choice and communicating risk – ‘things can change’

The way the midwives in the study provided information and support for the choices that women made in relation to risk, acknowledged and incorporated a value-laden approach to risk. It seemed that the connection that the midwives had made with the women and their families, facilitated decision-making that was more related to how the women perceived the problem and could understand risk, rather than being focused primarily on the scientific evidence. The following excerpt, related to the decision about whether to give Vitamin K to the baby at a birth, is typical of the way many of the midwives spoke:

*I often ask them about their decision-making processes and how they make decisions in their ordinary life and how they might make decisions as parents and that this actually may be one of the first ones that they will be making. And whether they like to make decisions that are based on research or decisions that are based on their life philosophy or decisions that are based on doing something to protect their baby, or doing something that is perceived to be seen as protecting your baby, or not doing something that is seen to be protecting their baby. (Pat)*

*And of course there are some that will say ‘oh I don’t care, you know, do what you think’. Most people do. With most people it’s quite common (Marg)*

*‘What would you do or what have you done?’ That’s what I get often. (Jo)*

None of the midwives in the groups mentioned that they provided a statistical indication of risk as a matter of course. They seemed more concerned about reducing anxiety and fear in the mothers and tended to avoid using the word ‘risk’ at all. They often seemed protective of the women, yet at the same time viewed the woman’s choice rather than the midwives’ choice as both pivotal and final. There was some tension therefore between protecting the mother and informed choice, and there was clearly an understanding that risk decision-making on the part of the women was not necessarily rational.

*It’s difficult though because if you dwell too much on that and they’re an anxious person it’s going to be very counterproductive. That’s the problem. Sometimes too, like, in say a primip wanting a home birth. They’ll say things like ‘so what would make you have to go to hospital?’ And that’s sort of like an opportunity to talk about the kind of things they want to experience. (Patsy)*

*But I don’t always think that we actually use the word risk. I always find myself using words that take it away from increasing fear into saying ‘this could change from what you wanted it to be’. (Yvonne)*

In their dealings with women, the midwives seemed to take on the role of mediating risk. They were, in a sense, attempting to protect the women from anxieties associated with risk, avoiding the use of the word. It was paramount that women should approach childbirth with confidence rather than with fear. It was important to develop trusting relationships, and for the woman to have confidence in the midwife’s decisions. In protecting the woman from anxiety they therefore tended to take on risk themselves.

## Discussion

There are two important findings of this research, both of which have implications about what should be retained and protected as fundamental midwifery values. The first is that midwifery, as practised in New Zealand, is not about caring only for low risk women, but about being with all women as they give birth. The survey revealed that 35% of women required a referral for obstetric consultation for a variety of reasons most of which were one-off consultations. However, when there was a need to transfer clinical responsibility, the majority of the midwives continued to provide some midwifery care. In their discussions about risk, the midwives did not distinguish between their attitudes to women with different risk diagnoses. This has not been explored in any other midwifery literature, and may well be unique to the way New Zealand midwives provide continuity. The second finding is that this belief in continuing care, even when risk was identified, was based in the relational nature of midwifery. The ‘being with’ was revealed not only in how the midwives spoke about practice but was also revealed in how they acted. Being ‘with women’ is clearly not mere rhetoric but is acted out in practice. The recently updated referral guidelines, continue to support continuity of maternity care and women-centeredness, but some consideration needs to be given to the continued ability and/or commitment of LMC midwives to stay and work closely ‘with women with risk’. This research was completed in 2005 and provides a snapshot of midwifery’s position and practice at that time. It is suggestive of midwives being highly committed to being with women despite the identification of risk. The question must be posed as to how the next generation of midwives will feel about being so closely involved with women with risk. As we acknowledge a growing body of knowledge identifying the challenges of working this demanding model (Cox & Smythe, 2011; Wakelin & Skinner, 2007), and the continued pressure of accountability, we need to keep attentive to: if and how midwives might be shifting in this way of working and how best to provide care in ways which sustain midwives to be able to do this.

## Strengths and Limitations

This research provides strong evidence of midwives’ commitment to being with all women as they make the transition to new motherhood, despite the level of risk. Both the high response rate and the mixed method nature of the study, added validity. However, the study did not examine the attitudes of core midwives towards: the referral guidelines, continuity of midwifery care, or the extent to which they can support the LMC model. Additionally it did not explore the processes of consultation and referral. Further research needs to be undertaken both into how today’s LMC midwives are faring in managing to stay with women with risk, and how best to support collaboration. Further work needs to examine how the current model of care works collaboratively, exploring how midwives in all settings—LMC midwives, core midwives, managers and educators— support each other when the women in their care are experiencing complexity.

## Conclusion

Midwives face considerable challenge in working the balance between the normality and the riskiness of childbirth. The risk context in which they work puts pressure on them, both to support the normal process and identify and act on risk, both at the same time. There is often a fine line which can be difficult to discern. What the midwives do manage to do is to keep women at the centre of care. They demonstrate this in the extent to which they stay involved when women’s care becomes complex. In order for our community to support midwives to continue to do this in the future, attention needs to be paid to ways that facilitate this. The referral guidelines have been one such support mechanism and the revised guidelines continue to do this. They support midwives and the midwifery profession to identify risk and to refer appropriately. We need to ensure that they are used thoughtfully and collaboratively.

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# The Effects of Childhood Sexual Abuse on Labour and Birthing: an Exploration to Assist Midwives

**Authors:**

- Ellen Clark MA (Health Practice), BN, SCM, RN, Midwife  
High Dependency Unit,  
National Women's Health  
Auckland City Hospital  
Email: ellenc@adhb.govt.nz
- Liz Smythe PhD, RM, RN  
Associate Professor  
Division of Health Care Practice  
Auckland University of Technology

**ABSTRACT**

The subject of childhood sexual abuse has found considerable attention in the popular press in recent times. While the common focus appears to be on the perpetrator of the abuse, less attention has been devoted to the effects of this abuse on the survivor, particularly on the effects for a childbearing woman. This article draws on the relevant professional literature and close observation using the heuristic of experiential anecdote to provide a practice context for midwives.

**INTRODUCTION**

Most, if not all, midwives have at some point pondered the unpredictable behaviour of some women in labour. When a woman dissociates, becomes inordinately tense, or when labour unexpectedly slows, health professionals are increasingly suspecting a history of childhood sexual abuse (CSA).

CSA has been variously defined. There is a loose consensus amongst authors though no generally accepted definition. Sanderson has, however, provided a useful definition of CSA:

*The involvement of dependent children and adolescents in sexual activities with an adult or any other person older or bigger, in which the child is used as a sexual object for the*

*gratification of the older person's needs or desires and to which the child is unable to give consent due to the unequal power in the relationship.* (Sanderson, 1990, as cited in Baker, 2002, p.29).

As there is an estimated incidence in New Zealand of between 20 and 30 per cent (Fyfe, 2005) midwives will regularly care for women for whom CSA is a reality. This highlights the fundamental importance of seeking to develop an understanding of this subject for midwifery practice.

This paper explores some of the key themes and issues relating to the identification of post abuse-related problems. It begins with a short discussion on general aspects of CSA. This is followed by the presentation of two anecdotes which represent the way in which some survivors of CSA may present. These anecdotes have been constructed in such a way as to reflect insights obtained through many years of midwifery practice. Midwives, however, are cautioned against assuming that all unpredictable behaviour exhibited by women in labour can be attributed to a history of CSA. Following this is a discussion of the effects of past sexual abuse upon women during childbirth and their implications for practice. Included is a summary of the main elements of 'universal precautions' in the childbirth context. These insights are offered to empower midwives to provide care which not only seeks to avoid re-victimisation but which also may begin to bring about healing for the mother.

**BACKGROUND**

Owing to the myriad health problems that arise as a result of CSA, there is on-going debate surrounding the best approach to this issue in the childbirth setting. Many practitioners advocate the routine screening of women for CSA (Courtois & Riley, 1992; Seng & Hassinger, 1998). Screening for family violence is mandatory in New Zealand and indeed it is recommended that the screening be repeated regularly throughout the pregnancy. However, many women with CSA experiences, as women who have had family violence issues, are reluctant to disclose such abuse. Other women would not disclose abuse simply because they have no memory of it. Some authors have proposed instead the alternative measure of

'universal precautions'. This term was first used by health professionals to describe a means of protecting health workers from blood-borne infections such as Hepatitis B and HIV Aids. This phrase has recently been applied in a mental health setting, and is eminently suited for use with CSA survivors. Coles and Jones (2009) have re-coined the phrase, proposing a way to "protect vulnerable patients from physical and psychological trauma" (p.203). This concept is expanded upon later in the paper.

Rhodes and Hutchinson (1994) state that CSA "impacts on every aspect of sexuality and its expression in personality" (p.213), and indeed its effects have the potential to intrude into all aspects of adult life. Sexual identity, self-concept, anxiety and depression as well as learning difficulties, dissociative disorders, survival prostitution, substance abuse, poor parenting, and post-traumatic stress disorder may all have their roots in CSA (Rhodes & Hutchinson, 1994; Hobbins, 2004; Seng & Hassinger, 1998). Manifestations will differ between individuals as each CSA survivor will have dealt with, or will be dealing with, the trauma in her own unique way. Kendall-Tackett (2004) commented:

*On one end of the continuum is the abuse survivor who experiences the birth as the ultimate healing experience, on the other is the woman who feels that her birthing experience is tantamount to a recurrence of the sexual abuse.* (p. 205)

Of critical importance here is the fact that sexual abuse is the genesis of many physical and emotional problems. It significantly increases the risk of an individual developing a mental illness in adult life (Glaister & Abel, 2001). Regrettably, the usual approach is to treat the physical manifestations rather than the root of the problem (Geller, 1998; Monahan & Forgash 2000; Waymire, 1997). According to Geller, the mental illness of CSA survivors has its origins not in an inherent predisposition to mental illness, but in the sexual abuse which was "a violation of their very being" (Geller, 1998, as cited in Hobbins, 2004, p. 487).

**ANECDOTES FROM PRACTICE EXPERIENCE**

Reflection is an integral part of professional practice and allows one to explicate the meaning

of practice. Reflective thinking emphasises the consequences of ideas and implies future physical action (Dewey, 1933). The practising midwife is involved in close observation of those in her care and is thus, wittingly or unwittingly, a collector of experiential material. Close observation, like the midwifery partnership itself, assumes a close relationship (Guilliland & Pairman, 2010). At the same time, the retaining of a “hermeneutic alertness to the situation”, van Manen (1990) asserts, “allows us the perspective to reflect on the meaning of the situation” (p.69). Those who involve themselves in closely observing situations for their lived meaning, he claims, are gatherers of anecdotes.

An anecdote is a succinct, evocative description, which emerges from varied accounts of a type of lived experience, and is a device which “make[s] comprehensible some notion that easily eludes us” (ibid, p. 116). According to van Manen (1997), the close observation method is reflective; requiring one to be both participant and observer at the same time. Van Manen (1990) emphasises the importance of developing a keen sense of the point inherent in the anecdote. In a midwifery practice spanning in excess of three decades, the authors have had an abiding interest in women who are survivors of sexual abuse. This has brought with it a significant alertness to cues. As we reflect on, and draw together practice realities and relevant insight from the literature on the subject, recurring client profiles emerge. These women’s stories express some of the myriad problems faced by survivors of CSA in the childbirth experience, presented here as anecdotes (van Manen, 1990).

The purpose of the anecdotes presented below it is not to declare “truth” but rather to open the reader to possibilities of thinking, engendering alertness (Smythe, Ironside, Sims, Swenson & Spence, 2008). The anecdotes have been written in a manner to make them seem real; while they are based on real women, they represent no single individual’s story.

### JENNY

*Jenny, a thirty-four year old teacher expecting her first baby presented in early labour to the birthing suite. After initially requesting early in the pregnancy that her baby be delivered by caesarean section, she had been convinced of the wisdom of preparing for a normal vaginal birth. Jenny had booked early and conscientiously attended all her antenatal appointments and childbirth education classes. Both she and her husband, Jeff, who had accompanied her to the birthing suite, had prepared well, reading widely and attending hypno-birthing classes.*

*On arrival at the birthing suite Jenny was armed with a detailed birth plan to ensure that she would achieve a normal birth, unimpeded by the use of analgesia or unwanted medical intervention. Jenny seemed comfortable with the normal admission process but became distressed with the mention of an examination per vaginam. When the procedure was explained and she was asked to position herself in preparation for the examination, she appeared to freeze. She turned her head away from*

*the midwife and simultaneously tensed her buttocks and vaginal muscles to the midwife’s examining fingers. While giving careful encouragement, the midwife was finally able to complete the examination but she reported later to a colleague that she felt as though her fingers would become ischaemic. Jenny seemed embarrassed about her discomfort at the time of the vaginal examination but did not verbalise the origin of this discomfort. Her husband however confided to the midwife privately that he had long suspected that Jenny had suffered sexual abuse at the hands of her father.*

*At the completion of the examination per vaginam, Jenny was informed that her cervix was three centimetres dilated and fully effaced, with ruptured membranes. These comments were met with a look of discouragement on Jenny’s face. She had, she said, been having strong surges (contractions) for fifteen hours already and thought that she would have been much further on. The midwife reassured her that first babies took quite a long time to come. She said that Jenny was making progress and this was evidenced by the fact that she had effaced her cervix. Jenny appeared tense and seemed to be distressed with the contractions. She made use of the bath for pain relief and used hypno-birthing which helped her to cope with her surges.*

*After several hours Jenny’s midwife informed her that it was usual to re-examine the cervix to assess progress in labour and perhaps use syntocinon to speed up the labour. This brought a renewed distress in Jenny. She said that she was not keen on the use of syntocinon and did not consent to this. The midwife said that of course she would respect her wishes, and Jenny seemed to relax a little. The next examination per vaginam was as difficult as the first and findings were the same as in the previous examination with the fetal head high. Jenny appeared defeated and her midwife said she would leave her with her husband to think about whether she would like some pain relief as she was looking a little tired. She reassured her that the baby seemed fine.*

*On returning to the room Jenny’s midwife found her more composed and she announced that she would like to walk around in the hope that this would help make the contractions more effective. Jenny’s midwife was encouraging, saying that mobilisation was indeed a good thing to do. Jenny continued to mobilise and four hours later she again consented to a further vaginal examination. This time Jenny’s cervix was found to be five centimetres dilated and the fetal head was found to be in the occipito-anterior position. There was neither caput nor moulding of the fetal head. Jenny’s midwife was also keen to give her intravenous antibiotics as Jenny’s membranes had been ruptured for 24 hours. Jenny was initially not happy but reluctantly agreed to this. Jenny seemed particularly upset when her midwife suggested that an intravenous infusion be commenced for hydration.*

*Reluctantly Jenny agreed to her midwife consulting with the hospital obstetric team as the progress had been slow. The obstetric consultant recommended epidural analgesia*

*and augmentation of the labour with syntocinon. The consultant’s view being that the epidural would allow Jenny to relax and descent of the fetal head to take place. Jenny’s baby was subsequently delivered by lower segment caesarean section, when, at the next vaginal examination, there was noted to be no further progress in labour.*

## DISCUSSION

On the surface, Jenny displays few signs of her abuse. She appears well adjusted and is outwardly functioning at a high level. Holz (1994) observes however that the overachieving, overworking individual “who continually neglects her own needs to meet everyone else’s is just as likely to have an abuse history as the drug addict who smokes heavily and presents with pelvic inflammatory disease” (p. 14). Jenny may or may not be aware of her CSA. Survivors of CSA may have partial or total amnesia. This survival mechanism prevents survivors being overwhelmed by the enormity of the abuse on their psyche. Hobbins (2004) explains that repressed memories may resurface at any time but, until this time, the psychological and emotional pain is kept carefully ‘under wraps’ in the protective mechanism.

Childbirth may, owing to its physical nature, act as a primary trigger to memories of CSA. ‘Flashbacks’, or the re-experiencing of abuse as if it were actually happening, may be triggered by examinations per vaginam or indeed by the pain of labour itself (Kendall-Tackett, 2004; Rhodes & Hutchinson, 1994; Waymire, 1997; Heritage, 1998). Rhodes and Hutchinson (1994) have described four distinctive coping styles which a CSA survivor may adopt in labour. These are: taking control, surrendering, retreating and fighting. The latter is a panic response or self-defensive posture. These styles are not mutually exclusive and survivors may employ a number of styles in the course of their labours.

Jenny’s dominant style clearly is taking control. Women demonstrating this behavioural style may show signs of anger and appear mistrustful of their caregivers. They may display this by controlling behaviours such as insisting on an inordinately detailed birth plan, incessant questioning, and demanding an explanation for every action and intervention. Intimate examinations are difficult for most women but especially so for many survivors of CSA. Jenny found examinations per vaginam particularly difficult. She appeared frightened and found it difficult to relax. It was inordinately difficult for the midwife to perform the examination because of Jenny’s tense vaginal and buttocks muscles. From the outset, Jenny avoided eye contact with her midwife at these times. Midwives may choose to delay examinations per vaginam until labour appears to be established unless there is a pressing need to perform one. Midwives can also make the procedure more acceptable by providing adequate explanation and helping the woman by instructing her to breathe deeply and by performing the examination slowly and gently.

Midwives may also use their skills to avoid performing unnecessary examinations per

vaginam. Anecdotally midwives have for some time noted the phenomenon of the reddish purple line. Byrne and Edmonds (1990) described this clinical sign which indicates the progress of the first stage of labour without vaginal examinations.

*This sign is a line of red/purple discolouration seen to arise from the anal margin and extend cranially between the buttocks; the onset of the second stage of labour is indicated when it reaches the nape of the buttocks. The line may arise because of the vaso-congestion at the base of the sacrum. This congestion possibly occurs because of the increasing intra-pelvic pressure as the foetal head descends which would account for the correlation between the station of the foetal head and the red line length (p. 122).*

Simkin (2005) commented on the labours of CSA survivors claiming that such women are more likely to have a caesarean section for 'failure to progress'. Their non-abused 'sisters' on the other hand are more likely to have an operative birth as a result of fetal mal-position. Simkin (2005) labelled this phenomenon emotional dystocia. In this form of dystocia, emotional distress causes excessive catecholamine production. This in turn reduces uterine and placental circulation during labour and causes inefficient contractions and reduced fetal oxygenation. The psyche of the woman exerts a powerful effect on the progress of labour. Smythe (2000) relates such an example:

*It was a homebirth. The woman had made no progress at all. Her sister was fluffing around. I didn't pick it up right away that that's what the problem was, because her sister was very attentive. And so eventually her labour stopped. I took the woman aside and I said "well what's the problem? She said "well it's my sister and I can't ask her to go home. I said "I'll ask her to go home", so I explained to her that the labour had stopped and that it would probably be a good idea if she went home and let the woman have a rest. What it turned out was that this girl had been sexually abused by her brother and when she told her sister, the sister denied this could have happened to her. So there was all this hostility between them. As soon as the sister went, away went the labour and she had a nice normal birth. (p.19)*

This example illustrates the wide ramifications of CSA. It points towards the disruption of family relationships through the victim's experience of not being believed, and the resultant damage to family loyalties. Something about the on-going hostility had influenced the progress of labour.

Rhodes and Hutchinson (1994) conducted an ethnographic study of labour experiences of CSA survivors. They reported the claim of some incest survivors that labour triggers the re-experiencing of the sexual abuse through 'body memories'. Hobbins (2004) explains that one's physical body has the potential to store the feelings and activities of sexual abuse; these are then re-experienced by the survivor. The channelling of these memories within their bodies by some survivors, Hobbins claims, contributes to the development of such systemic

conditions as chronic pelvic pain, and eating disorders (p.492)

Kitzinger (1990) reported one woman's recollection of abuse. The woman related that her father had tied her up prior to raping her. Labour served to recall to her consciousness the memory of the abuse. She described her experience as follows: "I was spread-eagled on a bed. My arms tied to drips (intravenous lines), someone fiddling around down there – it brought back the bondage." (p. 39)

#### SALLY

An alternative revealing is conveyed through Sally's life story. Her story, by contrast, leads one more readily to the prospect of a history of CSA and re-victimisation.

*Sally, a twenty-eight year old, former sex worker, was a 'late booker' and poor attendee of antenatal clinic appointments. Sally had been a rebellious teenager, frequently being truant from school, leaving home early and experimenting with illicit drugs. She had been involved in many relationships, some of which had been abusive. She had suffered from bouts of depression and been involved in self-harm. She had however recently met Trevor who had been a stabilising influence in her life. Both she and Trevor were excited about the pregnancy and together were committed to becoming smoke-free.*

*On admission to the hospital Sally did not seem unduly distressed by her labour. Having no birth plan she informed her midwife that she was happy to "go with the flow" and rely on her midwife's advice. Unlike Jenny, Sally did not seem at all distressed by the vaginal examination. Sally's midwife in fact was surprised at how relaxed Sally was, and commented so to Sally. Sally readily agreed to her midwife's suggestion that she rupture her membranes as the cervical os was already 5 cm dilated and in her opinion this would expedite the labour. Once the membranes had been artificially ruptured, the labour became very intense. Sally, however, who had seemed to be managing the pain with relative ease, now became very distressed as the contractions became more intense. She began screaming in an uncontrolled manner, and requested "something for the pain". She declined an epidural explaining that the thought of a needle in her back scared her. A pethidine injection provided some respite, and Sally dozed fitfully between contractions. Sally progressed to full dilatation but then appeared to 'freeze' - not wanting to push. She seemed instead to be retreating into her own space. When encouraged to bear down with contractions she did not seem to be able to coordinate her bearing down effort and it was some time before she achieved this. After what seemed a considerable time Sally gave birth to her daughter.*

## DISCUSSION

Sally's late booking meant that she had not received comprehensive antenatal care. This is a common occurrence, Coles, (2009) points out, some CSA survivors feel unsafe, making it difficult for them to access care (p.235). This is particularly concerning as many of these women

may experience infection, pain and medical problems with a greater frequency than those who have not suffered abuse.

Sally's reaction to labour was, from the outset, submissive. In response to vaginal examinations she appeared uninhibited and merely relaxed her legs and permitted the midwife to proceed with the examination. Rhodes and Hutchinson (1994) in their discussion of the coping styles of CSA survivors, describe the surrendering or submitting style. This is in contrast to the 'fighting' style which is more likely to alert the caregiver to the possibility of CSA. Those with a submissive coping style might have learned to dissociate, the defence of last resort which Salter (1995) asserts, occurs "when trauma cannot be prevented, endured or escaped" (p. 235). Dissociation, Holz (1994) explains, causes a split between mind and body, a "numbing out", or the ability to be "off in the distance watching what was happening to their body but not to feel it" (p. 15).

Sally was keen to please doctors and midwives and readily agreed with the midwife's suggestion that she have her membranes ruptured. She was easy to care for and seemed very agreeable. This submissive attitude can be mistakenly taken for 'compliance'. With the membranes ruptured and the labour being now more intense, Sally suddenly appeared out of control. She had managed well to this point but had exhausted her reserves. Rhodes and Hutchinson (1994) have commented that survivors of CSA may be averse to epidural analgesia as they are frightened by the prospect of being confined to bed with no freedom to move. This may bring back memories of the situation in which they found themselves at the time of their abuse.

Sally's reaction in the second stage of labour would perhaps have come as a surprise to her midwife who may have mistaken Sally's submission earlier in the labour for a relaxed easy-going attitude, or merely as a willingness to 'comply'.

The second stage of labour, challenging for most women, can be particularly terrifying for CSA survivors. Rhodes and Hutchinson (1994) claim that the actual pushing of the baby through the birth canal can cause the CSA survivor to experience a 'flashback,' or even use dissociation as a means of coping. The baby moving through the vagina can be experienced as forced penetration, so the process may be experienced as an earlier rape. Authors have commented that:

*When a sexual abuse survivor becomes fully dilated, progress in pushing may be particularly difficult because she misdirects her pushing energy into the upper part of her body. She tenses her vaginal muscles, raises her buttocks off the bed, and arches her back and neck. (Rhodes & Hutchinson, 1994, p. 216)*

It is especially important at this time that the midwife be present for the woman. She must resist the temptation to judge the woman for her apparent unwillingness to cooperate. The midwife can instead provide her client with the gentle reassurance that she can do this, and that her body is capable of carrying through until her baby is born.

## IMPLICATIONS FOR PRACTICE

Inherent in the term midwife (with woman) is the special relationship midwives form with the women they care for. Contingent with this is the responsibility of midwives and their professional colleagues to be informed as far as possible of the physical and psychological needs of the women in their care. This is not always an easy task especially for core midwives working in birthing suites. In such situations, midwives have often not previously met the women for whom they must provide sensitive and appropriate care during labour and birthing. Some CSA survivors will be known to the maternity service as they will have difficulties with addictions and problematic lifestyles in general. These at-risk women are able to benefit from a multidisciplinary approach, with input from social workers, clinical psychologists and physicians skilled in their care.

Coles and Jones (2009) conducted a semi-structured qualitative study of eighteen women. They concluded that survivors of CSA may experience pain, dissociation, fear, blame, helplessness and guilt at the hands of their health care providers. As a result of this work they developed a set of 'universal precautions' for health professionals caring for women and their children. These were strongly focused on the notion of informed consent. The following is a discussion of these precautions:

### Consent

Coles and Jones (2009) emphasise that consent should never be assumed. While consent may be given by a 'yes' or a non-verbal nod, consent is also embodied in the woman's response to what is happening. If she becomes tense, defensive, withdrawn or exhibits other behaviour that suggests she is not at ease with the procedure, consent can no longer be assumed.

### Continuing consent

The health professional is advised to recheck with the woman that she is still comfortable with the examination proceeding and be prepared to stop at the woman's request or in response to her distress. Yet there can be a tension for the person doing the vaginal examination if they know that the findings could make a difference between the woman being left to progress to a vaginal birth or to be taken for a caesarean section. The woman needs to be kept fully informed so that she also appreciates the need for assessment information.

### Consent for baby examinations

Maternal consent for all procedures and examinations relating to the baby should be sought following a thorough explanation of all important aspects of the procedure or examination. CSA women may feel very protective of their babies. Practitioners need to be sensitive to the possibility that any woman may lack trust in handing her baby over to other people.

### Explanations

Any necessary professional touch should be preceded by an explanation which includes what is to be done and why, with alternatives if possible. The practitioner needs to be careful to remain attuned to each situation. If it is clear

that there is a strong bond of trust established, and the woman is focused on other things, long explanations may not be welcomed. It requires alertness and responsiveness to each situation including assisting with breastfeeding and bathing the baby.

### No procedure or examination should be 'routine'

The likelihood that most professionals will not be informed of the woman's past history of CSA, should mean that no procedure or examination may be undertaken as 'routine'. The concern is that midwives and obstetricians may forget that it is not essential to do an examination per vaginam. When practice becomes 'routine' and assessment results 'expected' it is easy to forget that the woman still has the right to say 'no'.

Implicit in all this is the principal precept of medical ethics, non-maleficence, summarised by the maxim "first do no harm". Jackson and Fraser (2009) explored United Kingdom (UK) midwives' knowledge and attitudes towards caring for women who have been sexually abused. A strong theme of 'avoidance of harm' was apparent; midwives clearly recognising the potential for the re-traumatising of survivors of CSA within the maternity service. Inextricably linked to the avoidance of harm is the notion of 'being safe'. Smythe (2003) reminds us that the meaning of 'being safe' lies in the experience, and that the midwife must always be open to what she does not yet know. A woman may speak to her midwife in a variety of ways. She may be silent or display uncontrollable rage; she may seek a reassuring hug or she may find touch intolerable. Survivors of CSA with their attendant problems will indeed challenge midwives' ability to provide sensitive care for them. Midwives, however, must not shrink from the task of understanding the many ways in which CSA survivors may reveal their situation. By using the principles of 'universal precautions' and listening to what women themselves require in order to be safe, midwives will be equipping themselves to provide a high standard of care. This, it is hoped, will bring about empowerment for some of the most vulnerable of women.

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## BOOK REVIEW

# Qualitative Research In Midwifery And Childbirth: Phenomenological Approaches

### Authors:

- Thomson, G., Dykes, E. & Downe, S. (Eds) 2011
- Published by Routledge, London and New York
- ISBN 978-0-415-57501

Reviewed by Susan Crowther  
BSc (Hons), MSc, RM, RN,  
PhD Candidate,  
Midwife Lecturer  
Rural Locum Midwife

This has been a long awaited publication, providing a wonderful, erudite exposé of what phenomenology is, and how to do it. Phenomenology can bring us closer to a truer understanding of the meaning of experiences in

and around childbirth, for all those involved. This book would suit all levels of knowledge and can be revisited again and again. It provides a well referenced anthology of midwifery-related research projects—using this methodology—that illustrates the author's passion and commitment to this mode of enquiry. The book emphasises the philosophical underpinnings of phenomenology and the various philosophers and researchers that have contributed to the development and deepening of this popular approach to health science research. The reader is taken on a journey of the personal lived experiences of each of the authors through their respective chapters. All three authors have undertaken this approach to research. The expertise and experience provided in these pages are valuable assets to anyone seeking to use or/and understand phenomenology. Words, such as: hermeneutics, epistemology, ontology, life world, epoché and Dasein, are explicated throughout the book.

The use of phenomenology in childbirth research allows rich, moving and emotive subjects to be examined. The research projects presented in this book, such as the lived experience of lesbian women in gynaecological services, and the experience of women with severe pre-eclampsia, help reveal a world often concealed from us in

practice. There are chapters on the experience of 'abandonment of being' in traumatic birth, the lived experience of parents participating in the care of their babies in NICU, and the harrowing, in-depth uncovering of the world of post natal emotional illnesses and how the different types are defined through the words of the women interviewed. There is a wonderful chapter on interpreting 'being with women' using midwives' poetry. The editors have brought together and crafted a wonderful book. From a New Zealand perspective we should be proud to see how well we are represented in this international publication. Three New Zealand-based researchers have contributed to this publication: Liz Smythe, Joyce Cowan and Marion Hunter. If you are contemplating starting out on a research project, are involved in one now, or just want to understand more about this way of researching, you will be rewarded by this book. If you have not yet read any phenomenological research or are perhaps sceptical of its value in 'serious' academic circles, or worry about the usefulness of the findings from such studies, you could become both surprised and 'hooked-in' by the freshness and aliveness by reading this important contribution to the development of midwifery research.



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