Fenerbahçe Üniversitesi
Sağlık Bilimleri Dergisi
Cilt 2, Sayı 1, 290-298, 2022

Fenerbahce University
Journal of Health Sciences
Volume 2, Issue 1, 290-298, 2022

FBU-JOHS

A Lighthouse for Midwifery Practices: Model of Woman-Centred Care

Ebelik Uygulamaları için Bir Deniz Feneri: Kadın Merkezli Bakım Modeli

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Özet

Ebelik teori ve pratiğin bütünleştiği bir sağlık disiplinidir. Modeller ve teoriler, ebelik için bilimsel bir bakış açısı oluşturur ve klinik uygulamalara rehberlik eder. Aynı zamanda ebeliği diğer sağlık mesleklerinden ayıran bir referans noktasıdır. Kadın merkezli bakım yaklaşımını içeren ebelik modellerinden biri olan Doğumda Kadın Merkezli Ebelik Bakım Modeli; İsveç ve İzlanda'da kadınların ve ebelerin doğum deneyimlerine ilişkin nitel araştırma bulgularının sentezine dayalı olarak geliştirilmiştir. Bu derleme, Doğumda Kadın Merkezli Ebelik Bakım Modeli'nin temel kavramlarını incelemek amacıyla yapılmıştır. Üç ana (temel) ve iki arka plan olmak üzere iç içe geçen beş tema içerir. İç içe geçen üç merkezi tema; karşılıklı ilişki, doğum ortamı ve temellendirilmiş (gömülü) bilgidir. Kalan iki tema kültürel bağlam (ebelik yaklaşımı ve kadın merkezli bakım için engelleyici ve teşvik edici normlarla birlikte); ve ebenin dengeleme eylemleridir. Modelin İsveç'te bir hastanenin doğum ünitesinde uygulanmasına ilişkin sağlık profesyonellerinin deneyimleri ve görüşleri incelenmiş ve modelin ebelik uygulamasını geliştirmek için faydalı olabileceği ve diğer kültürel alanlarda da uygulanmasının ilginç olacağı sonucuna varılmıştır. Gelişmiş bir ülke olarak Türkiye'de annelik bakım ve hizmetlerinin kadın merkezli olması gereklidir. Gebelik, doğum ve doğum sonrası dönemde ebelik modeli veya teorisinin kullanılması, doğuma ilişkin hizmetlerin kalitesini artırabilir. Ayrıca ebeler mesleki özerkliklerini model kullanımı yoluyla güçlendirebilirler.

Anahtar Kelimeler: Doğum, ebelik, kadın merkezli bakım, model.

Abstract

Midwifery is a health discipline that integrates theory and practice. Models and theories establish a scientific perspective to midwifery and guide clinical work practice. They also constitute a reference point that distinguishes midwifery from other health professions. Midwifery Model of Woman-Centred Childbirth Care (MiMo), one of the midwifery models that includes a woman-centred care approach, has been developed based on the synthesis of qualitative research findings on childbirth experiences of women and midwives in Swedish and Icelandic birth settings. This review has been carried out to examine the basic concepts of MiMo. It includes five intertwined themes: three main (basic) and two in the background. The three central intertwined themes are a reciprocal relationship, a birthing atmosphere, and grounded knowledge. The remaining two themes are the cultural context (with hindering and promoting norms for a midwifery approach and woman-centred care) and the balancing act of the midwife. The experiences and opinions of health professionals about applying the model in a hospital labor ward in Sweden have been examined. It has been concluded that the model could be useful to enhance midwifery practice and that it would be interesting to apply MiMo in other cultural contexts. In Turkey as a developed country, maternity care needs to be based on a woman-centred approach. During pregnancy, childbirth and postpartum, using a midwifery model or theory could increase the quality of maternity care services. In addition, midwives can strengthen their professional autonomy in this way.

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Atıf için (how to cite): Kızılkaya, T., Dolgun, G. (2022). A Lighthouse for Midwifery Practices: Model of Woman-Centred Care. Fenerbahce University Journal of Health Sciences, 2(1), 290-298.

1. Giriş / Introduction

Midwives must base their care during the childbirth process on a midwifery model or theory, shape their clinical work practices accordingly, increase the quality of their services, and strengthen their professional autonomy (Eri et al., 2020). The presence of profession-specific models and theories for midwifery distinguishes midwifery from other professions that provide healthcare services (Bryar and Sinclair, 2011).

There are various common features of midwifery models, such as ensuring the continuation of the birth physiologically, avoiding unnecessary interventions, following the labor and birth under the leadership of the midwives. A Midwifery Model of Woman-Centred Childbirth Care (MiMo) has been developed based on the synthesis of qualitative research findings on childbirth experiences of women and midwives in Swedish and Icelandic birth settings. How the themes are addressed, and the underlying philosophies single out the model and theory developed for midwifery that could be applied to other countries. The MiMo model is linked to the salutogenic perspectives and the woman-centred care approach (Berg et al., 2012., Eri et al., 2020., Lundgren et al., 2020). This study is carried out to review the basic concepts of the MiMo.

2. Using of the Midwifery Model in Practice

Midwifery is a health discipline that requires theory-based practice (MacKenzie and Van Teijlingen, 2010; Bryar and Sinclair, 2011). Midwifery models gudide the activities to be performed to develop midwifery practices and contribute positively to the autonomy of midwives (Stockdale, 2011). In addition, the use of models is recommended to increase the quality of research on pregnancy, birth, postpartum and neonatal care (Çiçek Okuyan et al., 2019). Although there are various midwifery models in the literature (Fahy et al. 2006; Mander, 2011; Berg et al., 2012; Hodnett et al. 2013; Brunstad and Hjälmhult, 2015), in Turkey, studies in which models or theories of midwifery are put into practice are quite limited. After the systematic literature review of master's and doctoral theses in the field of midwifery, it was determined that midwives in Turkey were able to benefit from nursing models or theories (Çiçek Okuyan et al., 2019).

2.1. Woman-Centred Childbirth Care

Emerged with the impact of the second-wave feminism movement on healthcare services, the concept of woman-centred care means focusing on women's individual needs and expectations for the provision of healthcare services (Andrist, 1997; Leap, 2009). While woman-centred care is a quality indicator for prenatal, natal, and postnatal maternity services (De Labrusse, 2016; Fontein-Kuipers et al., 2018), it also forms the basis of midwifery philosophy (ICM, 2017; WHO, 2018).

In the "biomedical model" that has been internalized in the current health system, pregnancy, childbirth, and postpartum processes are perceived as pathological (Bryar and Sinclair, 2011). These processes are evaluated under two groups as low-risk and high-risk processes. Evaluation of a woman as a low-risk pregnant is only possible retrospectively. In other words, for pregnancy and childbirth to be defined as a low-risk process, they must be overcome healthily. Therefore, in the biomedical model, all pregnant women are treated as if they are at risk. The most important indicator of this is childbirth under the observation of obstetricians in high-tech units in hospitals (Van Teijlingen, 2017). As a result, interfering with the birth processes negatively affects the natural course of birth, increases cesarean rates, and negatively affects women's childbirth experience by increasing the rate of intervention (Vural and Erenel, 2017).

The increasing rates of cesarean section, birth intervention, and fear of childbirth in Turkey in the last decade reveal the need for woman-centred care (Barol Kurtoğlu and Kaya, 2019; Crepinsek et al., 2021, OECD, 2018). It is inevitable to prevent negative or traumatic childbirth experiences and to create a woman-centred birthing environment where women can feel free and safe (Dencker et al., 2018).

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Since every woman and every birth is unique, the care provided to a woman during the childbirth process should be individualized. Women experience childbirth in different ways and have different needs due to their cultural differences, previous experiences, and individual differences. According to the results of a meta-analysis of women's expectations during the childbirth process, the expectations of women in the childbirth experience were determined as the ensuring of their safety and responding to their sociocultural needs (Downe et al., 2018). The World Health Organization (WHO) emphasizes the significance of the concept of woman-centred care in the *WHO Recommendations: Intrapartum Care for a Positive Birth Experience* guide published in February 2018 and states that woman-centred care models serve as a bridge between society and healthcare professionals (WHO, 2018).

2.2. The Salutogenic Model

The Salutogenic Model was developed by medical sociologist Aaron Antonovsky (1996). While conducting research on the stress and coping of individuals with multiple sclerosis, cancer, and cardiovascular disease, Antonovsky examined the origins of health in the light of the question "What makes people healthy?" (Mittelmark and Bauer, 2017). While examining the origins of health, he developed a new perspective on the definition of health. Antonovsky chose to focus on one's capacity to build his/her health and on the resources available to one that serve to strengthen his/her health. As a result, instead of pathogenesis, he defined the Salutogenic Model as a model of stress and coping. When there is any health-related problem, the model tends to solve that problem, and in the second stage, it either uses the resources available from the environment or draws on the self-sourced resources that the person can utilize to solve the problem (Antonovsky, 1996; Bag, 2017).

Contrary to the pathogenic approach where diagnosis, treatment, and reducing risks are the main focus areas, salutogenesis promotes the physical and mental health of the individual, the family, and therefore the communities, with a holistic approach. The MiMo model has been defined as being salutogenic (Berg et al., 2012, Eri et al., 2020).

2.3. Midwifery Model of Woman Centred Childbirth Care (MiMo)

The MiMo is based on 12 qualitative studies on the experiences of women and midwives in Sweden and Iceland and was developed by hermeneutic synthesis (Berg et al., 2012). The model has five intertwined themes: three main themes and two sub-themes in the background. The three central intertwined themes are a reciprocal relationship, a birthing atmosphere, and grounded knowledge. The two background themes are the cultural context with hindering and promoting norms of woman-centred care, and the balancing act of the midwife (Figure 1, Berg et al., 2012).

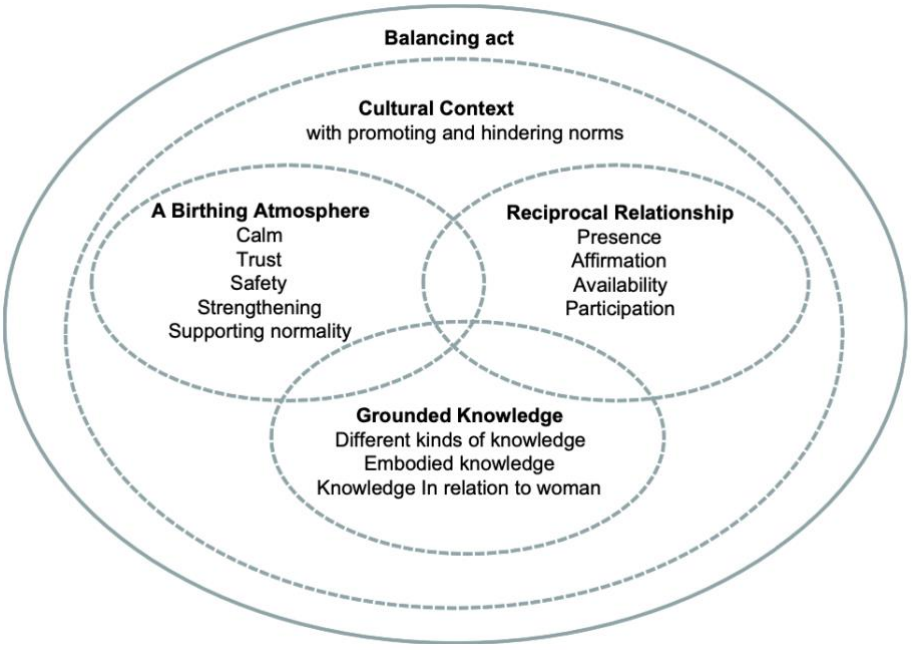

Figure 1: Midwifery Model of Woman-Centred Childbirth Care

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2.3.1 Central Themes

2.3.1.1. *Reciprocal Relationship:* This theme includes the sub-themes of presence, affirmation, availability, and participation.

2.3.1.2. *A Birthing Atmosphere:* This theme includes the sub-themes of calm, trust, safety, strengthening, and supporting normality.

2.3.1.3. *Grounded Knowledge:* This theme includes the sub-themes of different kinds of knowledge, embodied knowledge, and knowledge in relation to woman.

2.3.2 Background Themes

2.3.2.1. Cultural context (with hindering and promoting norms)

2.3.2.2. Balancing act

2.3.1. Central Themes

2.3.1.1. Reciprocal Relationship

The relationship established between the woman and the midwife: This relationship has a critical significance in terms of positive childbirth experience (Lundgren and Berg, 2007; Davison et al., 2015; Goodwin et al., 2018). In the relationship with the woman, the midwife should first get to know the woman and be aware of her individual needs. There are four sub-themes under the reciprocal relationship established between the midwife and the woman; these are "presence," "affirmation," "availability," and "participation" (Berg et al., 2012).

Presence: This concept refers to being with the woman during childbirth and emphasizes that the midwife should be with the woman physically and mentally as a whole and have a trusting relationship with the woman. The midwife evaluates and supports the woman with a holistic approach, considering her physical, mental, and sociocultural characteristics as well as her individual special needs (Berg et al., 2012).

Affirmation: This concept means that the woman needs to be seen and understood, to be recognized as a genuine subject/individual. The relationship achieves affirmation when the midwife sees to it that the presence responds to the woman's needs. When this happens, the woman feels the strength and capability of giving birth. The woman becomes active in childbirth, acts responsibly, and takes control of the birth. At the same time, she feels competent to be a mother to a child. What is essential here is that the midwife affirms the woman both verbally and with body language (Berg et al. 2012).

Availability: The midwife is available for the woman, that she can reach the midwife when she needs the help and the support she needs. The midwife's theoretical knowledge and practical skills are determinants of the availability for providing such support to the woman. It also includes the act of being with the woman and being present, open, and adaptive, supporting each woman according to her unique requirements. The midwife should support the woman based on her special needs (Berg et al., 2012).

Participation: It refers to the woman's and the midwife´s involvement in the childbirth process. The woman is in a constant dialogue with the midwife who listens to her, informs her about the progress of the childbirth, supports her to take her responsibility, and allows her to make her own choices for the care provided during the childbirth. The lack of participation of the woman in childbirth can create the feeling of not being in contact with her childbirth and of not giving birth herself (Berg et al., 2012).

2.3.1.2. A Birthing Atmosphere

It is an essential component for the childbirth experience of the woman. According to the model, a birthing atmosphere creates feelings of safety including calm, trust, and a strengthening environment that supports normality (Berg et al., 2012).

Calm: This sub-theme includes tranquility. It also allows the midwife to use her knowledge and enhance trust and the normality of the childbirth process.

Trust: The midwife should create an environment of reciprocal trust with the woman giving birth. The woman should be able to trust the care provided by the midwife, and the woman and the midwife should

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be able to cooperate. In addition, this concept is associated with developing self-confidence for the woman.

Safety: It refers to medical and technical safety as well as the emotional. Here, the professional competence of the midwife and the care policy of the institution where he/she works is important. The midwife should create a safe birthing environment. If the midwife feels safe in a reciprocal relationship, the woman will also feel safe.

Strengthening: The midwife has confidence in the woman's ability to give birth and encourages the woman to let herself go and continue, for instance, to push with the flow of labor contractions.

Supporting normality: It involves supporting the normal flow of the childbirth process, avoiding disturbance, and being aware of the boundaries between a complicated birth and normal birth. In this process, midwife's role has been defined as an "anchored companion" in supporting the woman´s capability to go through the normal childbirth process (Berg et al., 2012).

The hospital, which is a foreign environment for many women, can increase the level of fear and anxiety. Fear and anxiety cause the hormones that activate labor to be interrupted, thereby prolonging the labor process and increasing pain. Jenkinson et al. (2014) stated that designing the birthing environment to feel safe and calm is correlated with reduced intervention rates and positive childbirth experiences for women.

2.3.1.3. Grounded knowledge

It is suggested that the knowledge of the midwife is grounded in a different kind of knowledge that is used to respond to the individual needs of each woman, thus providing woman-centred care (Berg et al., 2012).

Different kinds of knowledge: This sub-theme includes theoretical knowledge, based on experience-sensitive intuitive knowledge. It means to have a solid theoretical knowledge of the various conditions and diseases that can affect childbirth, that provides a sense of security to midwives in their professional roles. It is also a prerequisite to be a reliable guide during the natural course of childbirth. The midwife should use the reflective method together with her colleagues to increase her knowledge and should always question retrospectively where she acted correctly and incorrectly and should constantly increase her knowledge. Three types of sensitive and intuitive knowledge are identified in the model: intuition based on practical experience, intuition based on spiritual awareness, and intuitive knowledge based on bonds with women. As a result, this intuitive knowledge requires the use of different knowledge types, e.g., benefiting from both previous experiences and new technology such as evaluating fetal heartbeat (Berg et al., 2012)

Embodied knowledge: The word “embodied” has different meanings such as “concretized” and “incarnated.” Embodied knowledge means that the midwife is integrated with the knowledge she has. The midwife knows how to support normality and uses medical interventions if necessary (Berg et al., 2012). A midwife knows what will comfort the woman during labor and childbirth processes, when and how to intervene, and this knowledge is naturally reflected in the behaviors of the midwife because such knowledge is embodied in him/her.

Knowledge in relation to a woman: Specific knowledge is obtained and developed in interaction with the woman. The midwife should be sensitive to the individual needs of each woman and to the woman´s knowledge about herself. The reciprocal relationship of the midwife with the woman is very important for the development of her professional skills and embodied knowledge (Berg et al., 2012).

2.3.2. Background Themes

2.3.2.1. Cultural context (with hindering and promoting norms)

Cultural norms can be hindering or promoting woman-centred midwifery care. Promoting norms could be that the midwife can be present alongside the woman during childbirth, supporting the woman based on her needs. Hindering norms include different aspects between the expectations of the woman during the childbirth process and the cultural norms of the institution as well as the general healthcare system with risk and pathological models of care being dominant instead of the salutogenic. During the care, the midwife in a balancing act respectfully supports the woman but also reckons with the norms of the institution and the healthcare system (Berg et al., 2012). This situation can create conflict between cultures.

2.3.2.2. Balancing act

In the MiMo, the term balancing act refers to the actions that the midwife takes towards woman-centred care. The act is like a 'dance' between simultaneous tasks, time pressure, rules and regulations, and hard working conditions. Balancing act includes being an “anchored companion” throughout the childbirth process, respecting the individual needs of the woman. Balancing is providing the opportunity

to “go with the flow”, to perceive the birth and time of birth from a normal perspective. With the balancing act, the midwife ensures that the birth progresses in its normal, physiological course (Berg et al., 2012), which applies to the salutogenic model of care.

2.3.3. Benefits of Woman-Centred Care

There are benefits of providing woman-centred childbirth, thus using the MiMo in practice (Lundgren et al., 2020). They can be listed for women, newborns, their families, and midwives as follows: (Forster et al., 2016; Shaw et al., 2016; Lundgren et al., 2020)

2.3.4. Benefits for the pregnant woman

- Helps childbirth progress physiologically and without intervention
- Increases the woman's sense of sufficiency
- Increases the self-confidence of the woman as she will take an active part in her care process
- Makes it easier for the woman to let herself go “with the flow” during the childbirth process, for her privacy will be protected and she will be safe

2.3.5. Benefits for the newborn

- Strengthens the relationship between the woman and her infant, for the woman will be more autonomous
- Makes the woman more active in the care of her baby and makes her feel capable, for it will increase the woman's sense of sufficiency
- Ensures peaceful birth of a newborn, for it reduces the likelihood of interventions
- Facilitates mother-infant attachment
- Allows early initiation and continuation of breastfeeding

2.3.6. Benefits for the family

- Woman-centred care includes the active participation of the family and other individuals providing social support in the childbirth process. This situation can improve the process to be more peaceful and can contribute to the satisfaction of both the woman and the family by strengthening their feelings of being safe and keeping the situation under control.

2.3.7. Benefits for the midwife

- Improves the reciprocal relationship of midwives with women for a positive outcome of care
- Strengthens the autonomy of the midwifery profession
- Contributes to job satisfaction of the midwives

3. Sonuç / Conclusion

The dissemination of models of woman-centred care could contribute greatly to the field of midwifery in Turkey. Considering that it has a multicultural demographic structure, using a woman-centred model becomes even more important. And given the fact that we are the second country at cesarean section rate in the world according to OECD statistics and considering the high rates of traumatic and medicalized birth, there surely emerges the need for changes in techniques, attitudes, and ways of thinking about childbirth. MiMo could be a lighthouse in these struggling situations. And with salutogenic perspective, the medical model’s hegemony could be eliminated in clinical practice.

Midwives, obstetricians, and managers in healthcare institutions must learn more about this model. Thus, it can be used in practice to increase the quality of maternity services, it being beneficial for

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women, babies, and families. In addition, there is a need for research on midwifery models of care such as the MiMo, exploring further its concepts and impact on salutogenic outcomes of care.

Yazarların Katkısı / Authors Contributions

Topic selection: TK; **Design:** TK, GD; **Planning:** TK, GD; **Writing manuscript:** TK, GD; **Review:** TK, GD

Çıkar Çatışması / Conflict of Interest

None declared.

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