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Woman-centred care: An integrative review of the empirical literature

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ABSTRACT

Objective: The objective of this review is to explore, review and synthesize the empirical literature that reports on the concept of woman centred care.
Design: Integrative review of the empirical literature on the concept of woman centred care.
Data sources: A comprehensive search strategy was conducted using the phrase 'woman-centred care' 'women-centred care' (and all associated spelling variants) in the relevant databases including PubMed, Cumulative Index to Nursing and Allied Health, Intermid, Scopus, Informit and Web of Science. A concurrent search using the phrase 'patient-centred care' (and associated spelling variants) was also conducted, to ensure all studies about care of a woman in pregnancy, labour and postpartum were captured.
Review method: A comprehensive five stage integrative review methodology was used to review primary studies which addressed woman-centred care as either an intervention or an outcome. The quality of included studies was assessed using the appropriate Critical Appraisal Skills Programme tool.
Results: Initial searching located 1205 papers. Seventeen studies met the inclusion criteria (qualitative n=12 and quantitative n=5). The studies were conducted in Australia (n=5), Ireland (n=1), Japan (n=2), Netherlands (n=2), New Zealand (n=1), South Africa (n=1), Sweden (n=1), Switzerland (n=1), United Kingdom (n=1), and the United States of America (n=2). The quality of the studies varied. NVivo software was employed to abstract and synthesize the data. Analysis revealed 10 subthemes synthesized under three pre-determined main themes of clinical practice (choice and control, empowerment, protecting normal birth, relationships and the individual midwife), maternity service (model of care, continuity of care and maternity care systems) and education (registered practitioners and student midwives).
Conclusions: This review integrates the empirical literature to illuminate the concept of woman-centred care as it currently applies to clinical practice, maternity service, and education. The concept of woman-centred care is intertwined in the themes and subthemes identified in the studies. There is wide variation in how woman-centred care is interpreted and this contributes to the confusion and tokenism with which it is discussed in health policy documents and frameworks. Further research is also warranted in the development of a universal definition of woman-centred care and in how woman-centred care behaviours are developed in practitioners.

What is already known about the topic?

- The concept woman-centred care is used in the development of health policy frameworks and in clinical practice and education.
- The term wom*e*n-centred care describes a philosophy applied to maternity services, while the term wom*a*n-centred care shifts the emphasis onto each woman's individual needs.

What this paper adds

- We demonstrate the interwoven use and value placed on the concept of woman-centred care in the context of clinical practice, maternity service provision and to a lesser extent, education.

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- There is wide variation in how woman-centred care is interpreted and this contributes to the confusion and tokenism with which it is discussed in health policy documents and frameworks.
- The lack of a universally-accepted definition of woman-centred care and a paucity of evidence about how woman-centred care behaviours are fostered in educational programs impede translation of this desired level of care into policy to guide clinical practice, maternity service, and education.

1. Introduction

Woman-centred care is often seen as synonymous with midwifery care. It implies that midwifery care is focused on the woman's unique individual needs, expectations and aspirations, rather than the needs of the midwifery profession or institution (Leap, 2009). The International Confederation of Midwives espouses the woman-centred philosophy of partnership, cultural sensitivity, and normalcy around birth; the promotion of self-care, and the right to self-determination (Internationl Confederation of Midwives [ICM], 2017). Woman-centred care provides a fundamental philosophical approach for midwives and is integral to how the role of the midwife and standards of practice are defined (Internationl Confederation of Midwives [ICM], 2017; Nursing and Midwifery Board of Australia [NMBA], 2018).

Previous authors have suggested that key elements of woman-centred care are those of choice and control, and continuity of caregiver (Sandall et al., 2016; Snowden et al., 2011). The frequently cited characterisation of woman-centred care proposed by Nicky Leap also encapsulates the principles of choice, control, continuity of caregiver, and adds the right to self-determination. Leap (2009) also comments that definitions of woman-centred care in the literature vary and are more often implied rather than clearly articulated suggesting an overarching philosophy of woman-centred care may be a difficult concept to put into words. These differing approaches indicate that there is currently no one accepted universal definition of woman-centred care.

Exploring the use of woman-centred care in practice, Carolan and Hodnett (2007) examined several woman-centred philosophies that emerged in response to the increasing medicalization of pregnancy and birth. Whilst laudable, the authors suggest there were concerns that a focus only on normality and midwife-led models of care could exclude a growing number of women labelled as 'high-risk'. This suggests that definitions of woman-centred care need to encompass all women and not become a defacto division between midwifery and medical models. In a concept analysis Maputle and Donavon (2013) described woman-centred care as a process in which the woman has control, makes choices, and is involved all aspects of her care and relationship with her midwife. They established that woman-centred care was complex and experienced individually and was enhanced by collaborative partnerships with other healthcare-providers. A more recent concept analysis of eight studies by Fontein-Kuipers et al. (2018) concluded that woman-centred care has both philosophical and pragmatic meanings, with a strong emphasis on the woman- midwife relationship during the childbearing period. The 'with-woman' relationship, rather than the more overarching philosophical view of woman-centred care favoured by other aforementioned authors, was further explored in an integrative review by Bradfield et al. (2018) who identified the concept of 'with-woman' as both fundamental and dynamic in midwifery acting as an anchoring force necessary for contemporary practice in rapidly changing maternity care environments. Whilst the importance of the relationship between the woman and the midwife is a common theme in these studies, they also highlight the variation in the representation of woman-centred care in clinical practice.

Woman-centred care should inform the development, structure and function of maternity services and global notions of empowerment for all women (Renfrew et al., 2014). Used interchangeably throughout many health policy frameworks are the terms wom***a***n and wom***e***n-centred care, however, there is an important distinction to be made. The former refers to the needs of the individual woman and her situation. The latter is a philosophy which may guide service provision or may simply be a descriptor applied to maternity services (Leap, 2009). Defining woman-centred care requires an analysis of the language and terms used, as these play a part in constructing and perpetuating the culture of pregnancy, labour and birth (Hunter, 2006). Wom***e***n-centred care can denote a philosophy applied to an entire maternity service, while wom***a***n-centred care shifts the emphasis onto each woman's specific needs and her individual circumstances (Leap, 2009). Currently, there is confusion around the use of the terms wom***a***n and wom***e***n-centred care when applied to the description of maternity services.

Whilst the concept of woman-centred care in clinical practice and maternity services has been explored in numerous studies there is a paucity of evidence regarding the development of woman- centred care behaviours in educational programs. Brady et al., (2016) developed and piloted a scale to measure the performance of woman-centred behaviours in midwifery students. Videos of students simulating clinical encounters were assessed for woman-centred care behaviors by two experienced midwifery clinicians. These researchers observed that there was a lack of shared understanding of what constitutes woman-centred care amongst the assessors. Testing the philosophy that midwifery education is based on the women-centred model of care Yanti et al. (2015) compared the development of this philosophy in students undertaking clinical training in either fragmented models of care or continuity models of care and concluded that those exposed to the later had an increased understanding of midwifery care philosophy.

Given the lack of shared understanding and considering the diversity of perspectives surrounding woman-centred care, it is timely to examine contemporary interpretation of this concept. Therefore, the aim of this integrative review is to explore, review, and synthesize the empirical literature that reports on woman-centred care within the contexts of clinical practice, maternity service and education.

2. Methodology

Within healthcare there is an increasing demand for synthesis of research and both qualitative and quantitative evidence are needed to inform clinical decision making and evidenced based practice (Lockwood et al., 2015). Qualitative research methods support the analysis of the human experience, cultural and social phenomena while quantitative methods can justify, in a scientific manner, the outcomes of clinical actions and provide the basis for effective high quality and evidenced based clinical practice (Lockwood et al., 2015; Shields and Watson, 2012). An integrative review is a broad method of review which synthesizes both quantitative and qualitative methodologies and so has the capacity to capture the complexity of varying perspectives and emergent phenomena such as those included in the provision of woman-centred care (Hopia et al., 2016).

The use of a structured framework for integrative reviews ensures robust methodology therefore this review used the five-stage methodology proposed by Whittemore and Knafl (2005); 1) problem identification, 2) literature search (methods and outcomes), 3) data evaluation, 4) data analysis (results) and 5)

presentation (discussion). This type of methodological framework provides scaffolding to order the review process, and adds rigor (Hopia et al., 2016).

Whittemore and Knafl (2005) acknowledge the complexity of evaluating quality primary research sources in an integrative review and suggest choosing quality criteria instruments for each type of source. Katrak et al. (2004) agree that there is no 'gold standard' critical appraisal tool for any study design, nor are there any commonly accepted, generic tools that can be applied similarly across study types. For this reason, the Critical Appraisal Skills Program appraisal tools were chosen (Critical Appraisal Programme, 2017a, b, c).

2.1. Search methods

A comprehensive two-stage approach and search strategy was designed in conjunction with an expert librarian and used electronic database searching followed by a "snowballing" technique of data mining through citation tracking and reference list searches. The search was conducted using the phrase 'woman-centred care' (and all associated spelling variants). A concurrent search using the phrase 'patient-centred care' (and associated spelling variants) was also conducted, to ensure all studies about care of women in pregnancy, labour and postpartum were captured. An example of the search strategy used for PubMed is provided in Table 1. Similar strategies were used for additional databases; CINAHL, InterMid, Scopus, Informit, and Web of Science.

Inclusion criteria was primary research studies published in peer-reviewed journals written in English. Suitable publications from 1990 to 2017 were included, as the 1990′s had seen the beginning of continuity of care models and an increase in community midwifery, which focused on the provision of woman-centered care (Walsh, 1999). During this time in the United Kingdom the Royal College of Midwives and, in Australia, the Australian College of Midwives, along with the New Zealand College of Midwives, and the Canadian Association of Midwives, also began to mention the concept of woman-centred care in their philosophy and position statements (Leap, 2009). Because of the many of ways woman-centred care was represented in the empirical literature, studies which addressed woman-centred care as an intervention and those which detailed woman-centred care as a reported outcome only, were selected. Studies which only mentioned inherent traits of woman-centred care, those of choice, control and continuity, were not specifically included. Study designs included both descriptive and analytic studies.

Exclusion criteria were non-peer reviewed publications and studies that did not offer a description of the concept woman-centred care, and those which described woman-centred care in other service settings, not related to pregnancy.

The abstracted and synthesised data from the included studies were then analysed using data comparison and thematic analysis. During this process three main themes emerged, woman-centred care as represented in clinical practice, maternity service and education. These three themes were then used as a framework to organise emerging subthemes.

2.2. Data abstraction and synthesis

Hopia et al., (2016) suggest that the use of pre-determined subset groups during data abstraction and synthesis can assist in the data analysis stage. Therefore, studies were organised in themes based on the described contexts of clinical practice, maternity service and education. Regardless of methodology, related terms in the included studies were identified and these provided the primary data source in the chosen themes for analysis.

Data analysis was undertaken using the four-phase process as described by Whittemore and Knafl (2005). During the first stage (data reduction), data were divided and organised into groups of differing methodologies (qualitative, quantitative) as well as the themes of woman-centred care in clinical practice, maternity service, and education. The second phase (data display) used the NVivo coding system to highlight and collate data from the studies into organised reference coded nodes (NVivo, 2012). The third stage (data comparison) examined the data displays of the primary sources to identify patterns, themes and relationships (Whittemore and Knafl, 2005). The qualitative data offered rich descriptions of the woman-centred care concept and were used to identify components of woman-centred care and relationships between the characteristics, behaviours and outcomes of woman-centred care. The quantitative studies were analysed using a similar process with study content, outcomes and findings of the pre-determined themes allocated to themes and subthemes. To support interpretation and provide clarity, the data were also organised into a visual representation (Whittemore and Knafl, 2005).

The fourth and final stage (conclusion drawing and verification) assisted in developing interpretations, derived from the previous stages, into conclusions or assumptions about the presentation of the concept of woman-centred care in the empirical literature.

3. Results

Initial searching located 1205 studies; 249 duplicates were then removed. All titles and abstracts (n = 956) were then read using the set inclusion and exclusion criteria. After this process 64 studies remained. Each remaining study was read by two independent reviewers (SB & NL) to confirm final inclusion. A detailed and descriptive account was made regarding all decisions to include or exclude final publications from the review. The main reasons for exclusion were the use of the phrase woman-centred care in the title (n = 47), abstract or conclusion only (n = 14), woman-centred

Table 1
Example of search strategy PubMed.

Search ID #	Search terms	Search options	Results
1	((("woman-centred*" OR "woman centered*" OR "women centred*" OR "women centered*")) AND English[lang])	**Search modes**- Boolean/Phrase	413
2	((("woman-centred*" OR "woman centered*" OR "women centred*" OR "women centered*")) AND English[lang])	**Limiters** – publication years 1990-2017 English language **Search modes**- Boolean/Phrase	295
3	(((((("Patient-Centered Care"[Mesh]) OR ("woman-centred*" OR "woman centered*" OR "women centred*" OR "women centered*")) AND (midwi* OR maternity OR birth*))) AND English[lang])	**Search modes-** Boolean/Phrase	758
4	((((((("Patient-Centered Care"[Mesh]) OR ("woman-centred*" OR "woman centered*" OR "women centred*" OR "women centered*")) AND (midwi* OR maternity OR birth*))) AND English[lang])) AND "last 10 years"[PDat]	**Limiters –** publication years 1990-2017 English language **Search modes-** Boolean/Phrase	495

care was not an intervention (n = 20) or an outcome of the study (n = 12). One study was published in Japanese only and was not able to be included in the review (Iida, 2010).

Seventeen studies were identified for final inclusion from an initial 1205 papers (Fig. 1). Studies were then categorised as either qualitative (n = 12) or quantitative (n = 5) to enable appraisal and synthesis. The studies selected were from Australia (n = 5), Ireland (n = 1), Japan (n = 2), Netherlands (n = 2), New Zealand (n = 1), South Africa (n = 1), Sweden (n = 1), Switzerland (n = 1), United Kingdom (n = 1), and the United States of America (n = 2).

3.1. Quality of papers included

The 12 qualitative studies were assessed using the ten item Critical Appraisal Skills Program Qualitative research tool (Table 2) (Critical Appraisal Programme, 2017a). Of the five quantitative studies there were four cohort studies, and one randomised controlled trial and these were evaluated using the 12 item Critical Appraisal Skills Program cohort study tool and the 11 item Randomised Control Trial appraisal tool (Table 2) (Critical Appraisal Skills Program, 2017b, c). Each study was allocated a score by two independent reviewers (SB and one other from the research team). Differences in scores were resolved by discussion, and agreement was reached on the quality score of each study. Of the studies included in the integrative review most were of good quality meeting at least fifty percent of the applied appraisal guidelines. There were several exceptional papers (Borrelli et al., 2016; Giarratano, 2003; Iida et al., 2014a, b; Maputle and Hiss, 2010). One paper (Browne et al., 2014) achieved only two out of ten items on the appraisal tool, However, given the paucity of studies which research woman-centred care in education, it was decided to include this study in the review. No studies were excluded based on quality appraisal.

Drawing on the three main themes of woman-centred care in clinical practice, maternity service and education, we further identified 10 subthemes. Subthemes of woman-centred care in clinical practice were identified as (choice and control; empowerment; protecting normal birth; relationships; and the individual midwife). The subthemes of woman centred-care in maternity service were identified as (model of care; continuity of care and maternity care systems). And subthemes of woman-centred care as it is depicted in education were identified as (registered practitioners and student midwives). The relationship between these themes and subthemes is represented in (Fig. 2).

Further analysis revealed each of the studies included addressed between three and 10 of the total 10 subthemes and this is represented in (Table 3). Each of these themes and subthemes will be discussed in turn.

3.2. Woman-centred care in clinical practice

Nine studies linked woman-centred care as demonstrated in clinical practice. Predominantly qualitative in methodology, these studies sought to understand woman-centred care as perceived by both women and midwives. Seven studies (Ahlund et al., 2017; Daemers et al., 2017; Davis and Walker, 2010; Hunter et al., 2017; Maputle and Hiss, 2010; Saftner et al., 2017; Thompson et al., 2016) sought midwives' perspectives of how to incorporate woman-centred care into their practice; for example, exploring factors influencing clinical decision making (Daemers et al., 2017) and attitudes to promoting physiological childbirth (Saftner et al., 2017; Thompson et al., 2016). Two studies examined women's

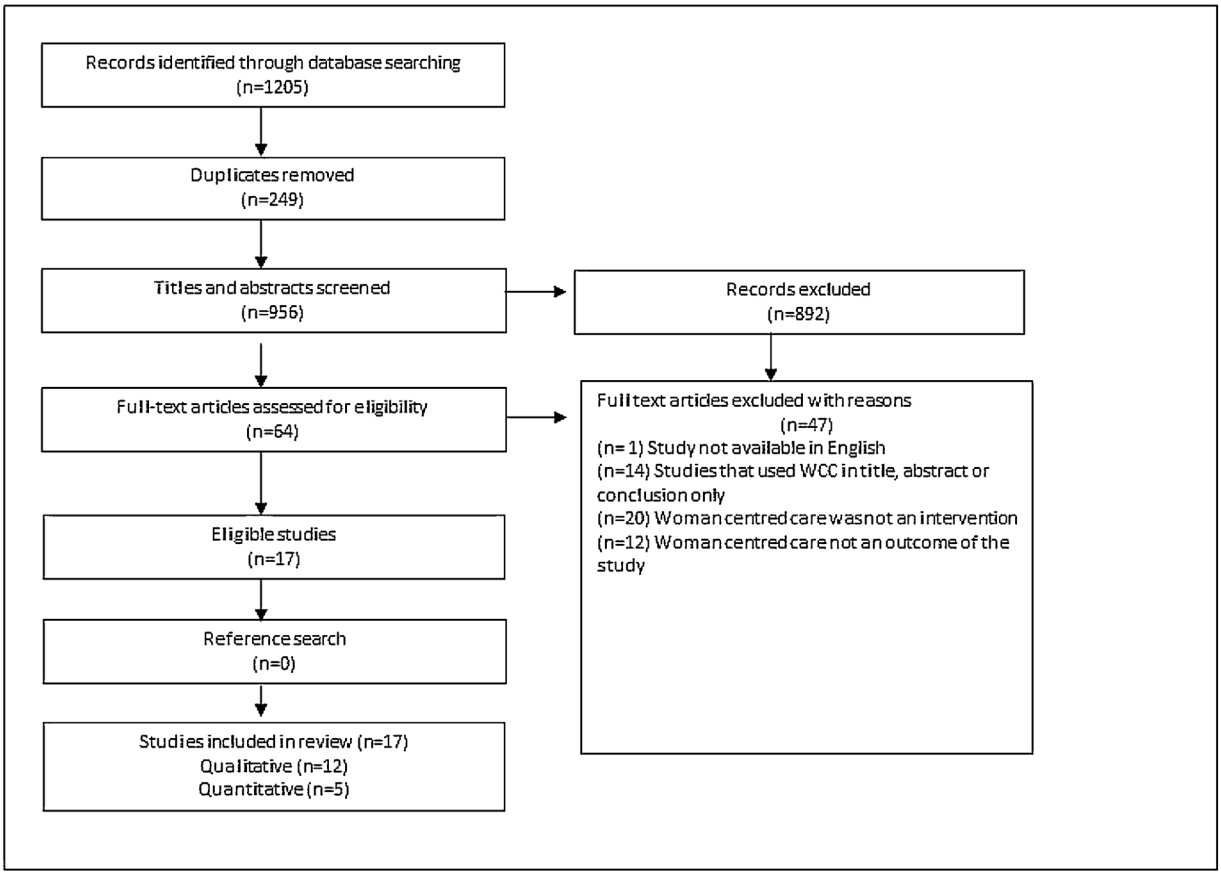

Fig. 1. Search and selection process.

Table 2
Summary of characteristics of the included studies examining woman-centred care.

Author, Publication Year, Country	Study Aim	Design/Approach Data Collection	Sample	Summary of Findings	Relevant CASP Score/ Possible Total
Ahlund et al. (2017) Sweden	To understand how midwives experienced implementing woman-centred care during second stage of labour.	Qualitative/Group discussions and individual interviews.	Purposive sample midwives who worked at 2 different labour wards in Stockholm. n = 20 midwives.	The participating midwives' experiences were understood as an increased awareness of their role as a midwife.	5/10
Borrelli et al. (2016) United Kingdom, Australia	To conceptualise first-time mothers' expectations of a 'good' midwife during childbirth in the context of different birth places.	Qualitative/Straussian grounded theory. Two semi-structured interviews for each participant. Before and after birth.	Purposive sample n = 14 women giving birth for the first time.	Created a model named the kaleidoscopic midwife. The model is dynamic and woman-centred and works when the individual midwife adapts to each woman's needs.	10/10
Brady et al. (2017) Australia	To develop and validate an instrument to measure woman-centred care behaviour development in midwifery students.	Quantitative/Randomised 3 ar m intervention trial. Video performance of skill performance was assessed using woman-centred care scale by 2 independent raters.	Convenience sample n = 69 first year midwifery students recruited to undertake simulation activity randomised into one of 3 intervention arms.	Test and re test validity of the scale was high, however individual raters of woman-centred care revealed differences in expectations of woman-centred care behaviours in students.	9/11
Browne et al. (2014) Australia	To better understand continuity of care experiences in midwifery education from the perspectives of diverse stakeholders.	Qualitative/Focus groups and interviews.	Convenience sample n = 15 final year student midwives, n = 14 registered midwives, n = 6 maternity managers.	Paper presents part of a larger study. This one describes continuity experiences from the perspective of student midwives, maternity managers, and registered midwives in the region.	2/10
Daemers et al. (2017) Netherlands	To explore factors that influence midwives' clinical decision making.	Qualitative/In-depth interviews with midwives using the Vignette and think aloud method.	Purposive sample n = 11 midwives.	Identified 5 themes that influenced clinical decision making.	7/10
Davis and Walker (2010) New Zealand	To explore the way in which case loading midwives in New Zealand construct midwifery, and the concepts of woman and child birth.	Qualitative/In-depth interviews with case loading midwives, along with relevant professional, regulatory and contractual documents. Both texts were analysed using a feminist post structural framework.	Purposive sample n = 48 case loading midwives from the North (n = 25) and South (n = 23) Islands of New Zealand.	New Zealand midwives work across various places moving from community to primary obstetric hospitals. Midwives "make space" for childbearing women. This space sometimes, challenges obstetric constructions of the woman and childbirth.	7/10
Ebert et al. (2014) Australia	To provide an understanding of the issues that affect socially disadvantaged women's ability to engage in decision making regarding care options.	Qualitative/Interpretative Phenomenological Analysis. Part of a larger study this paper analysed data from focus groups with women.	Purposive sample n = 17 socially disadvantaged women.	Socially disadvantaged women participants did not feel safe to engage in discussions regarding choice or to seek control within their maternity care encounters.	8/10
Floris et al. (2017) Switzerland	To evaluate satisfaction and outcomes of the obstetric and neonatal care of women who received comprehensive support care during pregnancy, childbirth and the postpartum period and compare them with women who received standard care.	Quantitative/Prospective cohort study. Women's satisfaction was evaluated using French version of self-administered "Women's experiences maternity care scale" Questionnaires were used to assess maternal and infant health measured at 2 months, a medical record audit was also conducted.	Convenience sample women were enrolled, based on the group to which they belonged. n = 256 women received Comprehensive Supportive Care n = 190 women received standard care.	Comprehensive supportive care women were strongly associated with optimal satisfaction a significantly lower epidural rate (19.7% vs 39.3%; $p < 0.001$). There were no differences in the mode of delivery ($p > 0.05$). The satisfaction related to the Comprehensive Supportive Care programme was associated with having a plan for intrapartum and postnatal care.	10/12
Giarratano (2003) United States of America	To discover meanings of the clinical experiences of maternal newborn nurses following study of the philosophy of woman-centred care in a course.	Qualitative Phenomenology/Individual open-ended interviews	Purposive sample n = 19 maternal newborn nurses.	Nurses had an awareness of oppressive maternity care practices. However, creating woman-centred care, seen as a more humanistic approach, meant negotiating tensions and barriers in a medically focused maternity setting.	9/10
Homer et al. (2009) Australia	To research the role of midwives in Australia: views of women and midwives.	Qualitative / Multi method approach. Surveys completed by women and interviews completed by midwives.	Purposive sample of women who were consumers of midwifery care. Midwives randomly selected by the registration authority n = 28 women, n = 32 midwives.	Midwives and women identified a series of key common traits that are required of a midwife. These included being woman-centred, providing safe and supportive care, and working in collaboration with others when required.	5/10
Hunter et al. (2017) Ireland	To explore the concept of woman-centred care in pregnancy and birth through women's, clinicians' views, experiences and perspectives.	Qualitative/Individual interviews in person or by phone and focus group by profession.	Purposive sample from 2 geographically distinct maternity units n = 11 women, n = 10 midwives,	Five themes representing women's and clinician's views, experiences and perspectives of woman-centred care. Woman-centred care is not perceived to be experienced by most women.	8/10

Table 2 (*Continued*)

Author, Publication Year, Country	Study Aim	Design/Approach Data Collection	Sample	Summary of Findings	Relevant CASP Score/ Possible Total
			n = 5 obstetrician n- = 5 general practitioners.		
Iida et al. (2012) Japan	To investigate the perceptions and comparisons of women centred care at Japanese birth centres, clinics and hospitals.	Quantitative/Cross sectional. Self-reported retrospective questionnaires.	Convenience sample of women surveyed 1-5 days after birth from 13 healthcare facilities (2 hospitals, 4 clinics, 7 birth centres) n = 482 women.	Women who delivered at birth centres rated women centred care highly and were satisfied with care they received compared to those who gave birth at clinics and hospitals. Women centred care was positively associated with women's satisfaction with the care they received $p < 0.001$.	12/12
Iida et al. (2014a, b) Japan	To compare the health outcomes of women and infants who received midwife-led care with obstetrician-led care in Japan.	Quantitative/Observational study. Women-centred care pregnancy questionnaire. Stein's maternity blues questionnaire Edinburgh Postnatal Depression scale.	Purposive sample. n = 281 women who received either midwife-led or obstetrician-led care.	Continuity of midwife-led care was perceived by women to beneficial $p < 0.001$.	12/12
Johnson et al., (2003) Australia	To compare various aspects of woman-centred care and satisfaction in low risk women receiving maternity services from midwives using a partnership caseload primary health midwifery care approach with women receiving standard hospital care.	Quantitative/Descriptive comparative design using survey method.	Purposive sample. All women accessing public health services over a 2-year period. n = 637 antenatal women and n = 571 postnatal women.	More women who received the primary healthcare midwifery model experienced components of women centred care (informed choice, control and continuity) $p < 0.001$	11/12
Maputle and Hiss (2010) South Africa	To explore and describe experiences of midwives managing women during labour in tertiary hospital in Limpopo.	Qualitative/Phenomenological.	Purposive sample n = 12 midwives working in a childbirth unit.	Identified 5 categories which limited the provision of woman-centred care.	9/10
Saftner et al., (2017) United States of America	To explore maternity care providers beliefs and attitudes about physiological birth.	Qualitative/Descriptive study.	Purposive sample n = 31 maternity care providers n = 14 nurse midwives, n = 9 obstetricians n = 8 family doctors.	Maternity care providers overwhelmingly supported physiological birth, however there was variation amongst providers in different disciplines.	6/10
Thompson et al., (2016) Netherlands	To describe Dutch midwives' attitudes to physiological birth.	Qualitative/Focus groups.	Purposive sample n = 14 hospital-based midwives n = 23 community-based midwives.	Four themes emerged. Midwives view promotion and protection of physiological childbirth as central to their role.	5/10

perceptions of woman-centred care; Borrelli et al. (2016) sought to understand first-time mothers' perspectives of a 'good' midwife during childbirth, while Ebert et al. (2014) investigated socially disadvantaged women's views of the barriers to feeling safe to participate in decision making around their care. In their research into the role of midwives in Australia, Homer et al. (2009) investigated the opinions of both mothers and midwives and identified that key elements of midwifery practice are shared by both, including being woman-centred.

Within the theme of clinical practice, the subthemes identified were: the woman perceiving they have choice and control, empowerment of the woman, activities that occur in practice that protect normal birth, relationships that midwives form with the individual woman as a way of promoting woman-centred care, and the characteristics of the individual midwife that support woman-centred care.

3.3. Choice and control

A key element of the provision of woman-centred care identified in the studies was that of the woman having choice and control. These concepts emerged as a subtheme from both qualitative and quantitative studies (Borrelli et al., 2016; Davis and Walker, 2010; Ebert et al., 2014; Giarratano, 2003; Homer et al., 2009; Hunter et al., 2017; Iida et al., 2014a, b; Johnson et al., 2003; Maputle and Hiss, 2010; Saftner et al., 2017). Davis and Walker (2010) reported how the presumed passivity of women (both childbearing women and midwives) by predominantly male, obstetric colleagues, disrupts the work that midwives do in acknowledging the maternal body as competent to birth, and in repositioning the woman as leader in her decision making. However, other authors suggest it is not always medical practitioners who control birthing environments. Midwives interviewed by Maputle and Hiss (2010) suggest that women labouring in their care, accepted, without question, decisions made for them by the midwives. Even if the mother did not understand such decisions, "she still complied because of the trust she put in the decision-maker regardless of what the decision entailed" (p.8). The midwives in this study observed that women who had acquired accurate and up-to-date information about childbirth issues and available options, were able to make informed choices. However, the prevailing culture of limited information sharing resulted in feelings of powerlessness for the women and a general lack of autonomy, key elements of woman-centred care (Maputle and Hiss, 2010). These authors concede that care in this context was midwife-centred rather than woman-centred, which would better support both the physiological and psychological process of childbirth and contribute to a woman's sense of empowerment (Maputle and Hiss, 2010).

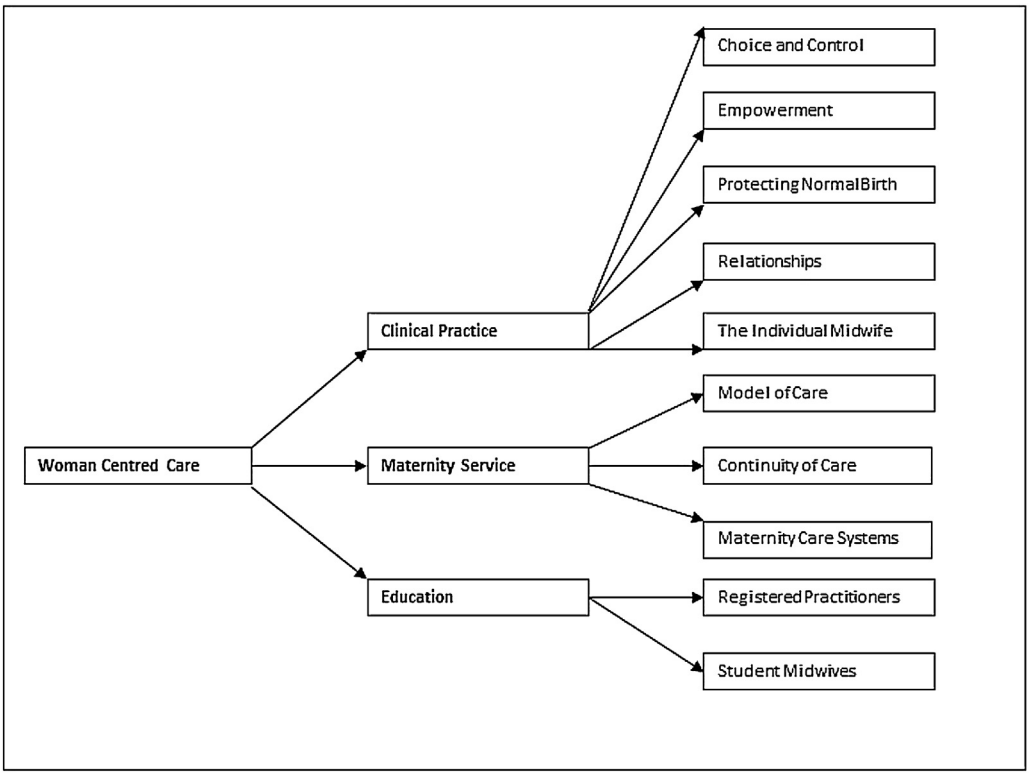

Fig. 2. Visual representation of themes and subthemes.

Table 3
Synthesis of studies by themes and subthemes.

Author/Year	Themes									
	Clinical Practice					Maternity Service			Education	
	Subthemes									
	Choice and Control	Empowerment	Protecting Normal Birth	Relationships	The Individual Midwife	Model of Care	Continuity of Care	Maternity Care Systems	Registered Practitioners	Student Midwives
Ahlund et al., (2017)			✓		✓	✓				
Borrelli et al., (2016)	✓			✓	✓		✓	✓		✓
Brady et al., (2017)				✓					✓	✓
Browne et al., (2014)			✓	✓			✓			
Daemers et al., (2017)		✓	✓		✓	✓				
Davis and Walker (2010)	✓		✓	✓		✓		✓		
Ebert et al., (2014)	✓	✓		✓	✓			✓		✓
Floris et al., (2017)		✓		✓		✓	✓			
Giarratano (2003)	✓	✓		✓	✓	✓		✓	✓	✓
Homer et al. (2007)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Hunter et al., (2017)	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Iida et al., (2012)		✓	✓	✓			✓			
Iida et al. (2014a, b)	✓	✓				✓		✓		
Johnson et al., (2003)	✓			✓			✓			
Maputle and Hiss (2010)	✓	✓		✓	✓	✓		✓		✓
Saftner et al., (2017)	✓	✓	✓	✓		✓	✓	✓	✓	
Thompson et al., (2016)		✓	✓			✓				

To mitigate a woman's feelings of powerlessness, Borrelli et al. (2016) conceptualised a framework to describe first time mothers' perception of a "good" midwife during childbirth. These researchers reported that there is often a gap between the woman's expectations and experiences of birth and suggest the midwife should assist the woman to adjust her expectations and "go with the flow" (p.107) allowing the labour events to unfold and adapting ideal expectations to the actual birth experience. Homer et al. (2009) surveyed both mothers and midwives about what makes a good midwife and cross-referenced the views of both. Commonality occurred when the role of the midwife included providing reassurance, building confidence, and allaying anxiety and fear,

while reinforcing the woman's choices. However, there is need for caution when providing care to a woman from a socially disadvantaged background. Ebert et al. (2014) investigated these women's views on the barriers to feeling safe to engage in decision making in maternity care encounters and found that the actions of midwives often contribute to the lack of control. This study suggests a premise common in all the studies of this subtheme, that the woman's perception of choice and control can be influenced by the model of care provision.

Johnson et al. (2003) demonstrated that partnership caseload midwifery supports woman-centred care by acknowledging the woman's need for choice and control and the need to know that these choices would be upheld by the health service. Iida et al. (2014a, b), when comparing midwife-led care with obstetrician-led care for low-risk women in Japan, suggested that in midwifery-led models of care, the perception of woman-centred care (inclusive of choice and control) was higher. Evidently, the actions of both women and midwives during pregnancy and childbirth, and the model of care provision, all contribute to the woman's perceptions of choice and control and ultimately of childbirth experiences.

3.4. Empowerment

One of the strongest subthemes to emerge from the studies was that of empowerment. It was mentioned in both the qualitative studies (n = 8) and the quantitative studies (n = 3). Empowerment entailed involving the woman in shared decision making by considering their individual preferences and needs during care provision (Daemers et al., 2017; Ebert et al., 2014; Floris et al., 2017; Homer et al., 2009; Thompson et al., 2016). Community midwives in the study by Thompson et al. (2016) described this relationship building as an ongoing process of "developing trust between themselves and the woman during pregnancy, with the aim of empowering the woman to feel confident in her own ability to give birth" (p.70). Midwives differed in the way that they made this happen. Some discussed everything with the woman, offering her real and acceptable choices through information provision (Daemers et al.,2017; Homer et al., 2009; Hunter et al., 2017) whilst others relied on clinical guidelines to direct decision making (Daemers et al., 2017).

Empowerment of women was achieved through developing trust, relationship building and working in respectful partnerships (Floris et al., 2017; Giarratano, 2003; Hunter et al., 2017; Iida et al., 2012). Feeling safe within the maternity care encounter was also seen as essential to empowerment, described as "a state in which the woman and the midwife can interact without fear of perceived or actual psychological (or physical) harm and directly impacts on the woman's ability to engage in decision making and obtain a sense of control" (p.134) (Ebert et al., 2014). If health care providers did not provide safe environments women felt disempowered and voiceless, deferring decisions to midwives who were seen as better equipped to keep both the mother and baby safe during pregnancy, labour and birth (Ebert et al., 2014; Maputle and Hiss, 2010).

Communication was another essential component to empowerment; women desire that midwives have excellent communication skills (Homer et al., 2009; Iida et al., 2012; 2014a, b). Where power differentials, poor health literacy skills and language barriers existed, women gave choice, control and autonomy of their own pregnancy and labour experiences over to care providers (Ebert et al., 2014; Maputle and Hiss, 2010). Overwhelmingly, within the studies reviewed, empowerment was a precursor to the provision of woman-centred care, a way of protecting physiological birth and the woman's ability to achieve this (Hunter et al., 2017; Iida et al., 2014a, b; Saftner et al., 2017; Thompson et al., 2016).

3.5. Protecting normal birth

Across the studies the promotion of physiological normal birth was closely linked to the provision of woman-centred care (Ahlund et al., 2017; Browne et al., 2014; Daemers et al., 2017; Davis and Walker, 2010; Homer et al., 2009; Hunter et al., 2017; Iida et al., 2012; Saftner et al., 2017; Thompson et al., 2016). Daemers et al. (2017) conducted in-depth interviews with Dutch, primary-care midwives (n = 11). All interviewees in this study agreed it was important to guard the physiology of pregnancy and childbirth by reassuring the woman that pregnancy and childbirth are natural, normal processes. Midwives with strong and positive attitudes toward the promotion of physiological birth and woman-centredness invested in empowering women to make their own choices.

Davis and Walker (2010) suggested midwives do this by "affirming the normality of childbirth and the fitness of women's bodies for the task of childbearing" (p.605). Homer et al. (2009) highlight that women expect, in the provision of fundamental midwifery care, that midwives are required "to use skills and expertise to keep the process safe and normal" (p.676). In the multidisciplinary study by Hunter et al. (2017) all participant groups (midwives, consultants and general practitioners) recognised the importance of normalising pregnancy and childbirth. Strategies to achieve this included respecting the woman's wishes and following proposed birth plans. Saftner et al. (2017) also looked at multidisciplinary groups and advocated that maternity care providers in their study (midwives, family doctors and obstetricians) overwhelmingly voiced support for the capability of women and the normalising of physiologic birth.

Despite these views, the normality of birth is often described in terms of the absence of complications. Thompson et al. (2016) noted that their study participants (hospital based Dutch midwives), define a physiological childbirth by " . . . what it is not. It is not pathology, or it is the absence of complications or medical intervention" (p.69). Many participants in this study had difficulty in defining normal birth without reference to the absence of pathology. Birth widely viewed only normal in retrospect, has long been the attitude in the biomedical model of care. Indeed, Davis and Walker (2010) suggest that the biomedical discourse of childbirth is most dominant in obstetric hospitals. Findings from their study suggest case-loading midwives need to work at "making space" (p.605) within these maternity services, reconstructing the woman's body as competent, and repositioning the woman in the centre of her own care to promote normal birth. In clinical practice, midwives uphold the normality of birth and promote woman-centred care by developing effective relationships with women and working in partnership.

3.6. Relationships

Thirteen of the studies discuss the importance of midwives building relationships and working in partnership with women in the provision of woman-centred care (Borrelli et al., 2016; Brady et al., 2017; Browne et al., 2014; Davis and Walker, 2010; Ebert et al., 2014; Floris et al., 2017; Giarratano, 2003; Homer et al., 2009; Hunter et al., 2017; Iida et al., 2012; Johnson et al., 2003; Maputle and Hiss, 2010; Saftner et al., 2017). Borrelli et al. (2016) who proposed a conceptual metaphor of what makes a "good" midwife during childbirth, suggested that "when trusting relationships are established between women and midwives, mothers are more likely to have positive memories of their childbirth experience, regardless of birthplace" (p.109) and recommend that midwives need to dedicate the necessary time that it takes to establish a trusting rapport. Davis and Walker (2010) also discuss how case-loading New Zealand midwives invest significant energy and time in the antenatal period developing trusting relationships assisting

in the provision of woman-centred care. Likewise, Homer et al. (2009) describe the role of the Australian midwife as needing to have "the capacity to develop trusting relationships with individual women" which included "getting to know the woman, listening, developing rapport and providing individualised care" (p.678). In this study the provision of woman-centred care was a way of working together rather than an organisational care model.

Sometimes care models can be detrimental to relationship building. Giarratano (2003) interviewed student nurses about their experiences of providing woman-centred care after studying the philosophy in a course. These nurses felt that "the medical environment that dictated routine care" impacted on their "relationships with the women, which are so important to providing woman centered care" (p.25). African midwives in the Maputle and Hiss (2010) study highlighted that when women in labour did not listen to them, they felt worthless. When this happened the midwife just went through the motions of care provision rather than establishing a mutual trusting relationship.

3.7. The individual midwife

In the studies included in this review the attributes of the individual midwife were a strong contributing factor to relationships, partnership and woman-centred care (Ahlund et al., 2017; Borrelli et al., 2016; Daemers et al., 2017; Ebert et al., 2014; Giarratano, 2003; Homer et al., 2009; Hunter et al., 2017; Maputle and Hiss, 2010) and were considered essential to the provision of such care.

Borrelli et al. (2016) suggested that women expect that midwives need to be able to "interpret knowledge, recommendations and guidelines in the light of each woman's individual preferences, providing woman-centred care rather than procedure-centred care" (p.110). Daemers et al. (2017) agree that there are several characteristics, both professional and personal, that can affect the midwife's decision making including "her attitude towards physiology, woman-centredness and shared decision-making; her experience and intuition; her attitude toward collaboration; and her personal circumstances" (p.6). Additionally, Homer et al. (2009) found that women valued midwives who had confidence in the woman's ability to birth. They wanted midwives to "do nothing unless something was wrong and to be able to put women first" (p.676). The women reported that the personal manner of the midwife was also important. "Being positive, calm but confident, professional, sensitive and friendly" (p.678) were all seen as important components of the midwifery demeanour. Further, Maputle and Hiss (2010) note that the manner of the midwife can have a powerful effect on birthing women; they suggest midwives should be aware that they have the power to influence both positive and negative childbirth experiences.

3.8. Woman-centred care in maternity service

Service provision of maternity care can also contribute to the experience of woman-centred care. This was reflected in three identified subthemes: model of care, continuity of care, and maternity care systems. Domination of the biomedical model of care in maternity services was evident in the studies which addressed this theme (Ahlund et al., 2017; Daemers et al., 2017; Davis and Walker, 2010; Floris et al., 2017; Giarratano, 2003; Homer et al., 2009; Hunter et al., 2017; Maputle and Hiss, 2010; Saftner et al., 2017; Thompson et al., 2016).

Davis and Walker (2010) propose that the risk approach to care starts during the antenatal period when challenges to the competency of the maternal body begin. The woman's confidence in her ability to grow and birth her baby is challenged by the requirement of engaging with the increasing number of obstetric screening practices. These authors maintain that "whether or not midwives recommend or support these tests, the informed choice process means that midwives must continually engage with and raise them as points of discussion, thus, paradoxically, highlighting the risks and dangers of pregnancy" (p.605).

Barriers to confidence in the woman's ability to birth physiologically were also identified by Saftner et al. (2017) where focus on risk was identified as a study theme. Participants described how when women were cared for in the medical system and labelled as "high-risk", it impeded their confidence and changed their perception of pregnancy as a normal physiologic process. Obstetric nurses interviewed in the study by Giarratano (2003) identified barriers to the provision of woman-centred care such as "routine and frequent use of medical intervention for all women" and the "power of the doctor's orders that controlled basic nursing care" (p.25). These actions, they believe, limit the nurse's abilities to promote the woman's autonomy and offer choices during labour and birth, elements of woman-centred care. To counter the medicalisation of birth, women in the study by Homer et al. (2009) identified that they wanted midwives to be able to "collaborate with others when other care was required" (p.676) and that working well with other midwives and hospital staff, including doctors, in an integrated way was important and highly valued. Continuity of care is one service model that attempts to mitigate the increasing medicalisation of birth and enhance the provision of woman-centred care and was identified as a subtheme along with maternity care systems in this theme.

3.9. Continuity of care

According to Floris et al. (2017) woman-centred care provided by a known midwife has a positive impact on maternal satisfaction without adverse outcomes. Hunter et al. (2017) noted that "consistency of the clinician over the term of the pregnancy, was considered synonymous with good quality care" (p.6). Saftner et al. (2017) suggest that "continuity was noted to be an important piece of the trusted woman-provider relationship" (p.30). However, continuity comes in many different forms, through one provider throughout pregnancy, shared philosophy and practices amongst clinicians or alignment of antenatal and intrapartum care. In the Homer et al. (2009) study, continuity of care emerged as a strong theme. Seventy-five percent of the women surveyed made specific reference to "continuity of midwife during pregnancy, labour and birth" (p.676). Most midwives in this study recognised that the provision of continuity of care was best practice and that it made their job easier if they were able to provide indivdualised care.

Johnson et al. (2003) demonstrated that woman-centred care was supported in their primary health midwifery care model. Women receiving this model of care "experienced the key aspects of woman-centred care: choice, control and continuity" (p.30). Key conclusions of the study by Iida et al. (2012) were that women who birthed in birth centres had the most positive perceptions of woman-centred care related to effective communication and continuity of care. These researchers identify these as core elements of woman-centred care.

3.10. Maternity care systems

Analysis of the studies identified systems that either supported or hindered the provision of woman-centred care. Time allotted for the provision of woman-centred care within maternity care systems came across strongly. Saftner et al. (2017) identified that issues with the systems were a major barrier to promoting women's confidence in physiologic birth. Maternity care providers in this study identified "inadequate time for antenatal visits and systems that encourage medical intervention" (p.32). Davis and

Walker (2010) identified that modern birthing units are often "frenetically busy" and there is pressure on core midwives and obstetricians to "hurry things along" (p.606). Maputle and Hiss (2010) agree with midwives in their study stating they were unable "to spend quality time with the women during labour to verify their preferences" (p.11). To counter this, women in the study by Homer et al. (2009) suggested that "having, or making time, being accessible and not being rushed were also essential to enable the development of relationships" and identified this as midwives being "with woman" (p.678). One possible way of addressing the current shortfalls of the provision of woman-centred care in maternity services is through the education of health care providers.

3.11. Woman-centred care in education

Eight studies suggested that education could be an effective approach to improving woman-centred care in practice (Ahlund et al., 2017; Brady et al., 2017; Browne et al., 2014; Daemers et al., 2017; Ebert et al., 2014; Hunter et al., 2017; Maputle and Hiss, 2010; Saftner et al., 2017). The studies address the education of both registered practitioners and student midwives.

3.12. Registered practitioners

Hunter et al. (2017) and Saftner et al. (2017) both examined the education of registered practitioners. Hunter et al. (2017) describe that what emerged from their data was a common voice across participants for "greater inter-professional understanding and emphasis on a shared ethos of WCC" (p.6). Saftner et al. (2017) found that maternity care providers in their study desired to "do better" and wanted access to training on "counselling women on physiologic birth" (p.32). The idea that education of women also plays a role in the provision of woman-centred care also came across in the study by Maputle and Hiss (2010); midwives suggested that the sharing of information was a mutual responsibility of both the mother and the midwife, recommending individual or group teaching sessions, presented in the woman's own language. This approach, these researchers hypothesised, would make "a significant contribution towards putting most women at the centre of their own care" (p.12).

3.13. Student midwives

Ebert et al. (2014) add that "changing the maternity care environment requires a cultural shift that may stem from education" (p.137). Brady et al. (2017) developed and piloted the Woman-centred Care Scale, a validated and reliable scale, which measures the development of woman-centred care behaviours in midwifery students. The authors suggest the scale has implications not only for "education but the wider midwifery profession in recognising and maintaining practice consistent with the underlying philosophy of woman-centred care" (p.225).

4. Discussion

The findings of this integrative review demonstrate the interwoven use and value placed on the concept of woman-centred care in clinical practice, maternity service provision and to a lesser extent, education. As well as reporting on the concept of woman-centred care, the insight gained through this integrative review has served to map the development and use of the woman-centred care concept in the themes studied, and to highlight how contemporary healthcare practice either supports or hinders the provision of this desired level of healthcare. The findings may also serve to endorse and augment the notion of woman-centred care in policy development and maternity service provision planning.

The idea that women desire care that is centred around them in childbirth is not new, initially emerging from the feminist ethics of the time, as a care philosophy of the women's health movement of the 1960's and 1970's (Leap, 2009). In the 1980's Michel Odent, a French obstetrician, emerged as an enduring advocate of the need for modern societies, in developed countries, to rediscover the basic needs of women in labour (Odent, 2001). Using a multi-method approach to assess key areas of quality in maternal and newborn care, Renfrew et al. (2014) examined the contribution midwives make to the quality of care of women and infants globally. These researchers detail care needing to be "safe, effective, accessible, appropriate, affordable, equitable efficient and woman-centred care" (p.1130). Further, Nicholls and Webb (2006) conducted an integrative review of methodologically diverse research on what makes a good midwife and concluded that having good communication skills was paramount. Other attributes considered important were being compassionate, kind, supportive, knowledgeable skilful and woman-centred.

In the majority of the studies included in this review there was no shared understanding of the concept of woman-centred care. Ahlund et al. (2017) describe woman-centred care as "being with woman" (p.2) in which the midwife considers the woman's wishes and takes the need for support into consideration rather than following established care routines. Homer et al. (2009) suggest that woman-centred care is a way of practicing rather than an organisational model of care, while Saftner et al. (2017) propose that woman-centred care means providing a woman with options and choices. Lack of clarity around the understanding of woman-centred care could be contributing to the confusion and tokenism with which it is discussed in health policy documents and frameworks.

Many of the studies included in this review confirm that the concept of woman-centred care is fundamental to, and a cornerstone of, good midwifery practice (Borrelli et al., 2016; Davis and Walker, 2010; Ebert et al., 2014; Homer et al., 2009; Hunter et al., 2017; Maputle and Hiss, 2010). The provision of woman-centred care offers the woman choice, control and empowerment (Borrelli et al., 2016; Davis and Walker, 2010; Ebert et al., 2014; Giarratano, 2003; Homer et al., 2009; Hunter et al., 2017; Maputle and Hiss, 2010). However, the options of having choice and control are considered the dual responsibility of both the woman and the midwife (Homer et al., 2009). In the broader literature, the aspects of the provision of choice and control for the woman and her family during pregnancy and birth are considered paramount to both physical and psychological wellbeing. These ideas have long been understood, with earlier studies identifying that women who experienced social aspects of maternity care, for example the development of relationships, continuity of carer, and having choice and control, had greater satisfaction with their individual experiences (Hundley et al.,1997; Sandall, 1995). More recently Meyer (2013) undertook a concept analysis of control in childbirth and noted this is a tenuous concept, and that control has a variety of definitions over a wide range of disciplines. Meyer (2013) suggests that practitioners should understand the critical relationship between control in childbirth, and maternal satisfaction with childbirth experiences. Snowden et al. (2011) also analysed choice and control in childbirth and agree that the elements of choice and control are closely connected for women and positive childbirth experiences.

Whilst the provision of key components of woman-centred care, such as continuity of care, coupled with maternal birth satisfaction, and positive outcomes, are now well understood features (Floris et al., 2017; Hatem et al., 2008; Iida et al., 2014a, b) the emergence of some clarity around woman-centred care and

the importance of the midwife's professional relationship with the woman, regardless of level of risk or model of care provision, adds to the understanding of contemporary midwifery practice. Feeling safe, developing trust and creating relationships through effective communication is essential (Borrelli et al., 2016; Davis and Walker, 2010; Ebert et al., 2014; Iida et al., 2012) and time to do so is seen as a crucial requirement in the provision of contemporary maternity healthcare. This notion that building relationships and working in partnership is supported by earlier studies, Walsh (1999) suggested that women's perceptions and experiences of labour and birth were influenced by the relationships that they developed with their own midwife whom they referred to as their "professional friend" (p.169). Further, Lundgren and Dahlberg (2002) described the need for midwives to act as an anchoring companion, by listening to the woman, giving her opportunities to participate in her own care and building trusting relationships.

In Australia, lack of clarity around maternity service provision, poor midwifery and medical leadership, and fears about the autonomy of midwives, are preventing women from gaining access to woman-centred care service models (Homer, 2016). The medicalisation of birth and the biomedical model of care have long been and continue to be obstacles to midwives seeking to provide holistic care (Dawson et al., 2016). Recently, increasing litigation and risk management practices are also fuelling a social construct of risk discourse in maternity services (Spendlove, 2018). As the boundaries of midwifery and obstetric practice become more intertwined, they have the potential to erode woman-centred care practice and the role of the midwife (Spendlove, 2018). Therefore, it is essential that midwives are allocated time to develop effective relationships with women to assist them to navigate the complex landscape of contemporary health care and the introduction of more midwife-led continuity of care models may support this (Hatem et al., 2008). While there is evidence in the studies reviewed that the biomedical models of care may impact on the provision of woman-centred care (Ahlund et al., 2017; Daemers et al., 2017; Davis and Walker, 2010; Giarratano, 2003; Homer et al., 2009; Hunter et al., 2017; Maputle and Hiss, 2010; Saftner et al., 2017) there is also a counterpoint that a woman-centred approach could bridge the gap between care models and not be risk-based or birth place dependant (Borrelli et al., 2016; Davis and Walker, 2010; Homer et al., 2009). A woman's need for more effective collaboration with multidisciplinary models of care when required may be the answer (Homer et al., 2009). Perhaps contemporary midwifery practice should focus on guarding and guiding women through health services and encouraging women to allow care and labour events to unfold, adapting ideal expectations to actual individual care experiences (Borrelli et al., 2016; Ebert et al., 2014).

In analysing the literature on woman- centred care, care needs to be taken to not infer the provision of woman-centred care with the protection of normal birth as they two are separate and distinct issues. Further, defining the concept of normality in childbirth is complicated, given that it differs between cultures and subcultures (Downe, 2006).Whilst midwives do work to protect normality around pregnancy labour and birth, they are also committed to upholding the process of informed decision making for women in childbirth (O'Brien et al., 2017). Feminist theory might argue, however, that in the current climate of increasing medicalisation around childbirth, the impact of a dominant obstetric hierarchy may be affecting a woman's ability to make a true, informed choice (Davis and Walker, 2010).

An important finding of the review was the distinct lack of research that explicitly explores how the concept of woman-centred care is developed and taught in midwifery education. In undergraduate education the mandated requirements for continuity of care experiences may provide students with opportunities to experience care aligned with woman-centred care practices, yet little research has been conducted into the best ways to instil this philosophy of practice in undergraduate students and this remains a gap in the evidence base (Browne et al., 2014). Only Brady et al. (2017) have ventured to articulate and measure woman-centred care behaviours in Australian midwifery students. In the context of developing a woman-centred care philosophy in registered health practitioners, the review demonstrated that there was a desire for this to happen. Hunter et al. (2017) suggested that there is a need for inter-professional understanding and a shared ethos of woman-centred care. Saftner et al. (2017) found registered practitioners desired to 'do better' in the provision of woman-centred care. This adds strength to the findings of this study that whilst the philosophical idea of the provision of care that is woman-centred is embedded in midwifery clinical practice and maternity service provision, there is little evidence of how the next generation of health care providers are being educated to implement woman-centred care.

5. Strengths and limitations

To our knowledge, this is the first review to investigate the emerging concept of woman-centred care as it applies to contemporary clinical practice, maternity service, and education and, in doing so, makes a valuable contribution to the literature. To ensure rigour of the review process we employed a robust methodological framework. However, investigating the meaning of woman-centred care as a theoretical construct, posed inherent threats to the rigour of this integrative review. Specific threats lay in defining search terms and in the inability to use an overarching theoretical framework for evaluation and interpretation. Integrative review methodology relies on the application of a well-considered search strategy with clearly defined terms and inclusion and exclusion criteria. The results of our original search suggest that the search terms captured a wide range of literature which we then carefully screened to exclude discussion and opinion, by including woman-centred care as an intervention or as an outcome and confirming inclusion by applying a rigorous quality appraisal process. It may be that in this process we have excluded some relevant publications.

There is also a potential for bias in that we proposed using the initial identified themes of woman-centred care in clinical practice, maternity service, and education as a means to evaluate and interpret the findings; it is possible that analysis favoured findings that supported these themes. However, using NVivo to process the language used in included studies in an objective way as an initial step in the analytic process, followed by manual confirmation of these meanings limits any bias in interpretation.

6. Conclusion

This review brings together for the first time, the concept of woman-centred care as it is represented in the empirical literature. The findings demonstrate the interwoven use and value placed on the concept of woman-centred care in the chosen themes of clinical practice, maternity service provision and to a lesser extent, education. The insight gained has served to map the development and use of the woman-centred care concept in the themes studied, and to highlight how contemporary healthcare practice either supports or hinders the provision of this desired level of healthcare. Woman-centred care is fundamental to, and seen as, the cornerstone of good midwifery practice, yet, what is lacking is a shared understanding of what woman-centred care means, and this may be contributing to the confusion and tokenism with which it is discussed in health policy documents and frameworks. Many of the studies in this review showed that the domination of

biomedical models of care in contemporary maternity services is impacting on the provision of woman-centred care. Perhaps contemporary midwifery practice needs to focus on helping women to navigate the complex health services that are currently available to them. A further important finding of this review is the distinct lack of research about how woman-centred care behaviours are fostered and developed in both student and registered practitioners, and this remains a gap in the evidence base. Further research is also warranted in the development of a universal definition of woman-centred care.

Contributions to paper

All authors made substantial contribution to the paper (1) SB, FB, KG & NL were involved in the conception and design of the review and analysis and interpretation of the data. (2) SB drafted the article and FB, KG & NL critically revised it (3) SB, FB, KG, & NL provided final approval of the version to be submitted.

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