

Working for socially disadvantaged women

Abstract

Background: Socially disadvantaged women have less choice and control over their maternity care and experience poorer birth outcomes than more advantaged women. Midwifery literature suggests that woman-centred care improves birthing experiences for women. However, challenges in providing socially disadvantaged women woman-centred care have been identified.

Method: This paper reports on literature relating to social disadvantage, health inequalities and birth outcomes within the Australian context as well as international literature regarding interpersonal challenges identified by women and midwives during interactions.

Findings: The establishment of positive, mutually respectful relationships between midwives and women has the potential to improve women's emotional wellbeing, birthing experiences and reduce birthing inequalities. Midwives' ability however, to preserve woman-centred care and develop relationships with women have been identified as challenges when working with socially disadvantaged women.

Conclusion: Midwives, as the primary health professional group working with birthing women, are in the best position to enhance maternity experiences and improve birth outcomes. The midwifery profession can strengthen its sociological underpinnings to ensure socially disadvantaged women are supported emotionally as well as physically during pregnancy, birth and their transition to motherhood. Midwifery education that endorses woman-centred care from both a theoretical and clinical perspective can generate stronger midwife-woman relationships and assist in the alignment of ideological stances and practice.

Introduction

Social disadvantage is defined as “a range of difficulties that block life opportunities and which prevent people from participating fully in society”.^(1, p. 1) Disadvantaged people more commonly experience social isolation, stress, anxiety and low self-esteem. They often have limited access to resources and services and less control over life circumstances.⁽²⁾ Ferrie⁽³⁾ reports that there is a clear correlation between people’s social positioning in society and their health status. Midwives working with socially disadvantaged women can benefit from a greater understanding of the link between social disadvantage and poor maternal-foetal health. There is an abundance of research on social disadvantage, poverty and midwifery work in developed and developing countries.⁽⁴⁻⁸⁾ This paper adds to midwifery knowledge by exploring social disadvantage and health inequalities within the Australian context in relation to childbearing women. Three separate but interrelated features of social disadvantage; poverty, deprivation and social exclusion, are examined. The relationships between health inequality, birth outcomes and social disadvantage are presented followed by policy recommendations aimed at improving the health of disadvantaged women, as well as their maternity experiences. In addition, the importance of developing mutually respectful midwife-woman relationships is explored. Finally, possible barriers to developing such relationships are discussed as well as suggestions to enhance future midwives’ proficiency at working with socially disadvantaged women.

Social disadvantage and the Australian context

While Australia’s economy grew steadily over the 15 years prior to the current global economic crisis, economic indicators demonstrated that Australia failed to provide a “fair go” for all people.⁽⁹⁾ The Organisation for Economic Cooperation and Development (OECD) reported in 2007 that Australia’s economic performance was above average when compared with other developed countries. Corporate profits increased, official unemployment rates fell

and government budgets resulted in a surplus. The cost however, of housing, and the number of people living on less than half the national average weekly wage are two areas where Australia performed poorly.⁽⁹⁾ Australia's economic growth did not benefit all Australians equally; there are clusters of disadvantage within Australia's economically healthy nation. Indigenous populations, people living in remote or rural regions of Australia, refugees, older persons and single parent households constitute the major groups of disadvantaged persons in Australia.⁽¹⁰⁾ The New South Wales Department of Health acknowledges that women, based on gender alone, incur a greater chance of being disadvantaged and that women often experience disadvantage more harshly than men in the same circumstances.⁽¹¹⁾

Among Australia's Indigenous population there is a greater number of socially disadvantaged persons and health inequalities per head of population than in the non-indigenous population.⁽¹²⁾ In this paper, information concerning indigenous and remote birthing women's data will be weaved throughout the discussion of social disadvantage that occurs over all cultural divides and localities. Social disadvantage and health inequalities are issues that must be addressed by all midwives in all regions of Australia. The following sections examine the three interrelated elements of social disadvantage - poverty, deprivation and social exclusion - so that midwives can develop a greater awareness of the role social disadvantage plays in health inequities and poor birth outcomes.

Poverty

The Australian Council of Social Service describes poverty as a concept used to portray people who are unable to participate in activities enjoyed by most Australians.⁽¹³⁾ Poverty is usually measured by household income, that is people receiving less than 50% of the average disposable income of fellow Australians.⁽¹³⁾ It was estimated that 10% or 2.2 million Australians were living in poverty during 2005-06⁽⁹⁾ and that the number continues to rise. During the decade prior to 2000 poverty rates rose from 11.3% to 13%.⁽¹⁴⁾ A family living in

poverty is largely excluded from choice in consumption of essential elements such as food, health visits and daily living activities.⁽¹⁰⁾ People living in poverty commonly have no funds allocated for emergencies and limited support mechanisms should an adverse event occur. Essential living requirements, such as access to and affordability of health services are often not met.⁽¹⁰⁾ A lack of resources, however, does not adequately describe the conditions of poverty. It could be argued that most people consider they are restricted to some degree in their consumption and participation in social activities due to financial constraints. Lister⁽¹⁵⁾ proposed that poverty is about having imposed or restricted control over financial resources.

Throughout the world it is generally women who bear the brunt of poverty on a daily basis, they are the ones struggling to feed and clothe the children, pay the rent or house repayments and maintain utility services.^(4, 16, 17) Women, and in particular mothers, have extrinsic constraints placed on their consumption patterns through economic and institutional policies failing to account for gender inequalities.⁽¹⁸⁾ Hunt⁽¹⁶⁾ found mothers also place intrinsic constraints upon their personal consumption patterns, they often place their children's needs before their own and see this responsibility as part of parenting, closely linked with love for their children. An Australian report on poverty and financial hardship published in 2004, supports Hunt's findings; earning capabilities, expenditure and ability to accumulate savings are significantly affected for women who are the sole carer for children.⁽¹⁹⁾

Indigenous birthing women and non-indigenous women living in rural and remote areas of Australia are more likely to suffer the consequences of living in poverty. The Australian Institute of Health and Welfare⁽²⁰⁾ found that people living in rural and remote areas obtain lower academic levels of achievement which reduces their educational, employment and earning capabilities; three indicators of income poverty. Indigenous Australians in particular are more likely to be unemployed,⁽²¹⁾ are overrepresented in statistics on homelessness and

have a higher chance of living in overcrowded dwellings, particularly in remote geographical areas.⁽²⁰⁾ Indigenous women more often give birth to low birth weight (LBW) infants, and have a higher perinatal mortality rate than non-indigenous women with infant child mortality rates three times that of non-indigenous children.⁽²¹⁾ Mayhew and Bradshaw⁽²²⁾ argue that poverty alone as a cause of poor birth outcomes is questionable when other socio-economic factors such as employment, family type, educational level, ethnicity and age of mother at birth are controlled for. When the focus of disadvantage is household income only, the effects of social deprivation and social exclusion are neglected.⁽¹⁰⁾ These issues are discussed next.

Deprivation

Deprivation is not a simple concept to define and measure. Being deprived can be described as lacking what are deemed to be the essential elements of one's own social group.⁽¹⁰⁾ Essential elements are things considered a basic requirement by the majority of that society to achieve a minimum standard of living. Essential elements as identified by Australians include "medical treatment if needed, a safe place for children to play outdoors near their home, a decent and secure home, a car and to be treated with respect by other people".^(10, pp.33-34) Deprivation is different from poverty in that, although essential elements may be established by society as a whole, it is the individual that determines if they consider themselves to be deprived of an element. Saunders et al.⁽¹⁰⁾ claims people can be deprived without being classified as poor if the availability of or access to local resources and services is inadequate. The locality in which a person lives may be unhealthy, unsafe or underserved. In other words, deprivation is an enforced lack of goods or services regardless of finances and the individual has little or no control over service consumption or participation patterns.

Women living in rural and remote areas of Australia have limited access to health and welfare services and limited choice in quality and models of maternity care. The size of the

population in a rural community influences the number and size of health services available⁽²³⁾ with only 1 in 10 indigenous people living in rural areas having access to a hospital and few rural women having access to birthing centres or midwifery-led care. Lack of access to health services is a contributing factor in poorer health outcomes for rural and remote birthing women and their infants. Twenty five percent (25%) of indigenous people live in remote areas compared with 2% of non-indigenous people.⁽²¹⁾ Essential items and services such as electricity, town water, sewerage systems and good quality housing are absent for a large proportion of indigenous people living in remote areas of Australia. In 2006, only 28% of indigenous households in rural communities had access to town water and 30% used a connected sewerage system for waste.⁽²³⁾ Twenty eight percent (28%) of the indigenous population in remote communities used electricity sourced from an electrical grid with 62% using generators.⁽²³⁾

There are also non-indigenous groups of people experiencing deprivation in Australia. In 2007, Saunders, Naidoo & Griffiths reported that the mean incidence of deprivation in Australia was 6.1%. That is, approximately 6% of a community is deprived of items considered to be essential by more than half the community.⁽¹⁰⁾ Single parent families are amongst the most deprived people in Australia with 14.2% lacking essential elements.⁽¹⁰⁾ Similar to poverty, it is women who bear the brunt of deprivation with single parent families headed mostly by women.⁽²⁴⁾

To cope with a lack of essential elements and control over life circumstances, people subconsciously adjust their outlook regarding personal needs;⁽²⁵⁾ they outwardly verbalise to others that they do not need the required item or service. Sen⁽²⁵⁾ suggests people self-identify as not deprived to maintain their self-worth. For example, a woman with small children living in an area without adequate public transport requires a car to access health care visits and social outings. If the woman is without the car due to financial limitations she

is deprived even though she may verbalise that cars are not necessary. This woman is disadvantaged; through deprivation she has limited access to health and welfare services and other social networks that have the potential to improve her well being.

Social exclusion

Social exclusion is a broader concept than poverty and deprivation. Social exclusion, while including the lack of, or denial of, resources, rights, goods and services, takes account of the individual's inability to participate in relationships and activities within their society.⁽²⁶⁾

The three indicators of social exclusion are disengagement in social activities, i.e. no regular social contact with others; service exclusion, that is no access to a local doctor or hospital; and economic exclusion, that is no reserve of money (\$500) for emergencies.^(10, p.70)

Institutional, community and societal attitudes can create barriers that exclude or include individuals and groups in a society's workings. Individuals can be socially excluded through power relationships, gender, race, ethnicity or locality.⁽²⁵⁾

Social exclusion varies in Australia from 12% of single older people to 36.2% of public renters. Single parent families are amongst the most socially excluded with 31.2% experiencing some form of exclusion.⁽¹⁰⁾ Women living without control over household income have limited personal power, access to financial resources and access to social or community activities; the cycle of poverty, deprivation and social exclusion is maintained. Using social exclusion as an added measure of disadvantage shifts the focus from income and consumption as the key indicators of disadvantage. Social exclusion indicators have a strong political use; policies can be implemented to ensure exclusion is reduced or eliminated.⁽¹⁰⁾ Income poverty, enforced deprivation of goods and services and social exclusion impact on a person's choice of and access to health sustaining activities.

Social disadvantage and health inequalities

While 'social disadvantage' is a broad term as previously discussed, people classified as having a low level of income or education tend to have poorer health outcomes and/or higher risks of ill health than the more advantaged people within any society.⁽²⁷⁾ The World Health Organisation⁽²⁸⁾ states that socially disadvantaged people are more likely to smoke, exercise less, be overweight and eat less fresh fruit and vegetables. These lifestyle behaviours are contributory factors to the increased incidence of cardiovascular disease, arthritis, respiratory illnesses such as asthma and mental health problems.⁽²⁸⁾ Poor health outcomes associated with disadvantage cannot, however, be solely attributed to the individual's lifestyle behaviours.

Statistics from developed countries reveal that the 'gap' between the wealthiest and poorest people is widening. Health inequities within these countries are widening equally^(4, 29) and are a direct result of the distribution of power; either power over, or power to act in one's own interest.⁽³⁰⁾ Decreased control results in psychological stress; and prolonged stress is linked to poorer health.⁽²⁸⁾ Decreased financial resources also limit a person's personal power to access required health care options. It can be argued that socially disadvantaged women have limited power to act in their own best interests since Australian research indicates that they are less likely to have completed year 12,⁽³¹⁾ or own a computer to access health information.⁽³²⁾ Reduced access to and understanding of health information is thought to contribute to the lack of participation in healthy behaviours.

In 2006, 59% of Australians were assessed as having less than adequate health literacy levels. Health literacy refers to a person's ability to retrieve, understand and evaluate health information; to make informed choices regarding health thereby reducing health risk factors and improving quality of life.⁽³³⁾ Income and educational attainment influences literacy levels. Sixty three percent (63%) of people assessed as having adequate or higher literacy levels

were also assessed as having high earning capacity and/or higher educational attainment. Only 26% of people with low educational levels or earning capabilities had adequate or higher health literacy levels.⁽³⁴⁾ Place of residence can affect one's health literacy. Of those living in rural and remote areas of Australia 64% had lower than adequate health literacy levels.⁽³⁴⁾ Women up to the age of age 45 years generally have higher health literacy levels than men,⁽³⁴⁾ women identified as income poor or having low educational qualifications, have reduced capabilities to achieve adequate or higher health literacy levels.

Although health literacy statistics published in the Australian Health Literacy Report,⁽³⁴⁾ identified some vulnerable groups within Australia, statistics specific to indigenous persons were absent from the document. Midwives therefore, must be aware that indigenous women and those from lower socio-economic households do not necessarily have diminished ability to comprehend complex health issues. As health literacy is the best indicator of improved health outcomes⁽³⁵⁾ there are two health promoting strategies that urgently need to be addressed in Australia. First, indigenous health literacy levels must be assessed so that health professionals can identify all vulnerable groups requiring greater support in understanding health information; second is the implementation of a national health literacy improvement directive. Midwives are in the best position to improve health literacy for birthing women. Improving a pregnant woman's health literacy has the potential to benefit not only the woman's maternity experience; it can improve the health of her infant and family.

Social disadvantage and maternal health

"Maternal mortality is one health indicator that shows the greatest gap between the rich and the poor — both between countries and within them".^(36, p.26) In September 2000, the United Nations Millennium Declaration⁽³⁷⁾ was adopted by the largest gathering of government leaders from around the world. There were eight goals listed that were intended to reduce extreme poverty or disadvantage in the world. Goal five 'improve maternal health' has

shown the least progress towards the target of reducing maternal mortality by 75% by 2015. This is thought to be a consequence of the economic crisis which has compromised funding for programs aimed at improving maternal health.⁽³⁶⁾ The latest figures reveal that more than half a million women die every year as a result of childbearing complications.⁽³⁶⁾ Although 99% of these deaths occur in developing countries there remain health inequities between groups of women within developed countries. In Australia the maternal mortality rate for indigenous women is three times higher than non-indigenous women. Indigenous women are twice as likely to birth a premature or low birth weight infant and have higher perinatal mortality rates⁽³⁸⁾. Between the years 2000-2005 there were 15.7 perinatal deaths per 100,000 indigenous births compared to 10.3 per 100,000 non-indigenous births.⁽³⁸⁾

Birth outcomes

Literature consistently demonstrates a link between social disadvantage, health inequalities and poor birth outcomes.⁽³⁸⁻⁴¹⁾ Birthing outcomes for both the woman and her baby are shaped by biological factors such as maternal weight, nutritional status, parity and age, or environmental factors such as substance use, stress or reduced access to health care and social services. These factors are impacted upon directly and indirectly by socio-economic status⁽⁴²⁾ and health literacy levels.⁽³⁵⁾ Socially disadvantaged women, regardless of ethnicity, are more likely to have premature rupture of membranes, and pre-term labour and birth,^(43, 44) are at increased risk of pre-eclampsia,⁽⁴⁵⁾ or drug and alcohol problems.⁽⁴⁶⁾ Socially disadvantaged women give birth to low birth weight infants more frequently^(44, 47) and their babies are admitted to neonatal nurseries⁽⁴⁸⁾ more often than their advantaged peers.

Existing literature demonstrating the relationship between social disadvantage and poor birthing outcomes indicates a further disadvantage to these women; health professionals are more likely to categorise these women as 'high risk' and deny them a midwifery 'continuity of carer' model of care.⁽⁴⁹⁾ Health complications associated with social disadvantage frequently

deprive disadvantaged women of the opportunity to birth either naturally or unassisted by medical intervention.

Policies aimed at improving maternal health for socially disadvantaged women

The Australian Government is currently consulting with key stakeholders to develop a new national women's health policy. The last women's health policy was published 20 years ago, in 1989. The purpose of the new policy will be to improve women's health, especially disadvantaged women; promote health equity; and increase women's involvement in decision-making regarding their health.⁽⁵⁰⁾ Also in 2009, the Australian government published 'Improving Maternity Services in Australia: report of the maternity services review'. The review arose in response to a number of issues. There was recognition that not all women's needs are being met and choice of and access to models of care is limited. Women living in rural and remote areas have little or no local maternity services; maternity services are mostly provided in tertiary centres and by specialist doctors. More than 97% of women birth in hospitals in standard delivery wards. The review recommended changes to maternity services with greater choice of and access to a range of models of care. Recommendations included extending the role of midwives, including support for indemnity insurance and changes to commonwealth funding arrangements; improved access to maternity services for rural and indigenous women; and improved access to health information so women are able to be more fully involved in decision-making processes.⁽⁵¹⁾

Government reports, health initiatives and directives do not always achieve improvements for those in most need. The Rural Women's GP Service (RWGPS) is a federal government initiative with female doctors providing general practice services for women and their families in rural and remote parts of Australia. While access to care for indigenous and rural woman is high on the government's agendas, the RWGPS only services women in areas with 1,000 or more residents.⁽⁵²⁾ The RWGPS visits are scarce with visits scheduled for 1 to 6 monthly, and maternal health is not listed as a service provided.

Coordinated policies that link government department and services such as health, education, housing and social services are better suited to ensuring disadvantaged people are included in all support services as needed. The New South Wales Government has implemented one such program; the 'Schools as Community Centres' (SaCCs) initiative linking socially disadvantaged women with children from birth to 8 years of age with government and private services as required.⁽⁵³⁾ The aim of SaCCs is to improve health and reduce the impact of disadvantage on women and children in their local area by forming social and formal networks for the women. Providing midwifery services in venues such as SaCCs, where support networks have been established has the potential to improve socially disadvantaged women's access to health services, improve health information literacy and improve the woman-midwife relationship.

Socially disadvantaged women's experiences of maternity services

Socially disadvantaged women believe their social status directly influences how health professionals treat them; that their care is a lesser quality because of their social status and yet they feel powerless to do anything about it.⁽⁵⁴⁾ An observational study of Swedish midwives illustrated that midwives manipulate midwifery visits by initiating and directing most of the dialogue, and that women were reluctant to dispute information provided.⁽⁵⁵⁾ An inability to adequately express needs or make one's self heard results in women (and their children) having inappropriate access to and utilisation of health care services. When social support networks⁽⁴⁾ or institutional support systems⁽⁵⁶⁾ fail to meet women's needs their sense of worth is further decreased which, in turn, reinforces, conditions for disconnectedness, isolation and depression.

Interviews with a population of impoverished women using maternity services in England⁽⁵⁷⁾ illustrated that socially disadvantaged women are aware of midwives' attitudes towards them. Women know when they are being 'weighed up' by health professionals. Women are

aware that health professionals' assumptions regarding lifestyle options and circumstances are made based on clothing and appearance, area of residence, number of partners and pregnancies, and women's' health determinants.⁽⁵⁷⁾ Women recounted how they felt midwives distinguished between the 'deserving poor' such as widows and orphans and the 'disreputable or undeserving poor' such as teenagers, single parents, substance abusers, or multi-gravid women from lower income households. Women indicated that some midwives make assumptions that problems relating to poverty would disappear if women simply ceased engaging in unhealthy behaviours and spent their money more appropriately.⁽¹⁶⁾

Canadian research into patient-physician relationships⁽¹⁷⁾ indicates that disadvantaged women find it difficult to be assertive or proactive regarding health information when attending health care visits, particularly with health professionals with whom they have not established a relationship. Women report health professionals are less likely to listen to them and, tend to hasten the interaction if no relationship exists. Women also perceive they are not trusted or believed in this situation.⁽¹⁷⁾

Midwifery relationships and socially disadvantaged women

The importance of relationships between health care professionals and socially disadvantaged women emerged as a major finding in a Canadian study involving women living in temporary accommodation.⁽¹⁷⁾ Furthermore the women felt 'respected' and 'valued as members of society' when the relationship with their doctor was viewed as collaborative by the women. A Swedish study⁽⁵⁸⁾ involving 18 women receiving care from birth centre midwives revealed women want respect from their midwife, to be seen as an equal by their midwife and have their individual needs met. In Australia a recent evaluation of the Southern Aboriginal Maternity Care Project in South Australia, recommended developing "trusting and respectful relationship[s]" to improve indigenous maternity experiences.^(59, p.29)

Neuroscience studies such as that by Goleman⁽⁶⁰⁾ strongly support a correlation between relationships and physical health. Goleman found that the quality of a relationship can influence physical and emotional wellbeing and that positive relationships have the power to boost the body's immune system.⁽⁶⁰⁾ Midwives too, are well positioned to influence socially disadvantaged women's emotional and physical wellbeing, and contribute to the improvement of birth outcomes. Contemporary midwifery practice is framed within continuity of care models in which a woman develops a partnership with a midwife for the duration of her pregnancy and birthing experience. However socially disadvantaged women are more often allocated to a model of care that fragments their health care visits between doctors, midwives and allied health professionals. The establishment of an ongoing relationship with a known midwife is therefore difficult, which further disadvantages this group of women.

A systematic review published in 2008, involving more than 12,000 women classified as low or mixed risk⁽⁶¹⁾ found women receiving midwife-led care had better birth outcomes such as less antenatal hospitalisation episodes, less intrapartum analgesia requirements, less episiotomies and instrumental births. Women were more likely to have a known midwife in attendance at their birth and felt in control during their childbirth.⁽⁶¹⁾ Furthermore a randomised control trial involving 1,000 women receiving various models of maternity care reported that the quality of individual interactions with health care providers is a significant indicator of women's satisfaction of care.⁽⁶²⁾ The study found that midwifery led models of care (such as team midwifery) provided women with greater emotional support and more involvement in decision-making processes. What is interesting in this study is that continuity of care, was not the primary source of satisfaction; rather the quality of individual communicative exchanges determined the degree of satisfaction.⁽⁶²⁾ It can be reasonably concluded therefore, that all midwives are able to positively influence women's birth experiences through intermittent actions and interactions.

Barriers to the development of midwifery relationships

In Australia, the national competency standards are embedded within a conceptual framework of woman-centredness while midwifery practice is guided by the Midwifery Partnership Model.⁽⁶³⁾ Many midwives in Australia however, continue to be restricted in their models of practice. A large proportion of maternity services provided within health organisations are aimed at workforce efficiencies. Focusing on institutional requirements means that midwives often attend to the completion of set tasks, comply with the standardisation of care and employ risk reduction strategies rather than practice according to individual women's needs;⁽⁶⁴⁾ increasing the incidence of work related stress among midwives.

A study examining communication between women and midwives in Ireland reported conflicting communicative ideologies as a causative factor of poor midwife-woman interactions. While midwives reported that their role and interactions were meant to empower women and facilitate choices; they tended to employ communication strategies aimed at meeting desired (institutional) outcomes.⁽⁶³⁾ Similar findings by Hunter⁽⁶⁴⁾ support the notion that contradictory professional ideology and clinical practice is a major cause of emotional stress for midwives, with student midwives and newly qualified midwives experiencing the greatest discord between professional ideology and clinical practice. A further study by Hunter⁽⁶⁵⁾ found midwives attempting to practice woman-centred care within an institutionally-focused workplace not only experience personal conflict; they experience intra-professional conflict with colleagues who support institutional foci. Reducing incongruities between workplace practice and professional ideology has the potential to improve midwives' experiences, augment the midwife-woman relationship and enhance care provided to women. The challenge for midwives is to balance the needs of disadvantaged women with those of employing institutions in order to develop and maintain "collegial

networks with midwifery colleagues and others to optimise outcomes” for socially disadvantaged women.^(66, p. 2)

Women with complex needs, such as those who are socially disadvantaged, require midwives who understand the interrelated issues impacting on their lives as well as knowledge of the services required to meet their needs.⁽⁶⁷⁻⁶⁹⁾ Women want a midwife with whom they have a relationship. Fragmentation of care however, reduces the individual midwife’s ability to know the woman and understand her needs. In addition midwives express their concern that attempting to address the complex issues of socially disadvantaged women places additional strain on their workload.⁽⁶⁸⁾ Additional time however, is not required to establish respectful relationships with women. The establishment of a mutually respectful relationship with a known care giver reduces time wasted during health care visits with the woman empowered to express her needs more freely.

Discussion

Trusting and mutually respectful relationships between health professionals and women results in more frequent visits to health services, increased health literacy and better health outcomes for women and their families.^(60, 70) De Lashmutt⁽⁴⁾ asserts that a sense of connectedness established through the woman-midwife relationship and local networking is a cost effective means of improving birth outcomes and the health of future generations. Current work in the area of social intelligence indicates that participation in positive relationships improves one’s emotional and physical wellbeing.⁽⁶⁰⁾ Midwives who link socially excluded, isolated or disadvantaged women to local support services and other women facilitate positive community relationships and improve the emotional and physical wellbeing of women. Improved maternity experiences and birthing outcomes for disadvantaged women appears to be centred on the establishment of mutually respectful midwife-woman relationships.

Addressing the challenge of conflicting professional ideologies and employer commitments may become less of an issue with the introduction of the 'continuity of care experience' requirements in Australian, midwifery programs.⁽⁷¹⁾ Midwifery educators and researchers have been provided an opportunity to examine student midwives' experiential learning of midwifery and woman-centred care through early observation and participation in the midwife-woman interaction. As more universities introduce an undergraduate degree in midwifery, it is anticipated curricula will have a greater focus on woman-centred care, and pregnancy and birth from a sociological perspective.

Future midwifery curricula would ideally incorporate the social determinants of health into all subjects covering medical conditions associated with childbearing. Within each subject there needs to be a module on 'communicating in the clinical context; promoting health and midwifery relationships'. Throughout the students' midwifery education the connections between social disadvantage, health inequalities and specific disease processes should be explored. The relevant health promotion interventions and communicating health within a midwifery framework of woman-centredness should also be integrated. In this way, graduate midwives would have a clearer understanding of socio-political influences on health inequalities, socially disadvantaged women's health behaviours and appropriate midwife-woman interactions.

Changes to midwifery curricula may also improve professional ideology and practice alignment. Within the next decade Australia will see a large increase in the number of registered midwives with midwifery listed as their first degree. These graduates will have been educated within a midwifery philosophical framework. They will have been exposed to midwifery models of care during clinical placements and have a stronger professional identity as an autonomous practitioner. As the push for greater choice in models of care is

sought by women and recommended in government reports, graduating midwives will be in position to meet these needs.

Providing midwifery care in hospitals impacts on new graduate midwives' ability to maintain professional and practice ideologies. Hunter⁽⁶⁵⁾ suggests hospital based midwifery is hierarchical with a midwifery pecking order. New midwives are required to obey formal and informal rules, enforced with rewards and punishments. The end result is a midwife who is accepted as 'an insider' that is as one of the group or ostracized as an 'outsider'. With social consequences attached to being accepted or rejected as a group member, these socialising rituals maintain the 'status quo' of medically dominated, institutionally-focused maternity wards. The provision of midwifery care must be, where appropriate, outside hospital wards. The next few years are crucial for the midwifery profession and birthing women. Midwifery educators, student midwives and newly registered midwives can use this time of change to create a future for the profession and socially disadvantaged women that is woman-centred.

Conclusion

This paper provided an overview of social disadvantage in relation to childbearing women, and midwifery work within the Australian context. It showed how a range of social determinants are associated with socially disadvantaged women having worse health outcomes on maternity indicators. A review of contemporary literature revealed that socially disadvantaged women have less choice and control over their maternity care; that they are less likely to have continuity of care and that they experience poorer birth outcomes than more advantaged women. As the primary health professional group working with birthing women, midwives are in the best position to enhance maternity experiences and improve birth outcomes for socially disadvantaged women. Research findings support the notion that an established woman-midwife relationship provides greater emotional and physical support than previously realised. Increasing our knowledge of the social determinants of health and

the maternity experiences of socially disadvantaged women will assist in the establishment of woman-centred relationships. It is also anticipated that midwifery education promoting woman-centred care from both a theoretical and clinical perspective will generate stronger midwife-woman relationships. The midwifery profession, through changes to midwifery education, must strengthen its sociological underpinnings to ensure women are supported emotionally as well as physically. Midwives assisting in the creation and maintenance of strong emotional support networks will improve socially disadvantaged women's lives.

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