2-1-2023

Woman-centred ethics: A feminist participatory action research

Kate Buchanan
Edith Cowan University

Sadie Geraghty

Lisa Whitehead
Edith Cowan University, l.whitehead@ecu.edu.au

Elizabeth Newnham

10.1016/j.midw.2022.103577
Buchanan, K., Geraghty, S., Whitehead, L., & Newnham, E. (2023). Woman-centred ethics: A feminist participatory action research. Midwifery, 117, Article 103577. https://doi.org/10.1016/j.midw.2022.103577

Midwifery 117 (2023) 103577

Contents lists available at ScienceDirect

Midwifery

journal homepage: www.elsevier.com/locate/midw

Woman-centred ethics: A feminist participatory action research

Kate Buchanan[a,b,*], Sadie Geraghty[b], Lisa Whitehead[a], Elizabeth Newnham[c]

[a] School of Nursing and Midwifery, Edith Cowan University, Joondalup, WA 6027, Australia
[b] The University of Notre Dame Australia, 19 Mouat Street Fremantle 6959, WA, Australia
[c] School of Nursing and Midwifery, University of Newcastle, University Dve, NSW 2308, Australia

ARTICLE INFO

Article history:
Received 29 August 2022
Revised 15 November 2022
Accepted 9 December 2022

Keywords:
FPAR
Feminist research
Midwifery philosophy
Care ethics
Ethics
Woman-centred care

ABSTRACT

Introduction: Contemporary ethical issues in the maternity system are nuanced, complex and layered. Medicalisation and the reported rise in incidence of mistreatment and birth trauma, has been described as unethical. Some authors suggest bioethical principles are limited in terms of guiding everyday care of pregnancy and birth. There is currently no known published research which explores what birthing people say is ethical.
Aims: This study sought to explore women's experience of maternity care from an ethical perspective.
Method: A Feminist Participatory Action Research (FPAR) was conducted over three years, in two phases. A Community Action Research Group (CARG) was formed of nine participants, and data were captured from five focus groups. A further ten participants were recruited for individual in-depth interviews, the data corpus was combined, and thematic analysis was applied. All 19 participants had experienced a midwifery model of care in Western Australia.
Results: A unique ethical perspective was described by the participants. The central theme: 'Radical desires: Individuals values and context' placed the woman at the centre of the care, in determining what is ethical. Two categories captured the care experienced: Woman-centred ethics or Authoritarian ethics. A conceptual model Woman-centred ethics is offered to enhance everyday ethical midwifery care.
Discussion: The participants in this study perceived care as either ethical or unethical based on the quality of the relationship, the knowledge that was shared and the manner of the care given. The Woman-centred ethics model may be a starting point for moving the field forward in ethical discussion.

Introduction

Ethical issues in the maternity system are rooted in the philosophical underpinning of medicalisation, where pregnancy and birth are seen as pathological, dangerous and requiring intervention to control birth and save women and babies (Clesse et al., 2018; Jones, 2022; Salter et al., 2021). The phenomenon of over-medicalisation may be contributing to the increasing trend of disrespect and mistreatment (unethical care) in the maternity system (Downe et al., 2019; Miller et al., 2016). The World Health Organisation (WHO, 2014) formally recognises mistreatment in pregnancy and labour and detailed an explicit guide to respectful care to minimises harm (Stanton and Gogoi, 2022). And yet there remains an enduring and worsening crisis of rising incidence of psychosocial, emotional and cultural harm described by women in the maternity system (Glazer and Howell, 2021). These problems have not yet been researched from an ethical perspective with attention to what constitutes good (ethical) care; thus, research into the ethics that guides health professionals' behaviour is imperative.

The International confederation of Midwives (ICM) Code of Ethics (ICM, 2014) guide midwifery practice and considers four domains: Midwifery relationship, Midwifery practice, Professional responsibilities and Advancement of midwifery. However, within the health system, the medicalisation of pregnancy and birth is driven by the medical model and the bioethical principles of non-maleficence, beneficence, justice and autonomy (Beauchamp and Childress, 2019); supersedes midwifery ethics, autonomy and care practices (Newnham and Kirkham, 2019). Feminist researchers have described bioethics as abstract, difficult to translate to practice and as having the potential to derail women's authority over their own decisions and bodies because of patriarchal assumptions and interests (Maclellan, 2014; Newnham and Kirkham, 2019). Further research exploring women's experiences of pregnancy and birth from an ethical perspective may reveal key factors that con-

* Corresponding author at: School of Nursing and Midwifery, Edith Cowan University, Joondalup, WA, 6027, Australia.
E-mail address: Kbuchan2@our.ecu.edu.au (K. Buchanan).

https://doi.org/10.1016/j.midw.2022.103577

Table 1
Phase One, participant set and data set.

	Phase one
Data set	Data set 1
Participant	Participant set 1 (CARG) Nine participants
Data collection	Focus group x 1
Data analysis	A priori codes generated by CARG and template analysis

tribute to more ethical maternity care. This paper presents findings that connect empirical evidence with theory to create a conceptual model for every day, embodied ethical midwifery practice.

Objective: The aim of this research was to explore women's experiences of maternity care from an ethical perspective.

Ethical statement

Ethics approval was given by the University's Human Research Ethics Committee (HREC) (REM 2019- 2019-00296 and REM 2020 – 01707).

Methods: Feminist participatory action research (FPAR) integrates a feminist lens with participatory action research iterative cycles. FPAR is a complex research design with two branches, a research arm, and an action arm, designed to meet real needs of the participants, and generate transformative research (McDiarmid et al., 2021). The FPAR framework for midwifery was used to guide this study, and includes four intertwined elements; 1. Create, 2. Collaborate, 3. Consider, and 4. Change (Buchanan et al., 2022 a).

The methods in FPAR are flexible, in this study iterative cycles of action research were used with two main research phases. In phase one, the 'Create' element of FPAR, a community action research group (CARG) was formed (Participant set one), who guided the research over the three years. In 'Collaborate', the CARG defined the research problem, data were collected from one focus group (Data set one) and the CARG generated a priori codes, as set out in Table 1. Phase One, participant set and data set.

In Phase two, ten further participants were recruited (Participant set two), and data were collected from in-depth interviews. Further data were collected from the CARG via four more focus groups. The two data sets in phase two were combined for analysis, as set out in Table 2. Phase Two, participant set and data set. FPAR 'Consider' element was demonstrated through Reflexive Thematic Analysis, which was applied to the data corpus (Braun and Clark, 2021). FPAR 'Change' was organised and managed by the CARG as described in Table 3. CARG involvement in FPAR.

Participants and context: A total of 19 women were recruited for this study, nine women in the CARG focus group and ten women for in depth interview, in Perth, Western Australia. Participants who had chosen a midwifery-model of care were recruited via purposive sampling. Purposive sampling is useful for qualitative research in a small participant pool, relevant to this study because only 4% of birthing people can access a midwifery model of care in Australia (Australian Institute of Health, 2022; Campbell et al., 2020). An emailed participant information sheet was distributed via midwifery networks to birthing people who had experienced a midwifery model of care. The information sheet explained the purpose and details of the study as well as contact details of the researchers, and the secretary of the University's Human Research Ethics Committee. While all the participants had received midwifery model of care, they had also either experienced the medical model of care for a previous birth or had experienced an interaction with the medical system during their pregnancy or birth. The demographic represented in this group were educated, partnered, employed, born in Australia, and were cis-gender women (Table 4. Community Action Research Group (CARG): Demographic data and Table 5. Participant set 2: Demographic data). Although this is not representative sample of people who seek maternity care, it is reflective of people who choose or can access midwifery models of care (Sangster and Bayley, 2016; Grigg et al., 2014).

The term woman is used when referring to a participant who identifies as cis woman, or where we refer to other research which has used the term woman, or when following the ICM definition and scope of woman-centred care (ICM, 2017). We acknowledge that people who identify as male or non- binary give birth, and support inclusive language and care. We also use the term 'woman-centred' - a pillar of midwifery philosophy of care – as being inclusive of care given to the non-binary person. When none of these terms are in play, the more inclusive term, birthing person is used.

Consent

Participants self-selected to be included in the community action research group (CARG) and the study. Consent was voluntary and the participants exercised agency in responding via return email with the signed consent form having read the participant information sheet. Also included within the information sheet was the action to be taken if the participant felt discomfort during the interview or focus group. No participants withdrew from the study or sought counselling as an effect of being in the study.

Data collection: Multiple forms of data collection aid the researcher in gathering a rich data set (Olsen et al., 2018; Saunders et al., 2018). Data were collected through semi-structured interview methods using both focus group and individual in-depth interviews, from two participant sets. Focus group interview was chosen for participant set one (CARG) in line with feminist research methods, to democratise research, and produce rich data that is not just descriptive, but generates new ideas and the validation of opinions provides a deeper understanding of the issues (Kook et al., 2019). Three to six focus groups are suggested to provide enough data to identify prevalent themes (Guest et al., 2017). The focus groups were held between 2019 – 2021 at a local University, with one focus group held online due to COVID 19 restrictions, with the CARG and generally lasting two hours. The first author

Table 2
Phase Two of study, participant set and data set.

Phase 2	Participant set One	Participant set Two	Total
Data set	Data set 2 – Four focus groups	Data set 2 – Ten interviews	Two forms of data collection
Participant	CARG members -Same 9 participants Experienced midwifery model of care	10 other participants Experienced midwifery model of care	19 participants 9 – CARG focus groups 10 – in-depth interviews
Data collection	4 Focus groups	10 in-depth interviews	4 Focus groups 10 in-depth interviews Plus focus group data from phase 1.
Data analysis	Thematic analysis	Thematic analysis	Thematic analysis to entire Data corpus

Table 3
Community action research group (CARG) involvement in FPAR.

Research arm	Action arm
Consumer definition of research problem	Values, goals and vision for action and change withing maternity system
Group refined research question	Share research on social platform
Generate a priori codes	Focus on social justice attend women's march
CARG led focus groups 2 – 4	Joined with government agency to inform policy
Informed Interview questions for Data set 2	Joined with health consumer networks
Participant set two - snowball – Contacts from CARG	Advanced state representation at national maternity consumer group
Methods feedback – remove creative artefact	Created Birth Folk for non-binary maternity health workers
Analysis – feedback	
Final draft of manuscripts – feedback	
Disseminate research through social network	

Table 4
Community action research group (CARG) demographic data.

Pseudonym	1st birth	2nd birth	Parity	Occupation	Gender	Partner	Race
Bonnie	Public OB	Community midwifery program	2	Birth photographer	Woman	Yes	Caucasian
Sara	Endorsed midwife		1	Engineer	Woman	Yes	Caucasian
Solange	Birth centre	Community Midwifery Program	2	Accountant	Woman	Yes	Caucasian
Amy	Birth Centre	Community Midwifery program	2	Hairdresser	Woman	Yes	Caucasian
Kylie	Birth Centre		1	Physiotherapist	Woman	yes	Caucasian
Georgie	Endorsed midwife	Endorsed midwife	4	Physiotherapist	Woman	yes	Caucasian
Eve	Private OB	Endorsed midwife	3	General Practitioner	Woman	Yes	Caucasian
Jenna	Birth centre	Endorsed midwife	2	Bookkeeper	Woman	Yes	Caucasian
Elise	Endorsed midwife	Endorsed midwife	2	Occupational therapist	Woman	yes	Caucasian

Table 5
Participant set 2: demographic data.

Pseudonym	1st birth	2nd birth	Parity	Occupation	Gender	Partner	Race
Kathy	Endorsed Midwife	Endorsed midwife	2	Midwife	Woman	Yes	Caucasian
Diana	Private OB	Community Midwifery program	2	Personal trainer	Woman	Yes	Caucasian
Taya	Community Midwifery Program		1	Social Worker	Woman	Yes	Caucasian
Lucy	Endorsed Midwife		1	BioScientist	Woman	Yes	Caucasian
Mia	Endorsed Midwife	Endorsed Midwife	3	Midwife	Woman	Yes	Caucasian
Olive	Community midwifery Program		1	Singer	Woman	Yes	Caucasian
Anna	Endorsed midwife		1	Engineer	Woman	Yes	European
Zoe	Endorsed Midwife		1	Teacher	Woman	Yes	Caucasian
Fiona	Private OB	Endorsed Midwife	3	Psychologist	Woman	Yes	European
Ella	Private OB	Endorsed Midwife	2	General practitioner	Woman	Yes	Caucasian

Table 6
Example of interview questions.

1.	Can you tell me about your birth/s?
2.	Why did you choose midwifery-led care?
3.	Can you describe your relationship with your care provider?
4.	Can you give an example of how you made a decision, for example screening for GBS
5.	Can you share some examples of what you think was good and bad about the care you received?

was a co-member of the group, with another CARG member allocated to direct the sessions, to equalise power in accordance with FPAR. A topic guide per focus group was used, each focus group had a different topic as a guide to instigate discussion; 1. Generated a priori codes based on Research question 2. Midwifery-led care 3. Relationship with care provider 4. Decision-making, choice, and information 5. Care experiences - Ethical/unethical.

In phase two, as guided by CARG, ten more women were recruited for in-depth, semi-structured interviews. The rationale, to provide further rich data about the research topic and triangulate the data (Saunders et al., 2018). The topic guide with interview questions were developed by the research team, piloted and adapted with CARG feedback (Table 6. Examples of in-depth interview questions). The qualitative data were audio recorded and transcribed, and notes and reflections made during the interviews were recorded in a reflective journal. To ensure anonymity, participants were given a random pseudonym at the time of audio transcription.

Data analysis: reflexive thematic analysis

Both data sets were combined, and the data corpus was uploaded into NVivo, and the entire data set was initially coded line-by-line (Saldana, 2016). The data were analysed using Reflexive Thematic Analysis (Braun and Clarke, 2021). Analysis involved a recursive and reflexive process that developed over six months of deep thinking, refining and revising categories and themes, with four researchers involved in the analysis process, and member checked by the CARG (Braun et al., 2022). Reflexivity is a critical reflection of the research process that contributes to rigour by contextualising the researcher position and being open about biases whilst remaining true to the data (McDiarmid et al., 2021).

Table 7
Example of coding.

Raw data	1st level codes	2nd level codes	Subcategory
Z - And I think just because she seems really passionate about women's experiences and a natural birth was really important to us, every homebirth midwife we met there was just like no power imbalance there, like it was like just person to person, like woman-to-woman conversation instead of I'm the expert on everything, which obviously I definitely respect their expertise. But it was like I could approach them with anything	Normal birth valued Significant Relational person to person no power imbalance Midwife respecting woman as expert of her body	Normal birth valued Relationship Woman as expert	Midwifery solidarity
F - I look back, it was it was a very coercive, fear driven appointment and about risk of future rupture and stuff like that, and he started telling me about his own study that he'd been doing the in KEMH, that it was more like a one in 30 chance of rupturing. But he couldn't show me the data on it.	Feeling unsafe Threatened abruption Decision making based on risk and fear	Feeling unsafe / gendered safety	Saving women from themselves
L - I didn't have a good relationship with the obstetrician and but I didn't feel strong enough to probably question more or actually change my decision around it and then two male doctors came in and stood over the bed and started to say that they needed to talk to me, And I said, can we not talk about that right now? and they didn't respect that. And he was like, no, we need to talk about it now. And just every time I tried to implement boundaries; they would not listen	Didn't have a good Relationship Dr doesn't like questions Didn't listen didn't respect	Relationship affects birth experience Patriarchal deafness	Uneasy alliance

Line by line coding resulted in sixty-two first level codes (Saldana, 2016). First level codes were assigned to what was considered important in participants words and were more descriptive in nature (Braun and Clark, 2021). A record was kept which recorded the code, definition, salient points about the code, reflections and examples. The reflective journal assisted in developing the second level of codes. Second level coding grouped similar codes together and these were assigned code names such as patriarchal deafness, gendered safety, woman as expert, relational strength and were further developed into six subcategories. These categories were more interpretive (Braun and Clark, 2021), drawing categories together to describe unethical and ethical care. An example of the analysis process is set out in Table 7. Example of coding. Further analysis led to the construction of a central theme, and two subthemes, which describe the outcomes of unethical and ethical care.

Rigour and trustworthiness

The validity of this study was ensured through strategies that strengthen its trustworthiness. Trustworthiness refers to the credibility, transferability, confirmability and dependability of qualitative research (Olsen, 2018). Credibility is demonstrated in this study by engaging reflexively with the data, prolonged three-year engagement with the participants, and triangulation of data sets. Theory has been integrated through the discussion section and linked to contemporary literature which adds to credibility. Confirmability was adhered to by detailed record keeping of decision-making, recorded in a reflective journal, and the provision of raw data. Dependability is achieved through member checking with the CARG at each stage of the research, such as analysis, preliminary themes and providing feedback, and expert supervision. The Standards for Reporting Qualitative Research (SRQR) checklist was utilised as a guideline to ensure quality of reporting (O'Brien et al., 2014). The Reflexive Thematic Analysis checklist for quality was also used (Braun and Clark, 2021) to ensure dependability.

Reflexivity

The feminist researcher is addressing issues of power and oppression, as such they are often aware of their position and approach. Being open and reflexive about this position is therefore integral part of the research process (Reid and Frisby, 2008). Our stance as feminist midwives, nurses, cis women and researchers is acknowledged. Reflexivity has been ensured in this research by declaring the epistemology and theoretical framework, using reflexive journaling, as well as keeping true to the voices of the women by repeatedly going back to the data sources and though member checking (Braun et al., 2022; Shimei and Lavie-Ajayi, 2021).

Results

The findings from the analysis present new information about how women view the care they received from an ethical perspective. The participants clearly described what was ethical and unethical care, and the outcomes of their respective care. The central theme: Radical desires: Individual values and context represent the person at the centre of the care – their values and contexts. The categories represent the care received, as either: Woman-centred ethics or Authoritarian ethics. The subthemes represent how the woman was affected following care: Claiming Power: embodied and strengthened or Surrendered Power: disembodied and diminished. The relationship between central theme and subthemes and categories is set out in Fig. 1. Relationship of central theme, subthemes and categories

The women in this study valued: relationship with their care provider, being provided with information free of bias, being able to exercise choice and agency, as well as receiving care that encompasses both physical safety and psycho- emotional wellbeing. The experience of the care they received as ethical or not, had consequences for the woman and the outcomes of the care are presented as empowered or disempowered. This research amplifies women's voices by identifying what is valued as ethical care during pregnancy and birth and that this is core to understanding ethics in the maternity system.

The central theme: 'Radical desires' situates the woman at the centre of the care, in determining what is ethical. The theme 'Radical desires' was named because the women in this study chose a midwifery model of care, which could be considered 'countercultural' because it is a minority option, and the medical model of hospital is the mainstream option. The women in this study considered birth to be a normal, physiological process, and desired this process to be supported, placing value on the experience of pregnancy and birth as a rite of passage that they understood to contribute to a changing sense of self. This study revealed that pregnancy and birth were experienced as more meaningful than just the physical process, with personal meaning going beyond the childbirth experience and being felt long after the pregnancy and birth. When a woman's values and contexts were supported by the care provider, she deemed the care more ethical, and felt empowered. Acknowledging the meaningfulness of the pregnancy and

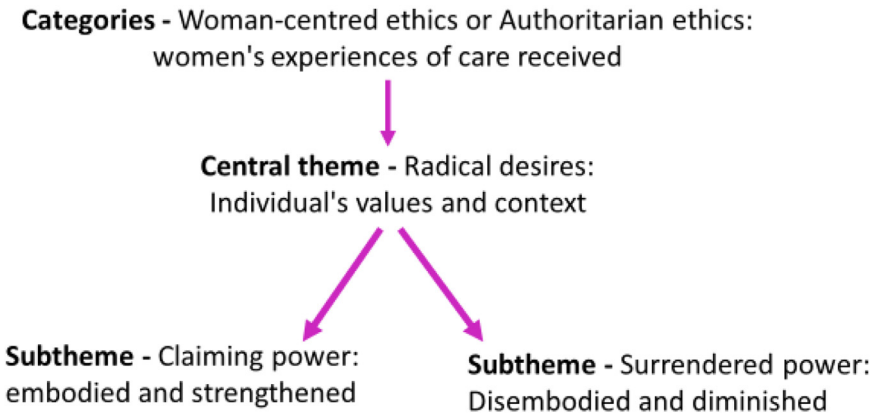

Fig. 1. Relationship of central theme, subthemes and categories.

birth experience and recognising the experiences were deeply important and are further supported by the categories, which describe how the care was given. First Authoritarian ethics are described, then Woman-centred ethics, where the conceptual model is presented and described.

Authoritarian ethics

Authoritarian ethics is made up of; Uneasy alliance representing relationships, Opaque Information representing how knowledge was used and Saving women from themselves captures how the care was given. Together, Authoritarian ethics describe a devaluing of the process of birth and of the woman, and result in perceived unethical care.

An uneasy alliance was described by women who had had an unsatisfactory experience of the hospital system or a medical model of care. They described the experience as standardised and devoid of any real relationship. The women were bound to the care giver by default which they described as being like a working alliance that met standardised needs and system processes. The women in this study used terms such as '*just a number*', '*didn't feel cared for*', '*superficial*' and '*standardised*'. Zoe best summarises the participants' experiences of uneasy alliance, describing an uneasy relationship with the obstetrician as feeling powerless, unheard, trapped in her choice and uncared for:

> *'And I just went with that I didn't have a good relationship with the Obstetrician, but I didn't feel strong enough to probably question more or actually change my decision around that. I never felt like my obstetrician really cared one way or another. He just really wanted everyone to have a pulse at the end of the day and, you know, not be sued. I think that's what he cared about. Yeah, yeah, yeah. I never felt like he actually had any idea what I wanted and how I wanted the birth to be.' (Taya)*

Opaque information is built around the experiences, described by the participants, of information being withheld or used incorrectly, or shared in a biased way, or of old evidence or standardised information presented, without alternatives. Many of the women in this study described information being reduced to threats to gain conformity to the recommended decisions, such as '*your baby will die*' and '*your placenta stops working*' as a way of conforming decision-making. Georgie describes her compulsory appointment with an obstetrician, as she was trying for a vaginal birth after caesarean (VBAC).

> *"I had to have an Obstetric appointment. It was it was a very coercive, fear driven appointment and about the risk of future rupture, and he started telling me about his own study that he'd been doing and that it was like a one in 30 chance of rupturing. But he couldn't show me the data on it. He'd gone through my notes and explained that actually the way my notes had been written that it was really code for I'm about to rupture. He was he was playing into whatever fears I had. He said homebirth is really risky because then they always come into hospital, and we have to rescue them. He actually said that we need to rescue them. And he said the way my uterus looked from the notes – and he actually made a visual where he said, you know, we wouldn't even need to put the knife on it. And it would do this (exploding noise and hands like an explosion)". (Georgie)*

Unethical care was described by women as when the health professional or the system took control of the pregnancy journey and the birth experience, which we labelled 'Saving women from themselves'. The implications of retaining control over the experiences is that the pregnancy and birth decision are removed from the woman. Care is standardised, women's bodies are policed, and physiology impeded through interventions, thereby removing women's agency and choice. Care was often given without consent, and at times was seen by the women as abusive, with unethical actions defended because they were justified as necessary to 'save' the mother or baby.

> *"And as a society and like the sisterhood, we're all in good girl mode like. we're going along with it (intervention) even though I don't agree it" (Eve)*

> *"And so, in some ways, then the feelings of feeling traumatized and devastated and disappointed and upset in some way so invalid because I should just be happy that I was saved and that my baby's safe and You've got a healthy baby. So, stop complaining kind of feeling." (Fiona)*

The consequence of Authoritarian ethics was described by the participants as leaving them '*disempowered*' because there was a lack of relationship, information was withheld, and standardised care removed control from the birth person. Surrendered power: disembodied and diminished encapsulates a surrendered conformity leading to a woman's negative or diminished sense of self, their instincts, and their bodies. Women reported *'I was left traumatised' 'I doubted myself' 'left fearful' 'didn't want to be responsible and didn't have faith in my body anymore'*

> *"Then you mistrust yourself, and I think this play into the postnatal period, when a baby is born a mother is born and that is every time you give birth. And that is not acknowledged at all in the medical model, it's all about the baby and you're not nourished as a woman and a new mother which is a part of the birth experience, I don't think you can separate it" (Ella)*

The category, 'Woman-centred ethics', brings together: Harmonised relationship, Transparent wisdom and Midwifery Solidarity. A conceptual model was created from the empirical evidence of what women described as ethical. This model contains four elements, these are: 1. Individuals' values and context 2. Harmonised relationship 3. Transparent wisdom and 4. Midwifery solidarity.

A Individuals' values and context – The person at the centre of the care determines what is ethical for them
B Harmonised relationship – Relationships built through continuity with a primary carer, through which all the other elements are realised
C Transparent wisdom – Information provision is transparent which equalises power and recognises woman's agency
D Midwifery solidarity – Unique midwifery practices, care and advocacy

The participants identified that ethical care was demonstrated when there was consideration of individual's values and context. The person at the centred of the care determines what is ethical to them and is central to understanding ethical care. This element of the model draws from the central theme Radical desires: Individuals values and context.

Harmonised relationship, one described as formed over time and through continuity with, for these women, a midwife. The women in this study acknowledged the role of the midwife in supporting them through their pregnancy and birth journey, through holistic care of both physical and emotional safety that recognised the liminality of the experience. The attributes of a harmonised relationship were described as hearing and respecting, as well as honouring and advocating, which over time developed trust. Relationship was viewed by the women in this study as important for informed consent and decision making because it strengthened and emphasised respect for autonomy, thereby ensuring the woman's selfhood remained intact. Through relationship and trust a woman was free to exercise her agency.

> *"Having a known midwife, I didn't have to re-cover or re-advocate for myself … it was something that became part of the relationship, she knew my values, trauma, history, …I think this probably also created the sense of safety needed to uncover more vulnerability and rawness which for me was essential in being able to let go and trust." (Fiona)*

Ethical care was also described by the women in subcategory Transparent wisdom; as information that was provided in a transparent way, which was accessible and shared with the woman. Current evidence was discussed, where the midwife was knowledgeable about how to provide evidenced-based care, and both benefits and risks were described for all options. Women were respected in the knowledge they had accessed, acknowledging the woman as expert of her own body and respecting other ways of knowing as an important wisdom. Through accessing current research, and transparent provision of information, women could provide truly informed choice.

> *"The way my midwife presented information; she wasn't making decisions for me, rather, she was really encouraging me to stand in my truth and own my own decisions and look at the evidence and the research and decide what was best for me." (Jenna)*

Midwifery Solidarity describes midwives supporting physiological pregnancy and birth via holistic care, with a unique set of midwifery skills, and advocacy for women's rights. The women in this study gravitated to midwifery models of care, which they understood to share their values and felt midwives were advocates for physiological pregnancy and birth.

> *"To me the essence of midwifery- led care that I experienced is the woman-centred ness and the midwives who we had supporting us believed in that – they believed in empowering us and supporting our choices and sharing information to make informed choices, so I guess the values they carry with them in their practice that enabled the normal birth to happen for us." (Elise)*

The participants described experiences where the midwife had advocated for them during times of necessary medical intervention. They described the midwife as '*holding space*', '*fought for me*', '*protected my wishes*' which ensured the woman retained decision making and felt they had retained control over the experiences. Lucy describes the move from home to hospital thus:

> *'She gave me back that sense of control (despite intervention) and oh ok it is my birth and I put my name on the birth certificate as the one who caught the baby'(Lucy)*

Woman-centred ethics was perceived by the participants as empowering, which we termed Claiming power: embodied and strengthened, as best representing the woman's positive growth and salutegenic journey through their pregnancy and birth experiences.

> *'Through pregnancy and birth, I've changed, a huge change I say that often – you're still the same person but you've changed and evolved so much. I think the hormones help that change but going through the process of preparing through pregnancy and then the normal birth I'm a lot more compassionate and thoughtful and empowered. It changed me as a woman, how I see the world and my perspective' (Georgie)*

The women in this study felt empowered when they were supported in the relationship with their midwife, when they were given transparent knowledge in order to make the made the decisions about their body and baby and takes responsibility for their own choices. Taya directly linked how she was treated by the midwives with this idea of empowered transformation

> *"I probably used to just think of it as the midwives just there to help that birth experience, whereas now that I think what that midwife actually helped me do was more things like finding my voice and my truth and my intuition and things that have served me and will continue to serve me long beyond my experience. And that's the power that a midwife can have" (Taya)*

Discussion

The central theme of this research 'Radical desires; Individuals Values and context' situates the woman's values and context as being at the centre of understanding what is ethical to the birthing person. Participants described ethical care in terms of being known in relationship, with care of socioemotional aspects, and care that enhances physiologic processes, with recognition of the liminality of pregnancy and birth. These values were set against a medicalised sociocultural context, that is risk averse and has less trust in childbirth physiology and promotes medical intervention to increase perceived safety (Clesse et al., 2018). The participants explained their views were deemed to be counter-cultural to mainstream ideas about safe birth, because in standardised, fragmented hospital systems, the idea of physical safety, upheld by intervention, is prioritised over the care of socioemotional, cultural, sexual or psychological safety. Thus, participants' views were deemed 'radical' despite the fact the demographics would describe them as mainstream. Contemporary literature supports our findings that women, generally, appreciated systems that support birth physiology, and value the idea of giving birth with minimal intervention but this can be hard to avoid in current medicalised systems (Cole, et al., 2019; Deliktas et al., 2019; Downe et al., 2018). The

central theme of this current study identifies the person at the centre of the care as the one who determines what is ethical for them, which is a key feature of care ethics theory (Tronto, 1993). The elements of care ethics theory are utilised to further describe the Woman-centred ethics model. But first, feminist theory is used to explain the subtheme: Authoritarian ethics and highlight the increased disrespect and mistreatment in the maternity system as a gendered issue.

Authoritarian ethics, as applied in maternity systems, can be experienced by women as unethical. The majority of the women in this current study, often found their expectations of good care to be regularly in conflict with medicalised and authoritarian principles, standards and policies. The care given which retains control over the pregnancy and birth experience, decentres the woman's voice, described in this study as 'Saving women from themselves'. This reflects deeper social meanings such as not trusting normal physiology, that women's bodies are broken, and women need saving from themselves and their ideas. With this experience, women felt they had been infantilised and deemed as incapable of looking after their own health. We identified this as a form of 'benevolent sexism' (Beauvoir, 1989), which is an underlying sexist belief and ambivalence toward women, whereby the women are not treated as fully competent adults and who need a subordinate figure, usually male, to save them. The manner of this saving may seem innocuous, but dependency-oriented saving undercuts the recipient's self-regard, competence and women's cognitive ability, and can lead to increased self-doubt, affecting mental health (Dardenne, 2007; Borgogna, 2020). Benevolent sexism can be recognised in the maternity system, where women's behaviours and decisions are restricted, or their intuitions minimised, because they are deemed unsafe or because the medicalised model doubts women's ability to be rational and make a good decision. Research into women's experiences of benevolent sexism in the maternity system have described scenarios such as: non-evidenced based medical advice for pregnancy, sexist valued judgments, as well as restricting women's freedoms of choice with outcomes that negatively impact their self-concept and wellbeing (Perrotte et al., 2020). A recent study in Sweden of 190 women's experiences of birth were collated and analysed from a gender perspective (Westergren et al., 2021), describing how woman conform to gendered roles during birth as passive and conforming agents in a medicalised setting, which in turn affects birthing women's ability to assert themselves and be involved in decision making. Van Der Waal et al. (2021) theorise how students entering the 'obstetric institution', both medical and midwifery, are pushed to cross ethical boundaries to collude in obstetric violence, as rites of passage into what is an inherently violent system, that does not inadvertently create systems of oppression but is founded on them.

The consequence of unethical care was described in the subtheme 'Surrendered power; disembodied and diminished'. The participants described a sense of surrendering as a consequence of unethical behaviour, derogatory language, retained authority of the birth by health professionals. Surrendered power negatively affected sense of self, related to women's confidence and capabilities. In this current study, evidence of unethical care resulted in a diminished sense of self.

Woman-centred ethics

In contrast, the participants described care that they had received within midwifery models that prioritised her values, that supported her beliefs about the birth physiology, and where power was equalised through transparent information provision, as being ethical. The subcategories Harmonised relationship, Transparent wisdom and Midwifery solidarity together with Radical Desires: Individual's values and context make up the Woman-centred ethics model. Woman-centred care is a core midwifery philosophy, which is individualised, holistic and respects human rights (Crepinsek et al., 2022; Davis et al., 2021; ICM, 2014). The label Woman-centred ethics, encapsulates midwifery philosophy and practice (ICM, 2014; ICM 2017) with feminist care ethics (Buchanan et al., 2021; Buchanan et al., 2022b; Gilligan, 1982; Tronto, 1993). Woman-centred ethics identifies the person at the centre of the care as the one who determines what is ethical for them, which is a key feature of care ethics theory (Tronto, 1993). Care ethics theory highlights that beneficence or the good care, comes from the way the care is given (Gilligan, 1982; Tronto, 1993). So, rather than abstract ethical principles guiding care from in a top-down way, care ethics is bottom-up – starting with the individual at the centre of the care (Gilligan, 1982). Care ethics is understood through relationship, which fosters individualised care and considers more than just physical factors, also encompassing a person's context, culture, environment and values (Held, 2006; Tronto, 1993). Care ethics places importance on paying attention to power imbalances, as well as structural and individual power, and aims to reduce authoritarian power (Held, 2006; Gilligan, 1982; Tronto; 1993). Next each element of Woman-centred ethics is described, which supports the Woman-centred ethics conceptual model, as way to enhance ethical practice (Fig. 2).

Harmonised relationship

The participants in this study explained that relationship was a central feature of ethical care. The women assigned a moral significance to this relationship, noting the quality of the relationship was described by the women in this study as the vehicle through which the woman's values were known (or not known). The importance of relationship was central to the person feeling that their family, context, culture, emotions and values were understood. The participants described this knowing as fostering greater ethical sensitivity; thus, better quality of care.

Research highlights that continuity of midwifery care supports both physical and emotional aspects of pregnancy and birth, where women describe being more informed and active partners in decision making, with their wishes respected because of the relationship (Brady et al., 2019; Perriman and Davis, 2018). A review by Perriman and Davis (2018) and more recently Brady et al (2019) around core aspects of midwifery explain that relationship, underpinned by personalised care, trust and protect-

Fig. 2. Woman-centred ethics: a model for midwifery care.

ing normal birth, results in empowerment where care and attention is given to the psycho-emotional aspects of the woman which was described as ethical in this current study.

Transparent wisdom

In this present study the transparent provision of information, free of bias or coercion, was shown to be valued by women, because it balanced power in the relationship and fostered agency. The women described themselves as being informed through reading research, discussions with their midwife, and through trusting their bodies. Free sharing of knowledge, which acknowledges the agency of the person receiving it is more useful that fixating on a right to autonomy and informed consent processes, which can be undermined by coercive behaviours.

The women in this study viewed the midwifery model of care as more ethical because it gave them power and knowledge to make decisions about their bodies and take responsibility for their choices. These findings align with contemporary literature that information provision in relational contexts, supports women to fully exercise their agency (O'Brien et al., 2018; Woollard, 2021). In this current study, shared information and respect for embodied knowledge was essential for women to make decisions which they perceived as ethical for safety, to exercise agency and balance power.

Midwifery solidarity

Midwifery solidarity captures the alignment of midwifery care with values held by the women in the study. Midwifery, as an autonomous profession, works in supportive partnership with women and is the only profession to have expertise in normal, physiological pregnancy and birth, relational practices and advocacy, toward the promotion of women's capabilities (ICM, 2017). The unique midwifery skills that support normal physiological processes were valued by participants in this study, featuring as the reason why they sought midwifery models of care. The midwifery support for physiology is reinforced by other studies which demonstrate the benefits of midwifery guardianship and trust rather than intervention to support normal pregnancy and birth (Downe et al., 2018; Perriman and Davis, 2018). Similarly, an integrative review by Olza et al. (2020) link normal physiology and psychological aspects that facilitate optimal adjustment to motherhood and recommended that birthing people have continuity of care. With the support for physiology comes the midwifery role in advocacy. Advocacy is highlighted as an important aspect of midwifery models of care (Downe et al.,2018; Perriman and Davis, 2018; Webb et al., 2021). Solidarity in this study was described by the participants as the unique midwifery care that supports physiology, the liminality of the experiences, and advocacy for the individuals' values.

These three subcategories Harmonised relationship, Transparent wisdom and Midwifery solidarity together demonstrated a different kind of ethics: Woman centred ethics. What was significant about the findings in this current study, is that when the care was perceived as ethical the women described themselves as feeling more powerful. We used the term 'Claiming power: embodied and strengthened' to describe the positive inner changes with women in this study describing. This study also highlights that the pregnancy and birth experiences go beyond the physical process, with personal meaning extending to a changing sense of self. Thus, how care is given, such as in Woman-centred ethics, recognises birthing peoples changing sense of self and transformation. A hall mark of midwifery care is supporting birthing people to have authority over the birth and their own body, as based on trustful relationships, informed choice, holistic care and empowerment (Downe et al., 2018; Menage et al., 2020). The positive experiences described in this current study are examples of ethical care which fosters women's empowerment.

This current study contributes to this literature by identifying ways to circumvent and rupture the obstetric institution using an ethical model that can only be upheld by centring the values of the individual, but also the advocacy of these values, offering a framework to resist institutional violence and unethical care. The Woman-centred ethics model offers a practical tool to guide everyday, embodied, ethical midwifery practice.

Limitations

This study included women who represent only a small portion of society, they were: white, educated, from higher socioeconomic backgrounds, were self-selecting and had experienced midwifery models of care. This homogeneity is acknowledged as a limitation because it does not address diversity or intersectionality. However, it presents a model of ethics from midwifery which, by placing the individual at the centre, can be used, tested ad adapted with more diverse groups. One other limitation of this study is that the primary research was a member of the CARG, which may have influenced focus group responses; however, this was countered with the allocation of another member to lead groups discussions. Reflexivity and the guidance of care ethics for researchers were used to minimise undue influence.

Conclusion

The findings of this study contribute empirical evidence of what childbearing people might value as ethical. The participants clearly detailed what was ethical and unethical from their perspective, and this new knowledge contributes to a better understanding of the ethics within the maternity care context. Centring what birthing people value at the core of any ethical care is an important first step to challenging the unethical aspects of care described in this study. Recognition of the context of pregnancy and birth as ethical liminality may change care to be more supportive of psychosocial aspects, to reduce unequal power relationships and oppressive behaviours. Equally, the identification of equal knowledge-sharing as experienced as increasing the power of the woman is an important contribution. Not knowing the woman, her context, her values, and not centring the woman in ethical understandings, is to not fully comprehend how ethics is lived out in everyday maternity care. This study has contributed to the body of knowledge that describes how women perceive ethics in the maternity; and therefore, contributes to philosophical underpinnings and practice issues within midwifery. The findings may be transferable to other health professions who care for birthing people during pregnancy and birth in providing ethical maternity care. There is opportunity for future research to explore ethics from other models of care, from more diverse backgrounds and to test the Woman-centred ethics model in practice.

Ethical statement

Ethics was approved (REM 2019-00296- BUCHANAN and REM 2020 – 01707- BUCHANAN).

Declaration of Competing Interest

There is no conflict of interest to declare.

CRediT authorship contribution statement

Kate Buchanan: Conceptualization, Data curation, Formal analysis, Methodology, Writing – original draft, Project administration.

Sadie Geraghty: Formal analysis, Supervision, Writing – review & editing, Validation. **Lisa Whitehead:** Formal analysis, Supervision, Writing – review & editing, Validation. **Elizabeth Newnham:** Formal analysis, Supervision, Writing – review & editing, Validation.

Funding

This research is/was supported by an Australian Government Research Training Program (RTP) Scholar

References

Australian Institute of Health, 2022. Australian Mothers and Babies, 2020 in Brief. AIHW, Canberra.

Beauchamp, T.L., Childress, J.F., 2019. Principles of Biomedical Ethics, 8th ed. Oxford University Press, New York, NY.

Beauvoir, S., de Parshley, H.M., Bair, D., 1989. The Second Sex (Vintage Books). Vintage Books.

Borgogna, N.C., Aita, S.L., 2020. Are sexist beliefs related to mental health problems? Soc. Sci. J. 1–15. doi:10.1080/03623319.2020.1809902.

Brady, S., Lee, N., Gibbons, K., Bogossian, F., 2019. Woman-centred care: an integrative review of the empirical literature. Int. J. Nurs. Stud. 94, 107–119. doi:10.1016/j.ijnurstu.2019.01.001.

Braun, V, Clarke, V, 2021. Can I use TA? Should I use TA? Should I *not* use TA? Comparing reflexive thematic analysis and other pattern-based qualitative analytic approaches. Couns Psychother Res 21, 37–47. https://doi.org/10.1002/capr.12360.

Braun, V., Clarke, V., Hayfield, N., 2022. A starting point for your journey, not a map': Nikki Hayfield in conversation with Virginia Braun and Victoria Clarke about thematic analysis. Qual. Res. Psychol. 19 (2), 424–445. doi:10.1080/14780887.2019.1670765.

Buchanan, K., Newnham, E., Geraghty, S., Whitehead, L., 2022. Navigating midwifery solidarity: a feminist participatory action research framework. Women Birth doi:10.1016/j.wombi.2022.06.004.

Buchanan, K., Newnham, E., Ireson, D., Davison, C., Bayes, S., 2021. Does midwifery-led care demonstrate care ethics: A template analysis. Nursing Ethics 29 (1), 245–257. https://doi.org/10.1177/09697330211008638.

Buchanan, K., Newnham, E., Ireson, D., Davison, C., Geraghty, S., 2022. Care ethics framework for midwifery practice: a scoping review. Nurs. Ethics doi:10.1177/09697330221073996, 9697330221073996-9697330221073996.

Campbell, S., Greenwood, M., Prior, S., Shearer, T., Walkem, K., Young, S., Walker, K., 2020. Purposive sampling: complex or simple? Research case examples. J. Res. Nurs. JRN 25 (8), 652–661. doi:10.1177/1744987120927206.

Clesse, C., Lighezzolo-Alnot, J., de Lavergne, S., Hamlin, S., Scheffler, M., 2018. The evolution of birth medicalisation: a systematic review. Midwifery 66, 161–167. doi:10.1016/j.midw.2018.08.003.

Cole, L., LeCouteur, A., Feo, R., Dahlen, H., 2019. Trying to give birth naturally was out of the question": accounting for intervention in childbirth. Women Birth 32 (1), e95–e101. doi:10.1016/j.wombi.2018.04.010.

Crepinsek, M., Bell, R., Graham, I., Coutts, R., 2022. A global review of the inferred meaning of woman centred care within midwifery professional standards. Women Birth doi:10.1016/j.wombi.2022.05.001.

Dardenne, B., Dumont, M., Bollier, T., 2007. Insidious dangers of benevolent sexism: consequences for women's performance. J. Pers. Soc. Psychol. 93 (5), 764–779. doi:10.1037/0022-3514.93.5.764.

Deliktas Demirci, A., Kabukcuglu, K., Haugan, G., Aune, I., 2019. I want a birth without interventions": women's childbirth experiences from Turkey. Women Birth J. Aust. Coll. Midwives 32 (6), e515–e522. doi:10.1016/j.wombi.2018.12.011.

Downe, S., Byrom, S., Topalidou, A., 2019. Squaring the circle: normal birth research, theory and practice in a technological world. Squaring The Circle: Normal Birth Research, Theory and Practice in a Technological World S. Downe & S. Byrom. Pinter & Martin Ltd, London.

Downe, S., Finlayson, K., Oladapo, O.T., Bonet, M., Gülmezoglu, A.M., 2018. What matters to women during childbirth: a systematic qualitative review. PLoS One 13 (4). doi:10.1371/journal.pone.0194906, e0194906-e0194906.

Gilligan, C., 1982. In a Different Voice: Psychological Theory and Women's Development. Harvard University Press, Cambridge, Mass.

Gilligan, C., 1982. *In a different voice: Psychological theory and women's development*. Harvard University Press.

Glazer, K.B., Howell, E.A., 2021. A way forward in the maternal mortality crisis: addressing maternal health disparities and mental health. Arch. Women's Ment. Health 24 (5), 823–830. doi:10.1007/s00737-021-01161-0.

Grigg, C., Tracy, S.K., Daellenbach, R., et al., 2014. An exploration of influences on women's birthplace decision-making in New Zealand: a mixed methods prospective cohort within the Evaluating Maternity Units study. BMC Pregnancy Childbirth 14, 210. https://doi.org/10.1186/1471-2393-14-210.

Guest, G., Namey, E., McKenna, K., 2017. How many focus groups are enough? building an evidence base for nonprobability sample sizes. Field Methods 29 (1), 3–22. doi:10.1177/1525822X16639015.

Held, V. (2006). The ethics of care: personal, political, and global [1 online resource (viii, 211 pages)]. Retrieved from http://site.ebrary.com/id/10211833

International Confederation of Midwives. (2014). International Code of Ethics for Midwives. In. Hague, Netherlands.

International Confederation Midwives. (2017). Definition of the Midwife. Retrieved from https://www.internationalmidwives.org/our-work/policy-and-practice/icm-definitions.html

Jones, C., 2022. The harms of medicalisation: intersex, loneliness and abandonment. Feminist Theory 23 (1), 39–60. doi:10.1177/14647001211062740.

Kook, R., Harel-Shalev, A., Yuval, F., 2019. Focus groups and the collective construction of meaning: listening to minority women. Women's Stud. Int. Forum 72, 87. doi:10.1016/j.wsif.2018.12.004.

MacLellan, J., 2014. Claiming an ethic of care for midwifery. Nursing Ethics 21 (7), 803–811. https://doi.org/10.1177/0969733014534878.

McDiarmid, T., Pineda, A., Scothern, A., 2021. We are women! We are ready! Amplifying women's voices through feminist participatory action research. Eval. J. Australas. 21 (2), 85–100. doi:10.1177/1035719X21998479.

Miller, S., Abalos, E., Chamillard, M., Ciapponi, A., Colaci, D., Comandé, D., Althabe, F., 2016. Beyond too little, too late and too much, too soon: a pathway towards evidence-based, respectful maternity care worldwide. Lancet (10056) 2176–2192. doi:10.1016/S0140-6736(16)31472-6, 388 North American Edition.

Menage, D., Bailey, E., Lees, M.S., Coad, J., 2020. Women's lived experience of compassionate midwifery: human and professional. Midwifery, 102662 doi:10.1016/j.midw.2020.102662.

Newnham, E., Kirkham, M., 2019. Beyond autonomy: care ethics for midwifery and the humanization of birth. Nurs. Ethics doi:10.1177/0969733018819119, 969733018819119-969733018819119.

O'Brien, B.C., Harris, I.B., Beckman, T.J., Reed, D.A., Cook, D.A., 2014. Standards for reporting qualitative research: a synthesis of recommendations. Acad. Med. 89 (9), 1245–1251. doi:10.1097/acm.0000000000000388.

O'Brien, D., Casey, M., Butler, M.M., 2018. Women's experiences of exercising informed choices as expressed through their sense of self and relationships with others in Ireland: a participatory action research study. Midwifery 65, 58–66. doi:10.1016/j.midw.2018.07.006.

Olsen, V., 2018. Feminist qualitative research in the millenium's first decade: developments, challenges, prospects. The Sage Handbook of Qualitative Research N. K. Denzin & Y. S. Lincoln. Sage, Thousand Oaks, California.

Olza, I., Uvnas-Moberg, K., Ekström-Bergström, A., Leahy-Warren, P., Karlsdottir, S.I., Nieuwenhuijze, M., Buckley, S., 2020. Birth as a neuro-psycho-social event: An integrative model of maternal experiences and their relation to neurohormonal events during childbirth. PLoS One 15 (7), e0230992. doi:10.1371/journal.pone.0230992.

Perriman, N., Davis, D., 2018. Understanding what it is that women value about continuity of midwifery care. Women Birth J. Aust. Coll. Midwives 31, S52. doi:10.1016/j.wombi.2018.08.155, –S52.

Perrotte, V., Chaudhary, A., Goodman, A., 2020. At least your baby is healthy" obstetric violence or disrespect and abuse in childbirth occurrence worldwide: a literature review. Open J. Obstet. Gynecol. 10 (11), 1544–1562.

Reid, C., Frisby, W., 2008. Continuing the journey: Articulating dimensions of feminist participatory action research. In: Reason, P., Bradbury, H. (Eds.), *The SAGE handbook of action research: Participative inquiry and practice*. SAGE Publications, pp. 93–105.

Saldaña, J., 2016. The Coding Manual for Qualitative Researchers, 3rd ed. SAGE, London.

Salter, C.L., Olaniyan, A., Mendez, D.D., Chang, J.C., 2021. Naming silence and inadequate obstetric care as obstetric violence is a necessary step for change. Violence Against Women 27 (8), 1019–1027. doi:10.1177/1077801221996443.

Sangster, S. L., Bayly, M. K., 2016. Anarchists, naturalists, hippies, and artists: beliefs about midwifery care and those who choose it. Can J Midwifery Res Pract 15 (2), 38–46.

Saunders, B., Sim, J., Kingstone, T., Baker, S., Waterfield, J., Bartlam, B., Jinks, C., 2018. Saturation in qualitative research: exploring its conceptualization and operationalization. Qual. Quant. 52 (4), 1893–1907. doi:10.1007/s11135-017-0574-8.

Shimei, N., Lavie-Ajayi, M., 2021. Four practices for conducting feminist participatory action research with young women. Action Res. doi:10.1177/14767503211036489, 14767503211036489.

Stanton, M.E., Gogoi, A., 2022. Dignity and respect in maternity care. BMJ Glob. Health 5 (Suppl 2). doi:10.1136/bmjgh-2022-009023.

Tronto, J.C., 1993. Moral Boundaries: a Political Argument for an Ethic of Care. Routledge, New York.

van der Waal, R., Mitchell, V., van Nistelrooij, I., Bozalek, V., 2021. Obstetric violence within students' rite of passage: The reproduction of the obstetric subject and its racialised (m)other. Agenda 35 (3), 36–53. doi:10.1080/10130950.2021.1958553, (Durban).

Webb, R., Ayers, S., Bogaerts, A., Jeličić, L., Pawlicka, P., Van Haeken, S., Ventura, S.S., 2021. When birth is not as expected: a systematic review of the impact of a mismatch between expectations and experiences. BMC Pregnancy Childbirth 21 (1), 1–475. doi:10.1186/s12884-021-03898-z.

Westergren, A., Edin, K., Christianson, M., 2021. Reproducing normative femininity: women's evaluations of their birth experiences analysed by means of word frequency and thematic analysis. BMC Pregnancy Childbirth 21 (1), 1–13. doi:10.1186/s12884-021-03758-w.

Woollard, F., 2021. Mother knows best: pregnancy, applied ethics, and epistemically transformative experiences. J. Appl. Philos. 38 (1), 155–171. doi:10.1111/japp.12464.

World Health Organisation, 2014. *The prevention and elimination of disrespect and abuse during facility-based childbirth*. World Health Organisation, Geneva.