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Research Article

Access to midwifery care – the perspective of women in life situations with psychosocial stress factors

Zugang zur Hebammenhilfe – die Perspektive von Frauen in Lebenslagen mit psychosozialen Belastungsfaktoren

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Abstract

Background: Women living with complex psychosocial needs have higher support requirements but less access to midwifery services than those with fewer needs. The determinants of the inequalities in service access remain unexplored.
Aim: This study aimed to explore what determines access to outpatient midwifery services for women with complex psychosocial needs.
Methodology: Semi-structured interviews (n=13) were conducted with two pregnant women and 11 mothers. These were analysed using content analysis. Categories were formed using a framework for access to healthcare.
Results: Women with complex psychosocial needs described accessing outpatient midwifery services as primarily determined by chance and seen as good fortune. Fundamentally, the provision of midwifery care is associated with well-being and an increase in self-competence for the women interviewed. However, negative experiences with midwives may lead to a sense of rejection and refusal of the services offered.
Discussion/conclusions: The lack of availability of midwifery care for women with complex psychosocial needs should be addressed to ensure that the access gained does not lead to the experience of powerlessness.

Keywords: maternity care, midwifery, access, vulnerable women, disadvantaged

Zusammenfassung

Hintergrund: Frauen in belasteten Lebenslagen haben einen erhöhten Unterstützungsbedarf, nehmen aber seltener Hebammenhilfe in Anspruch. Es ist wenig über Gründe dieser Ungleichheiten bei der Inanspruchnahme aus Sicht der Frauen bekannt.
Ziele/Forschungsfrage: Die Studie analysiert Einflussfaktoren des Zugangs zur Hebammenhilfe aus Perspektive von Frauen in belasteten Lebenslagen.
Methode: Es wurden 13 leitfadengestützte Interviews mit zwei Schwangeren und elf Müttern geführt. Diese wurden inhaltsanalytisch ausgewertet. Basis für die Bildung von Kategorien stellten die Dimensionen des Frameworks für den Zugang zur Gesundheitsversorgung dar.
Ergebnisse: Aus Perspektive der befragten Frauen wird der Zugang zur Hebammenhilfe vom Zufall bestimmt und wird als Glück erfahren. Grundsätzlich ist Hebammenhilfe für die befragten Frauen mit Wohlbefinden und Zunahme der Selbstkompetenzen assoziiert. Negative Erfahrungen mit Hebammen können zum Erleben von Abweisung und Ablehnung des Versorgungsangebotes führen.
Diskussion/Schlussfolgerungen: Die mangelnde Verfügbarkeit von Hebammenhilfe für Frauen in belastenden Lebenslagen sollte garantiert werden, damit der erschwerte Zugang nicht zur Erfahrung von Ohnmacht führt.

Schlüsselwörter: Hebammenhilfe, Zugang, psychosoziale Belastungen, soziale Ungleichheit, Barrieren

Background

Poverty makes people ill. This core socio-medical paradigm plays an important role in pregnancy. Difficult life situations, marked by, for instance, socio-economic disadvantages (low income, low level of education), experiences of migration and racism are proven to be associated with health disadvantages [39], [40], [52], [61], [70], [96]. The findings of socio-epidemiological studies using the life course approach emphasise the high relevance of pregnancy as a phase with lasting impact [19], [54], [77]. Thus, difficult living conditions during pregnancy result in increased risk of pathologies and complications as well as long-term effects on the health of the child [9], [15], [46], [54], [72]. When stresses accumulate, health consequences are particularly pronounced [15], [19], [60]. According to the findings of one study of prevalence, conducted in Germany, 12.9 percent of parents with children aged 0 to 3 years face multiple psychosocial stresses [24]. These families have higher support needs and could benefit from the provision of midwifery care [4], [16], [25].

This results in opportunities for midwifery to contribute to the long-term promotion of good health. There is evidence that the work of midwives can make a decisive contribution to achieving the right to health for all women and newborns [64], [74], [75], [78]. Due to their early access and the exceptionally trusting relationships they build with the women thy care for [57], [82], midwives serve a vital role as intermediary experts providing information on more extensive, needs-based care options [75], [83]. That said, relevant international studies have clearly shown that women in life situations with psychosocial stress factors find it more difficult to access midwifery care [16], [17], [21], [22], [25], [31], [65], [66], [67], [92]. International research findings show similarities when it comes to the low level of information these women have regarding access to care [21], [31], [65], [68], passivity in navigating the healthcare system [16], [33] and a need for support in negotiating the system [16], [21], [31], [68], [65]. For women with migration experience, access is made even more difficult by language and structural barriers [12], [28], [44], [53], [54], [67], [68], [73]. Women in stressful life situations who do receive midwifery care value and appreciate it [16], [25], [53].

The state of the research in Germany reveals bottlenecks, especially when it comes to outpatient midwifery services [3], [8], [37], [47], [79]. The predominantly qualitative studies that have been conducted show that the take-up of midwifery services is strongly dependent on socio-economic status. In a quantitative longitudinal study, respondents also reported the reasons for their difficulties finding a midwife [8]. Here it is evident that women with a high level of education find it easier to secure a midwife than those with a low level of education. The general conditions within the German healthcare system during the life phase around birth, marked by fragmented services and a lack of continuity of care, appear to barriers to access [6], [37], [81]. On top of this, there is also a midwife shortage in Germany [7]. Moreover, women with a low level of education are shown to lack information on outpatient midwifery services during pregnancy [62], [88]. Women with experience of migration encounter obstacles when trying to access midwifery care, especially due to language barriers and a lack of cultural and diversity sensitivity in the healthcare system [44]. However, little research has been conducted on the factors influencing (lack of) take-up from the perspective of women in life situations with psychosocial stress factors.

Theoretical framework

The conceptual framework on healthcare access by Levesque et al. [56] serves as the theoretical framework for the present study. The framework conceptualises access as an active process which begins with the presence of a healthcare need and then continues with the ability to perceive the need, seek, reach, and engage in healthcare, ideally culminating in an improvement in health status (see Figure 1). As well as looking at the different aspects influencing the dimensions on the side of the healthcare system and on the side of the user, the framework also focuses on the interaction between these dimensions.

Aim and research question

The aim of the study is to examine the experiences and perspectives of women in stressful life situations with regard to their access to midwifery care. In so doing, the study seeks to better understand the reasons for the decision to (not) use midwifery services. The study seeks to answer the following research question: what factors influence access to midwifery care in Germany from the perspective of women in life situations with psychosocial stress?

Methodology

Design

To answer the research question, we opted for a qualitative design with semi-structured interviews. This method allows a deeper insight into subjective views, desires, needs and conditions [27]. In the call for participation in the study, women were approached who were, at the time, either pregnant or had given birth in the previous 12 months and found themselves in life situations that

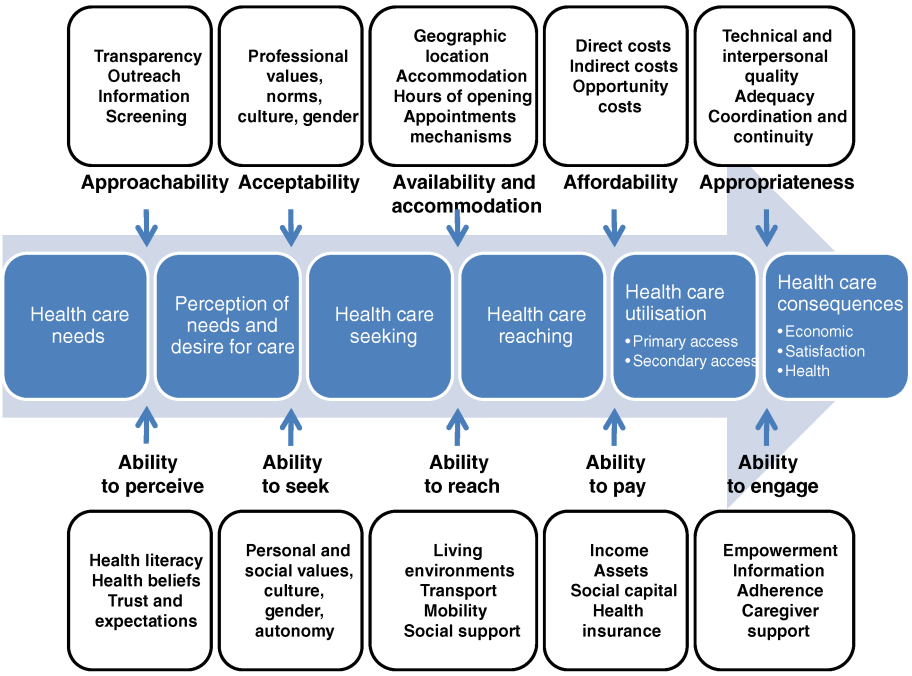

Figure 1: A conceptual framework of access to health care by Levesque et al. [56], licensed under CC BY 2.0 (https://creativecommons.org/licenses/by/2.0/)

they described as stressful. In addition to the recruitment of women via notices and announcements on social media, the author drew on the contacts in her professional network as a family midwife. Midwives were also approached as intermediaries via the information channels of the German Midwifery Association. Informed interested parties were asked to contact us by e-mail or phone. Informed written consent was obtained before the interview was conducted.

Sampling

The target group for the present study comprised women in life situations with psychosocial stress factors. This refers to women who are exposed to psychological and social influences at the structural, family and/or individual level, which can put strain on and overwhelm these women's resources [34], [76], [90]. These stress factors can be perceived in many ways. The literature addresses frequently mentioned aspects such as low income, low level of educational attainment, single parenthood, unemployment, migration-related stress, chronic illness, experiences of racism and experiences of discrimination based on sexual orientation [20], [23], [59]. Inclusion criteria for study participation were, in addition to the presence of at least one of the aforementioned aspects perceived as stress factors, that the woman was currently 20 weeks pregnant or more or that she had given birth in the last 12 months. When planning the sampling process, we sought to achieve heterogeneity of the women surveyed according to the principle of variance maximisation [45], [71], [85]. The sample is therefore intended to be criteria-driven, based on a strategy of purposeful sampling [84].

Data collection

The data was collected by means of semi-structured interviews, for the design of which we drew on elements of the problem-centred interview method proposed by Witzel [98]. The interview guide used was based on the framework developed by Levesque et al. [56]. In line with the principle of openness in qualitative research, in the first part of the interview, a narrative impetus was provided ([36], p. 21), [72]. The rest of the interview comprised guided, narrative-generating questions geared towards the topic of the research question [98]. To reflect on the interview situation and on her own position in the interaction, the author added a postscript as a memo shortly after each of the interviews [97]. She was also transparent, informing the interviewee of her dual role as a midwife and researcher. She accentuated the latter role, explaining that she was not conducting the interviews as a potential provider of midwifery services but rather out of an interest in the standpoint of the participants.
Ahead of this research project, on 23 July 2021, we applied for ethical approval from the Ethics Commission of the German Society for Nursing Science. This was granted on 26 August 2021 (No. 21-019).

Analysis

The current study used an interpretive hermeneutic design oriented towards the stepwise approach to qualitative content analysis for structuring content as described by Schreier [86]. This enabled targeted identification and conceptualisation of selected content-related aspects, while maintaining an open mind for new insights ([86], p. 5–7). The interviews were digitally recorded and

Table 1: Socio-demographic data regarding interview participants

Characteristic	Expression	Number
Altersgruppen	20–25	5
	25–35	6
	35–40	2
Number of children	1 child	6
	2 children	6
	3 children	1
Midwifery care	Yes	8
	No	5
Federal state of residence	Baden-Württemberg	11
	Hesse	1
	Thuringia	1

Table 2: Socio-demographic factors of participants which could point towards psychosocial stress

Characteristic	Expression	Number
Income	State social welfare benefits or long-term unemployment benefit (ALG II)	8
	No long-term unemployment benefit (ALG II) or social welfare benefits	5
Level of education	No school qualification	4
	Lower level school leaving qualification	2
	Intermediate level school leaving qualification	3
	University entrance qualification	4
Migration-related stress	Yes	4
	No	9
Relationship status	Long-term relationship/married	9
	Sole parent	4
Employment	Employed, currently on maternity/parental leave	3
	Unemployed	7
	In training or education	2
	Unable to work	1
Chronic illness	Yes	5
	No	8
Psychological stress	Yes	11
	No	2
Social isolation	Yes	4
	No	9
Other stress factors reported by participants	Husband in prison	1
	Discrimination on the basis of sexual orientation	1
Multiple stresses		10

promptly transcribed verbatim. They were then evaluated to determine the importance of the content ([50], p. 56). To begin with, the author created case summaries and memos ([50], p. 59) to familiarise herself with the data material [84]. She then deductively developed superordinated categories, geared towards the dimensions of the framework developed by Levesque et al. [56]. Next coding units were determined. In the interplay between deductive and inductive analytical steps, the system of categories was differentiated and tested [86]. In the process, one content-related aspect was identified as a top-level category, and the system of categories was modified accordingly [86]. Lastly, the data material was coded using the differentiated system of categories [86], ([51], p. 43ff.). The entire process of analysis was computer-assisted using MAXQDA software [94]. To assure the quality of the study, the author reflected on her own preconceptions throughout the research process. A discursive form of establishing traceability of the analytical process took place at regular meetings with the second author. From October 2021 to February 2022, n=13 semi-structured interviews were conducted. Table 1 presents the socio-demographic factors of the women interviewed (n=13).

Table 2 displays the stress factors identified in the literature and subjectively reported by the respondents.

Table 3: Final system of categories

Main category "Have good fortune"	Access as privilege	Poor availability
		Privileging factors
		Personal recommendation
	Advantage of a needs-based care structure	Modified care structure
		Provision of midwifery services
	Promising search strategies that increase the chance of access	Persistence
		Timeliness
		Frustration and rejection
		Limited resources
	Trust in and competence of the midwife as key factors in take-up	Empathy
		Empowerment
		Fear of stigmatisation
		Lack of respect

Results

The women surveyed see access to midwifery care as primarily determined by good fortune. This is reflected in privileges, a needs-based care structure, successful search strategies as well as a personal relationship with the midwife. Good fortune is perceived as a supporting factor, which reshapes the different dimensions of access and is seen by the interviewees as an important aspect in access to midwifery care. For some of the women interviewed, good fortune serves as a constant narrative element in their access to midwifery care. The results are classified based on the categories presented in Table 3.

Access as a privilege

From the perspective of women facing psychosocial stress, access to midwifery services is influenced by personal recommendations, social networks and contact with a particular midwife. This can result in access being perceived as *"a great privilege" (Philis, l. 108)*. The women we interviewed repeatedly referred to the poor availability of midwives. As a result, even though they would like to receive midwifery care, they often cannot find a midwife. Philis, who has an isolated life and was unable to find a midwife, reports:

> *Unfortunately, I don't think we can take midwifery care for granted. I see having access to such services as a great privilege (Philis, l. 106–8).*

According to Philis, in her region you can only find a midwife if you start looking early and preferably if someone personally recommends you.

> *By week 6 or 7, you will only get a midwife if you have a personal referral. And the midwife has to trust the referral made by your friend, because she has already cared for several of this friend's children or something (Philis, l. 220–2).*

Philis is of the opinion that not all women have the same access to midwifery services. Personal recommendations can play a role in enabling this access. This inequality can cause frustration and disappointment at the lack of support and, in Philis' case also exacerbated her social isolation.

When it came to access to midwifery care, Ruth, 33, was at something of an advantage. After resigning from her job as a research associate, she found herself in a difficult situation and, because of the stress she was under, was unable to look for a midwife in time. Despite the *"chronic shortage of midwives" (Ruth, l. 205)* in her region, she was then *"really, really, really lucky!" (l. 207)*. For Ruth, the fact that she was acquainted with a midwife and the fact that, as she was having her second child, the midwife felt she would require less care, put her at an advantage. She explained:

> *[…] when I was feeling really bad, I couldn't do anything […] somehow I just had other worries. And then I just called the midwife, and she said yes […], she would be happy to take me on. Erm, because she already knows me and because it's often not as much work with second children. Erm, everything's not quite as new as it is with a firstborn. And that's why she was still willing to take me on (Ruth, l. 5,863)*

The results suggest that the care shortage can increase barriers to midwifery services thus resulting in unequal access. This means that women in challenging life situations due to limited resources along with inadequate availability of midwives may not have appropriate access and thus find themselves in a disadvantaged position.

Advantage of a needs-based care structure

The good fortune described by some of our interlocuters was not the result of chance but rather of a care structure based on targeted outreach. Some of the women we interviewed saw this modification to the services available as beneficial. Nesrin, a Syrian immigrant, described the provision of midwifery consultation services in refugee accommodation as good fortune:

> *And I know the midwife who supported me four years ago which is why I found a midwife. […] From the camp. That was lucky – because of the camp. After*

that, everyone knew a midwife in Germany (Nesrin, l. 76–8).

Carla, on the other hand, was not so lucky when it came to accessing midwifery care. As an immigrant with limited knowledge of the German healthcare system, she was not informed about midwifery services in time.

So late, I was late, so late! I was already in my 9th month! Because I just didn't know about it. […] It all went wrong! […] Nobody told me that I needed a midwife […]. (Carla, l. 157–61)

For women struggling financially, it is difficult to access outpatient midwifery services if having their own car is a prerequisite. Philis told us about the services of a postpartum outpatient clinic:

But I simply couldn't get there. Because we haven't got a car and it's just too far away. (Philis, l. 305–6)

Outreach care provided by midwives, facilitated by interdisciplinary cooperation, can promote accessibility for women in such stressful situations.

Due to difficulties in establishing a relationship with her newborn after birth, Chantal, who was unable to find a midwife during her pregnancy, was assigned a family midwife by the hospital staff. She describes this kind of access as *"a blessing in disguise" (Chantal, l. 66)*. The support provided helped her to deal with her feeling of being overwhelmed.

Everything was just so new! If I'm honest, we were a bit overwhelmed by everything from the very start. (Chantal, l. 96–7)

Sophia, too, would have found being provided with a midwife beneficial. During pregnancy, she was *"…much more concerned about using drugs" (Sophia, l. 205)*.

I was, erm, a drug addict […] And because of that, I had a lot of appointments with drug counselling services, motivational groups, the child welfare office […]. […]. If I had had a midwife, she could have told me the best things to do in pregnancy. Maybe she could have talked me into doing something sensible. (Sophia, l. 47–8; 232–4)

When it comes to facilitating midwifery care, it is beneficial for this to be voluntary and participatory in nature. If midwifery services are imposed on a woman, this can lead to disempowerment and discomfort. Possibly under the influence of social norms, many of the women we interviewed attached great value to their autonomy and self-determination.

Wendy, a 23-year-old multigravida, was deprived of her autonomy. She was assigned a family midwife against her wishes. She wanted to overcome the challenges on her own to show her strength and capabilities. Wendy expressed the wish to go through her pregnancy and labour without external support.

But then I said: well, I managed it with Anton, my oldest, without a midwife. So I'll manage it again this time, too. But they were all against it. They were all so eager, they really insisted that I have someone. (Wendy, l. 232–5)

[…] that was my stubbornness […] I wanted to try to do it on my own first, […] just to show that I could! (Wendy, l. 380)

Promising search strategies that increase the chance of access

Our interviewees' access to midwifery care was influenced by various search strategies. This search is characterised by fierce competition, and successful strategies as well as self-initiated activities increase the chance of a woman accessing suitable care. Ena, a 23-year-old primagravida, was well informed about the midwifery services in her region. She put the rejections she received from midwives down to their high workload and selected a successful strategy.

So, you've got a [positive pregnancy] test! Sign up straight away! Don't even wait a week! (Ena, l. 401–2). Because you'll get a lot of rejections. […], just because they're so overworked. […] I was extremely lucky! (Ena, l. 147–8).

Determination and persistence in the search for a midwife can lead to a successful outcome. Pia, a 29-year-old secundigravida, who was unable to work due to health issues, described her tenacity in her search for a midwife:

I simply didn't give up. I just kept on calling. (Pia, l. 107)

Pia showed a very determined and proactive approach which suggests that she believed her efforts would result in success.

Well, I've heard from lots of women that it can't be that easy. But I think, I just thought 'if you stick at it and stay stubborn, you're bound to find one!' […] And that's something I'm really good at! (laughs) Being stubborn! (Pia, l. 299–301)

To choose successful search strategies, women need resources for self-activation in order to cope with a long and exhausting search. Difficult financial circumstances can result in women having no resources to take care of their own needs and participate in the competition for a midwife. Maria, on her fourth child, whose husband was sent to prison when she was pregnant, tells us about her situation:

I had other things on my plate because my husband had to go away when I was pregnant, and I basically had to do everything by myself. I had to organise everything. Financially, I had totally reached my limits, I'll tell you now. (Maria, l. 18–20)

For some of our interviewees, their search strategies proved unsuccessful. This can lead to frustration, resignation and a feeling of rejection.

Chantal had expected the search to easier and had hoped she would be able to get to know her midwife personally. Once she realised that the search was more complicated than anticipated, she gave up and resigned herself to not having a midwife.

I thought it would be […] quite different to this. I thought I'd just have to ring a few [midwives] and they'd come round for a coffee and whichever one

I liked most, I'd take. But unfortunately it was nothing like that. (Chantal, l. 281–3)

…we were really actively searching. (Chantal, l. 217)

Yes – at some point I just said: 'OK then – if no one wants me, I'll just leave it. (Chantal, l. 54–5)

Trust in and competence of the midwife as key factors in take-up

For the interviewees, the midwife herself played an important role. Empathy and trust promote the acceptance of midwifery services, whereas a lack of empathy can be a barrier. Chantal expresses it as follows:

[…] and if I don't like her, I can't develop any trust in her. Then I would think, no, I'd rather not have one at all. (Chantal, l. 292–94)

The unique vulnerability and intimacy of the reproductive years are the reasons a relationship of trust with the midwife is so important. This is Ena's view, who told us about her feelings of shame when we interviewed her:

[…] you really have to feel comfortable with this woman! […]. Because […] she is going to see you at the end of your tether, unshowered and all sorts. And just so exhausted. And she will constantly see you naked from the waist up. […] and so you really have to feel at ease with this woman! (Ena, l. 409–16)

Shame and the fear of being stigmatised by the midwife may impede access to midwifery care. Because of her drug abuse, Sophia had already experienced stigmatisation, which meant that shame became a barrier for her to even turn to a midwife.

I think that was also more of a feeling of shame […], erm, I guess, I thought that she thought […], for me as a mother to use drugs, erm, 'how awful!' and 'How can a mother do something like that? (Sophia, l. 217–9)

When it comes to acceptance, it is important that the individual has the option of choosing their midwife and shaping the range of services they receive.

Many of the women we interviewed spoke about the supportive and health-promoting effects of midwifery care. Particular emphasis was placed on how talking to a midwife can reduce anxiety thus resulting in relaxation and improved health. This was something Eva, who had experienced discrimination within her family due to her sexual orientation, also spoke about:

I was really lucky that I had such a great midwife where I lived. She also helped with discussions. She talked to us, to my father-in-law and really made a big contribution to it working so well. And I think it was because of this that my labour went so smoothly. Also, I was more relaxed. (Eva, l. 31–4)

Chantal emphasises that the way the midwife worked met her needs perfectly and that it helped her feel strong and empowered when it came to her own capabilities.

[…] she always gave me a lot of confidence that I could handle the little one. She said that we would look back on this and laugh, and she was right (laughing). (Chantal, l. 393–5)

The midwife's psychosocial competencies are vital for the provision of appropriate care. Some of our respondents had feelings of powerlessness and low self-esteem. Disrespectful care can reinforce these feelings. A lack of respect and discrimination in the obstetric context can diminish self-confidence and trust in midwifery care which is a big challenge for the women effected. Canan told us about the traumatic experiences she faced when giving birth to her first child, including physical and psychological violence on the part of midwife. Now she is reluctant to opt for midwifery care in her second pregnancy:

I would just like to feel comfortable with her. […] I had something of a traumatic labour. […], because the midwife treated me really, really, really badly. So, it was, […] I mean I still haven't fully processed it yet. (Canan, l. 252–5)

Discussion

The current study presents heterogenous experiences of and views on access to midwifery care from the perspective of women in life situations with psychosocial stress. The gaps in care described by various different studies [3], [8], [47], [79] have resulted in these women struggling to access midwifery services and thus experiencing uneven distribution of access to opportunities. This, in turn, leads to noticeable inequality and gives rise to frustration, powerlessness and feelings of rejection.

Given the legal obligation of the German state to ensure access to healthcare [18], there is an urgent need for action, which has already been identified by a number of studies [5], [8]. We need to develop a system of care which is suited to the limited possibilities of people in stressful life situations. The findings of these studies suggest that outreach midwifery work, and not only in refugee accommodation, can improve access to midwifery care for people with experience of migration [24], [30], [79], [87]. This also applies to other specialised institutions geared towards target groups with specific needs, such as addiction advice centres.

As already shown in other studies, effective coordination at interfaces and interdisciplinary collaboration can improve targeted support for families in stressful situations [11], [26], [52]. It is important that when designing midwifery services their voluntary and participatory nature are emphasised. Specific access to midwifery services by means of selective allocation instead of self-selection processes risks stigmatisation and restriction of autonomy [29], [93]. In contrast to other research [16], [33], the data from this study provides hardly any evidence of passive behaviour of women when it comes to navigating the healthcare system. Some women even report having a very high level of dedication and well thought-out strategies to find a midwife. However, the opportunities people have to use healthcare services are determined by social living conditions [1]. Similarly, these women are subject to certain restrictions when it comes to perception of care needs. This is because women in certain living

situations cannot afford [49], [55] some of actions required to access care, as described by Levesque et al. [56]. For example, difficult financial circumstances, limited mobility, psychological stress or addiction limit the use of midwifery services. Overall, the study shows, in line with other sources [38], [39], that, due to the complex interaction of social circumstances and psychological well-being, the experiences of people in stressful life situations are highly individual.

Consistent with other studies [8], [62], [75], here too the women interviewed had a fundamentally positive view of the provision of midwifery care and associated it with descriptions of good fortune. The study findings emphasise the importance of the role of the midwife herself for the acceptance and effectiveness of midwifery services. Empathy, trust, sensitivity to diversity and respectful, compassionate care are key factors in the well-being of the women. And it is precisely these aspects that Renfrew et al. [74] identified as evidence-based components of effective care provision for mothers and newborns. Not only the structure of the working alliance, but also the quality of the relationship with the midwife has a direct impact on both the take-up and effectiveness of midwifery services [13], [82], [99]. In line with other studies [10], [58], [96] the current data also show that experiences of discrimination in midwifery care can lead to a sense of rejection and not being supported. Such experiences can be an obstacle to women's acceptance of care services and may even contribute to these services being rejected entirely.

In keeping with other studies [14], [32], [43], we find significant opportunities for working with women facing psychosocial stresses. Through a practice of empowerment, a higher level of health-promoting self-competence could be achieved. According to Van Staa and Renner [93], imposed midwifery care can have a patronising character and be accompanied by potential stigmatisation and the woman rejecting the services.

As in the study by Simon [89], our findings show that a midwife's psychosocial competencies make a significant contribution to the acceptance and adequacy of care and thus promote take-up. On the other hand, the results of numerous international studies find that midwives providing outpatient care often do not feel sufficiently competent in dealing with the women's psychosocial problems [35], [42], [63], [67], [89].

The findings highlight the importance of midwives having communicative competencies, as emphasised by Pehlke-Milde [69]. Similar to Kraus ([48], p. 68ff.), the women surveyed reported that such communication skills create a positive enabling atmosphere. This can reduce internal barriers to take-up of midwifery services and increase the benefits.

The current study provides a comprehensive view of the complex process of access from the perspective of women in situations with psychosocial stress. Despite the challenge of reaching target groups [2], [11], [41], [95] that are "rarely heard" [80], we managed to conduct 13 interviews with the target group under study. This can be considered one of the study's strengths. For the most part, the women interviewed were very open and trusting in sharing their views and experiences. The rich results provided useful insights from which we were able to derive conclusions for the organisation and design of care services and future research. Limitations arose primarily due to the way in which participants were recruited. It can be assumed that the form of recruitment via a gatekeeper and the fact that the interviews were conducted by a researcher who herself was also a qualified midwife led to socially desirable responses.

Conclusions

The barriers to midwifery care for women with complex psychosocial needs identified in the study and the perceived inequality imply a need for action to prevent powerlessness and discrimination.

In addition to ensuring sufficient available midwife capacity, targeted optimisation of the care structure requires effective concepts which take the needs and challenges of these women into account. Examples of established care concepts in municipal structures are midwifery agencies [47] and outreach midwifery work in refugee accommodation. In some Swiss cantons, midwife networks such as Familystart [30] have been established, which specifically provide midwifery services to families and ensure guaranteed provision of care. One example of extended support is the evaluated Swiss model "*SORGSAM – Support am Lebensstart*" [87], which extends the services provided by Familystart and as an early intervention programme recognises the significant role played by midwives as important points of contact for families with complex psychosocial needs. The care model offers these families improved support from midwives who are continuously trained in family-centred counselling, as well as a hardship fund for services not covered by health insurance and emergency financial assistance. The model is offered in collaboration with the Basel section of the Swiss Association of Midwives and co-financed by the Basel City Health Department. Another way of optimising accessibility for women who already have contact with social services due to mental health problems, could be strengthened intersectoral cooperation between the healthcare system and social services.

Important factors for the acceptance of midwifery care are its voluntary and participatory nature. Women should be able to choose their own midwives and participate in the process of care provision. To meet the needs of families facing psychosocial stress and prevent disrespect, sensitivity to diversity and appropriate communication skills must be embedded in the development of the curricula for midwifery degrees and further training. Future research would be well placed to focus on diversity competencies and the practice of midwives in providing care for women with psychosocial stress.

Notes

Competing interests

The authors declare that they have no competing interests.

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