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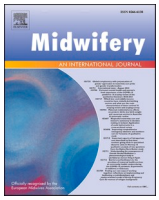

Defining woman-centred care: A concept analysis

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ABSTRACT

Problem: In midwifery a shared definition of woman-centred care is lacking, and this remains an identified gap in the evidence underpinning midwifery practice.
Background: Woman-centred care is an underpinning philosophy used in midwifery practice both nationally and internationally.
Aim: To analyse the practice of woman-centred care to clarify its meaning and comprehension and subsequently advance an evidence-based definition of the concept.
Methods: Using an adapted theoretical and colloquial evolutionary model a three-stage concept analysis was conducted to identify attributes, antecedents, and consequences of woman-centred care and subsequently construct an evidence-based, internationally informed definition.
Findings: Antecedents of woman-centred care are education, models of care and midwife characteristics. Attributes are choice and control, empowerment, and relationships. Consequences are shared and informed decision making which supports the woman in navigating complex health systems, and improved health outcomes. Whilst important to midwifery practice and midwifery-led models of care, continuity of care is not a core essential element of woman-centred care.
Discussion: Analysis, synthesis, and re-examination of the data on woman-centred care facilitated deep immersion, exploration and clarification of this concept that underpins midwifery philosophy and practice. The constructed definition can be used to inform health policy, midwifery research, education, and clinical practice.
Conclusion: An evidence-based definition of woman-centred care is necessary for conversion of this essential concept to practice. Regardless of model of care all women should receive woman-centre care improving the health outcomes of both the woman and neonate.

Statement of Significance

Problem: The lack of an international evidence-informed definition of woman-centred care is contributing to the tokenism with which it is applied in clinical practice, maternity-services, education, and research.

What is already known: Woman-centred care is fundamental to, and an underpinning philosophy of midwifery practice internationally.

What this paper adds: This concept analysis facilitated exploration and clarification of the concept woman-centred care which underpins midwifery philosophy and practice making it a valuable contribution to midwifery theory and practice. The resulting definition of woman-centred care provides the first evidence-based definition which can be used to further translate this concept into care provision.

Introduction

The principles of woman-centred care are interwoven in the underpinning concepts and philosophies of worldwide midwifery practice. Woman-centred care suggests that care is focused on the individual needs of the woman herself rather than the needs of the midwife or institution (Leap, 2009). Woman-centred care provides a philosophical ideal for practicing midwives regardless of the model of care or practice setting and as such has become fundamental in how practice standards and the scope of the midwife are defined (ICM, 2017; Renfrew et al.,

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2014). The principles of woman-centred care also feature in the development, structure and function of global maternity services and policies (Renfrew et al., 2014; World Health Organization 2016; World Health Organization 2018). For these reasons, it is crucial that woman-centred care is clearly defined and understood.

The most cited definition of woman-centred care was suggested by Leap in 2009. It incorporates consideration of the individual woman's right to autonomy, self-determination as well as her choice, control, and access to continuity of care (Leap, 2009). However, this definition was only informed by United Kingdom, Canadian and New Zealand midwifery college position statements, standards, and codes of practice and not empirical evidence (Leap, 2009) questioning its relevance for broader use (Brady et al., 2019). In the context of midwifery practice, the concept of woman-centred care has evolved, rather than being intentionally developed leading to variation in understanding and application, as confirmed in an integrative review where discrepancy in the understanding, interpretation, and practice application of the concept of woman-centred care was reported (Brady et al., 2019).

Within the contemporary literature detailed understandings of woman-centred care have been limited to studies involving midwives or healthcare professionals from single countries only (Hunter et al., 2017; Floris et al., 2023; Fontein-Kuipers et al., 2019). An exception to this is a recent international Delphi study which investigated the understanding of woman-centred care by an international panel of expert midwives.

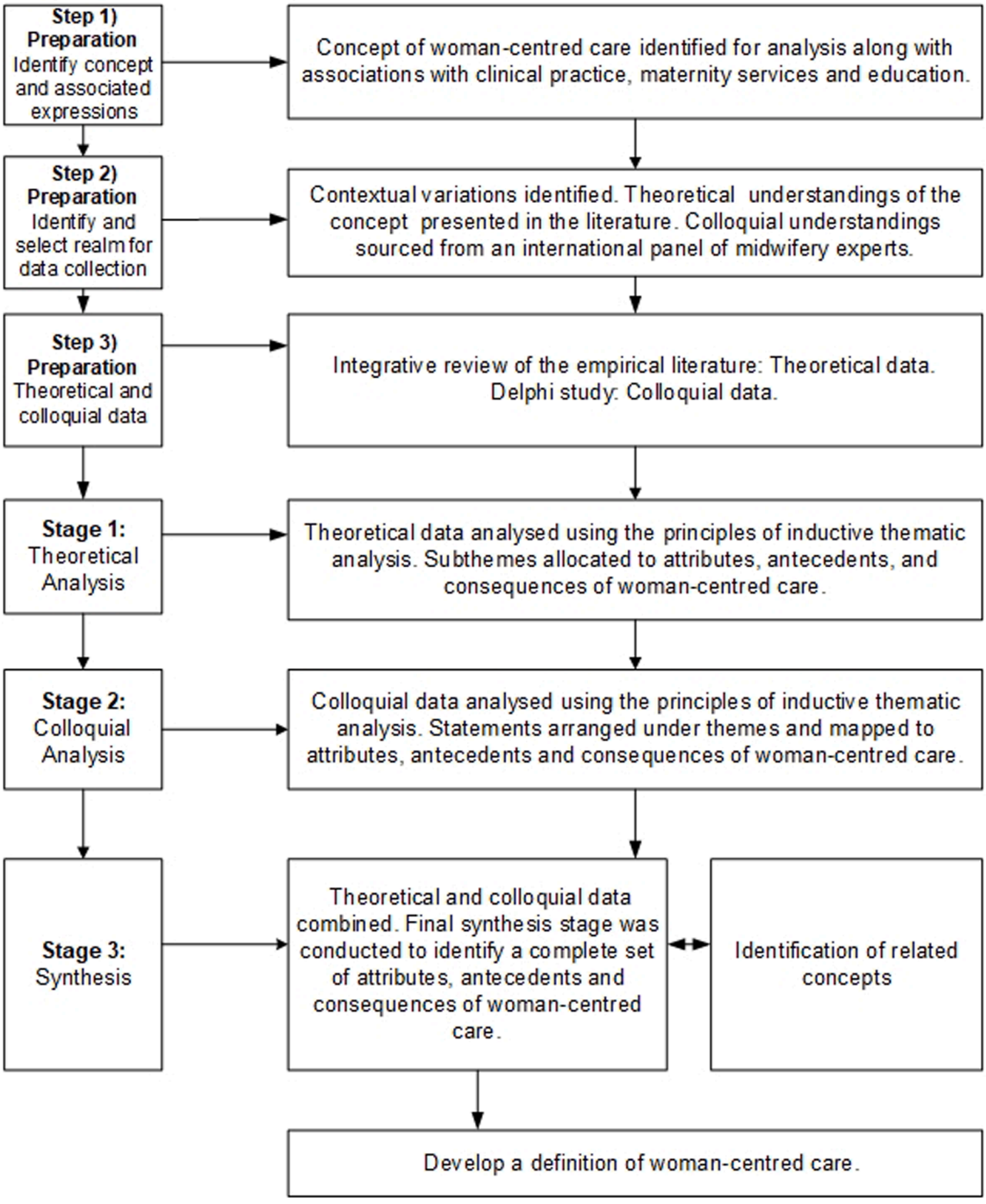

Fig. 1. Overview of Theoretical and Colloquial Evolutionary Concept Analysis of Woman-Centred Care (Adapted from Rogers 2000 and Risjord 2009).

This study concluded that an evidence-based definition is urgently needed to avoid the current tokenism and confusion with which woman-centred care is used in international midwifery practice, education, maternity services, and healthcare policy (Brady et al., 2023). There is a clear need to define the concept of woman-centred care, one such approach to definition generation is through concept analysis (Walker, 2011). This study used concept analysis to analyse the practice of woman-centred care, clarify its meaning enabling comprehension and use in clinical practice, education, and research, and develop an evidence-based, internationally informed definition.

Methods

A concept analysis can be used to clarify an ambiguous or abstract concept so that all practitioners that subsequently use the term will be speaking about the same thing (Walker, 2011). In healthcare there are several commonly used approaches to guide concept analysis. In common to all are the adherence to a systematic and phased processes of identification and analysis of the attributes, antecedents, and consequences of the concept (Foley and Davis, 2017; Rodgers 1989; Schwartz-Barcott and Kim, 2000). Relevant to midwifery, concept analysis has been used to investigate and clarify meaning of midwifery theory and practices such as aspects of choice and control in childbirth (Meyer, 2013) and empowerment (Hermansson and Mårtensson, 2011).

A concept analysis was undertaken to define woman-centred care using an adapted theoretical and colloquial evolutionary model drawing on methods suggested by Rodgers (2000) and Risjord (2009) (Fig. 1). The concept analysis re-examined data obtained from an integrative review and an international Delphi study on woman-centred care to identify the attributes (key characteristics that define the concept), antecedents (factors that need to be in place for the concept to occur), and consequences (what happens because of the concept) of woman-centred care (Tofthagen and Fagerstrøm, 2010).

Data collection and analysis (Fig. 1)

The concept analysis commenced with three preparatory steps: 1) identification of the concept and associated expressions, 2) identification of the realm for data collection, and 3) collection of the theoretical and colloquial samples.

Step 1) The concept of woman-centred care and all associated expressions in the context of clinical practice, maternity services, and education were identified in the empirical literature (1990–2017) on woman-centred care (Brady et al., 2019).
Step 2) Data collection realms were identified as data collected in both an integrative review and international Delphi study of woman-centred care (Brady et al., 2019; Brady et al., 2023).
Step 3) Theoretical and colloquial data were identified. Theoretical representations of woman-centred care were examined through scrutiny of the empirical literature (Brady et al., 2019). Colloquial representations of woman-centred care were examined through scrutiny of the data obtained in the Delphi study (Brady et al., 2023).

Following the preparatory steps, the analysis was conducted in three stages, each comprising of data re-examination and analysis of data obtained in the original studies. Stage 1: Theoretical Analysis, Stage 2: Colloquial Analysis, and Stage 3: Synthesis. Following the framework proposed by Rodgers (2000), it was necessary in Stages 1 and 2, firstly to identify attributes, antecedents, and consequences of woman-centred care.

Stage 1: Theoretical data comprised the data obtained in an integrative review of the empirical literature as this review had considered the dominant discourse relating to woman-centred care (Brady et al., 2019). The re-examination of the published data led to the identification of theoretical attributes, antecedents, and consequences of woman-centred care. In the integrative review the data in the results of each of the research studies had been coded into three main themes and ten subthemes. In the integrative review (Brady et al., 2019) data analysis was conducted using a four-phase process described by Whittemore and Knafl (2005) during the first phase, data were arranged into groups according to methodology (qualitative, quantitative) as well as emerging themes of clinical practice, maternity services, and education. The second phase used NVivo to review and code the data into organised referenced codes. The third phase examined the data displays to identify relationships between patterns and themes, which were organised visually to represent the identified themes and subthemes. The fourth phase developed interpretations of the woman-centred care literature by reviewing each of the stages to form assumptions and draw conclusions of the presentation of the concept of woman-centred care in the empirical literature (Brady et al., 2019). The subthemes identified in the integrative review were allocated as the attributes, antecedents, and consequences of woman-centred care for this study. The allocation was conducted by two researchers and agreement on their fittingness for use as attributes, antecedents and consequences in the theoretical analysis stage was achieved (Graneheim and Lundman, 2004).

Stage 2: Colloquial data was sourced from the opinions of an international panel of midwifery experts in a Delphi study (Brady et al., 2023). In this stage re-examination of the published data and the language used by the international midwives to describe woman-centred care was conducted to identify the colloquial attributes, antecedents, and consequences of woman-centred care. A qualitative synthesis framework developed by Gale et al. (2013) was used to guide the initial data collection, statements from the Delphi study that reached a 75 % consensus level were considered relevant for use as colloquial data in the concept analysis (Brady et al., 2023). In the original Delphi study (Brady et al., 2023) all, eligible statements were arranged under four themes: (1) Defining characteristics of woman-centred care; (2) The role of the midwife in woman-centred care; (3) Woman-centred care and systems of care; and (4) Woman-centred care in education and research. In the concept analysis these statements within each of these themes were re-examined by the researchers and classified as either an attribute, antecedent, or consequence of woman-centred care. Agreement on the alignment and statement suitability for use as either an attribute, antecedent or consequence in this stage was achieved through discussion and consensus (Graneheim and Lundman, 2004).

Stage 3: Synthesis of the data used the same qualitative synthesis framework by Gale et al. (2013) to compare and integrate the findings from the previous two stages. These findings were re-examined in the context of the initial focus of interest: woman-centred care. The attributes, antecedents, and consequences from the theoretical data were compared with the attributes, antecedents, and consequences found in the colloquial data. Characteristics of, and differences between, data were identified, and common attributes, antecedents, and consequences aligned. The original two data sets were subsequently synthesised to find the essential defining elements, attributes, antecedents, and consequences that distinguish the concept and practice of woman-centred care. These synthesised and interpreted findings were reviewed independently by the researchers and agreement about their relevance for use as final synthesised attributes, antecedents, and consequences in the development of the definition was achieved.

Identification of related concepts

A key feature of evolutionary concept analysis is identifying related concepts that can assist in understanding how the concept fits within the network of concepts surrounding it (Rodgers 1989). Therefore, it was essential to distinguish between surrogate terms and related concepts – that is, concepts which can have some bearing on, and relationship to, the concept under investigation but do not share the same set of attributes (Rodgers, 2000). The identification of these related concepts situated the concept of woman-centred care within the existing broader

knowledge base of theoretical underpinnings of midwifery.

Development of an international definition

The theoretical data contributed to an understanding of how the concept of woman-centred care features in the academic literature, and the colloquial data contributed to an understanding of how woman-centred care is used in the practice context of international midwives. Considering these findings, a definition of woman-centred care, informed by international midwifery, was formulated, using the outcomes from Stage 3: Synthesis. These outcomes were utilised to construct an internationally informed, definition of the concept of woman-centred care.

Results

Stage 1: theoretical analysis (Table 1)

The ten subthemes identified in the integrative review (Brady et al., 2019) were allocated as the attributes, antecedents, and consequences of woman-centred care for the theoretical analysis stage. Due to the frequency with which they were mentioned in the integrative review, attributes were considered as choice and control (subtheme 1), empowerment (subtheme 2), and relationships (subtheme 4). Precursors to the provision of woman-centred care were considered as antecedents, namely the education of midwives both registered and student (subthemes 9 and 10), continuity of care (subtheme 7), and characteristics of the midwife (subtheme 5). Consequences or outcomes of woman-centred care were allocated to protecting normal birth (subtheme 3), navigation of maternity care systems (subtheme 8), and models of care that upheld decision-making (subtheme 6).

Stage 2: colloquial analysis (Table 2)

Key attributes of woman-centred care in the colloquial data (Brady et al., 2023) identified were choice and control (which promoted autonomy), empowerment, relationships, and partnership, meeting the individual needs, both physical and psychological, of the woman (including her family), respect, and holistic care, which included cultural, social, and spiritual care.

Antecedents were identified as education, midwife characteristics, settings or models of care, institutional policy and procedures, and characteristics (such as time and quality) considered needed in the provision of woman-centred care. The consequences of woman-centred care identified were improved health outcomes, placing the needs of the woman above the institution, informed and shared decision-making, and the provision of evidence-based care and practice.

Stage 3: synthesis (Table 3)

Attributes of woman-centred care identified in Stage 1 were choice and control, empowerment, and the midwife–woman relationship. The colloquial data from Stage 2 contributed the additional attribute that woman-centred care was achieved when care met the woman's individual needs, which were inclusive of the woman's family. This attribute was synthesised with the attribute of choice and control. The Delphi study (Brady et al., 2023) participants also considered woman-centred care to be respectful care, so this attribute was synthesised with the attribute of relationships. Finally, the attributes of holistic care deemed inclusive of cultural, social, and spiritual needs was synthesised with the

Table 1
Stage 1: Theoretical Analysis: Attributes, Antecedents, and Consequences of Woman-Centred Care.

Studies	Attributes			Antecedents			Consequences		
Authors	Choice and Control	Empowerment	Relationships	Education	Continuity of care	Midwife Characteristics	Protecting Normal Birth	Navigating maternity care systems	Decision making
Ahlund et al. (2017)					X	X	X	X	
Borrelli et al. (2016)	X		X	X	X	X		X	
Brady et al. (2017)			X	X					
Browne et al. (2014)			X	X			X		
Daemers et al. (2017)		X				X	X	X	X
Davis et al. (2010)	X		X				X	X	X
Ebert et al. (2014)	X	X	X	X		X		X	X
Floris et al. (2017)	X	X	X		X			X	X
Giarratano (2003)	X	X	X	X		X		X	
Homer et al. (2009)	X	X	X	X	X	X	X	X	X
Hunter et al. (2017)	X	X	X	X	X	X	X	X	X
Iida et al. (2012)	X	X	X		X		X		
Iida et al. (2014)	X	X						X	
Johnson (2003)	X		X		X				
Maputle et al. (2010)	X	X	X	X		X		X	X
Saftner et al. (2017)	X	X	X	X	X		X	X	
Thompson et al. (2016)		X				X	X	X	X

Table 2
Stage 2: Colloquial Analysis: Delphi Study statements mapped to Attributes, Antecedents, and Consequences of Woman-Centred Care.

Attributes

Choice and control
1.5 advocating for the rights of the woman, defending, and promoting her right to self-determination.
1.9 care focused on the unique needs of the woman including her rights and hopes as well as physical and psycho-social aspirations.
1.14 respecting the woman as an individual human being, her freedom of choice and authenticity in order to promote positive care experiences.
2.1 respects the autonomy of the woman and supports this through the provision of evidence-based information sharing and working in partnership to plan care.
2.3 respects the values, beliefs, culture, choices, and preferences of the woman and her family within the context of promoting and endorsing best possible health outcomes.

Empowerment
1.1 empowering the woman with decision-making capabilities in the provision of her own care.
2.19 works in a continuous way to empower the woman and her family to make evidence-based informed decisions.

Relationship/partnership
1.8 care that actively engages the woman as an equal partner in the delivery and receipt of health services.
1.17 enables the woman and the midwife to work in partnership in a shared decision-making manner that builds confidence and trust.
2.1 respects the autonomy of the woman and supports this through the provision of evidence-based information sharing and working in partnership to plan care.
2.9 builds a respectful relationship with the woman, creating a supportive environment in which the woman can make independent informed decisions for herself, her baby, and her family.
3.11 supports the midwife taking the time to listen to the woman creating a one-on-one relationship of mutual recognition and respect.

Individual unique needs of the woman
1.2 holistic and respectful. It focuses on the woman's individual needs and desires.
1.3 respectful, anticipatory, and flexible care, that encompasses the needs of the woman, her newborn, family, and community.
1.9 care focused on the unique needs of the woman including her rights and hopes as well as physical and psycho-social aspirations.
1.14 respecting the woman as an individual human being, her freedom of choice and authenticity in order to promote positive care experiences.
1.15 addresses the woman's individual physical and psychological needs.
1.16 encompasses care that is inclusive of the woman and her family throughout pregnancy, labour, birth and beyond.
2.3 respects the values, beliefs, culture, choices, and preferences of the woman and her family within the context of promoting and endorsing best possible health outcomes.
2.19 works in a continuous way to empower the woman and her family to make evidence-based informed decisions.
3.1 are systems in which care is holistic and tailored for that individual woman rather than care that meets the needs of the institution.
3.3 are systems in which the institution makes room to accommodate the needs of the woman and her family rather than the woman having to fit in with the routines and protocols of the institution.
3.4 take an individualised approach to care and this care should always be offered rather than routine practice.
3.5 provide midwifery services which are based on the woman's individual needs.
3.8 provide a model of care that considers the individuality of the woman, including her social history and incorporates care in pregnancy, birth, postpartum and early infant life.

Respect
1.2 holistic and respectful. It focuses on the woman's individual needs and desires.
1.3 respectful, anticipatory, and flexible care, that encompasses the needs of the woman, her newborn, family, and community.
1.7 respectful care that recognizes all aspects of the woman's life including cultural, spiritual, social, psychological, emotional, and physical.
2.7 provides care that supports and guides the woman's decision making and respects the woman's expertise in this process.
2.9 builds a respectful relationship with the woman, creating a supportive environment in which the woman can make independent informed decisions for herself, her baby, and her family.
3.11 supports the midwife taking the time to listen to the woman creating a one-on-one relationship of mutual recognition and respect.

Holism (includes cultural, social, and spiritual care)
1.2 holistic and respectful. It focuses on the woman's individual needs and desires.
1.7 respectful care that recognizes all aspects of the woman's life including cultural, spiritual, social, psychological, emotional, and physical.
1.9 care focused on the unique needs of the woman including her rights and hopes as well as physical and psycho-social aspirations.
2.1 respects the autonomy of the woman and supports this through the provision of evidence-based information sharing and working in partnership to plan care.
3.1 are systems in which care is holistic and tailored for that individual woman rather than care that meets the needs of the institution.
3.8 provide a model of care that considers the individuality of the woman, including her social history and incorporates care in pregnancy, birth, postpartum and early infant life.

Antecedents

Education
4.1 developing in student midwives an understanding of woman-centred care and why it is important in midwifery practice.
4.5 ensuring the concept of woman-centred care is in all levels of midwifery curricula.

Midwife characteristics
2.5 accompanies the woman in making her own decisions. This requires the midwife to be open to new knowledge, and expand their skills in communication, and decision making.
4.3 developing in student midwives the ability to be assertive and to be able to manage conflict in a collaborative manner.

Settings/models of care
3.5 provide midwifery services which are based on the woman's individual needs.
3.13 ensure continuity of care when collaboration with medical colleagues is required for complexity.

Policy and procedure
3.3 are systems in which the institution makes room to accommodate the needs of the woman and her family rather than the woman having to fit in with the routines and protocols of the institution.
3.4 take an individualised approach to care and this care should always be offered rather than routine practice.
3.12 require the creation of maternity services with input from consumers at every level of policy making. Women should be at the heart and soul of all policy decisions.
3.16 place the woman in the centre of service delivery and this should be considered during the formation of policies and procedures.

Characteristics of care (time and quality)
3.1 are systems in which care is holistic and tailored for that individual woman rather than care that meets the needs of the institution.
3.11 support the midwife taking the time to listen to the woman creating a one-on-one relationship of mutual recognition and respect.
3.13 ensure continuity of care when collaboration with medical colleagues is required for complexity.
3.15 allocate time in the postnatal period to support breastfeeding and care of the mother and infant.
3.18 are flexible, friendly, non-threatening care that is available to all women.

Consequences

Improved health outcomes
1.4 can positively influence the outcomes of mothers and babies leading to improved health across the lifespan.
2.3 respects the values, beliefs, culture, choices, and preferences of the woman and her family within the context of promoting and endorsing best possible health outcomes.

Woman's needs placed above the institution.
3.1 are systems in which care is holistic and tailored for that individual woman rather than care that meets the needs of the institution.
3.3 are systems in which the institution makes room to accommodate the needs of the woman and her family rather than the woman having to fit in with the routines and protocols of the institution.

Decision-making (shared and informed)
1.1 empowering the woman with decision-making capabilities in the provision of her own care.
2.5 accompanies the woman in making her own decisions. This requires the midwife to be open to new knowledge, and expand their skills in communication, and decision making.
2.7 provides care that supports and guides the woman's decision making and respects the woman's expertise in this process.
2.19 works in a continuous way to empower the woman and her family to make evidence-based informed decisions.

Evidence based care/practice.
2.1 respects the autonomy of the woman and supports this through the provision of evidence-based information sharing and working in partnership to plan care.
2.19 works in a continuous way to empower the woman and her family to make evidence-based informed decisions.

attribute of empowerment. The resulting synthesised attributes of woman-centred care; were choice and control, empowerment, and relationships.

Antecedents to the provision of woman-centred care identified in Stage 1 were education, continuity of care, and midwife characteristics. The colloquial data from Stage 2 contributed additional attributes that considered the type of policies and procedures within an organisation, and characteristics of care inclusive of time and quality. In Stage 3, these antecedents from Stage 2 were synthesised with the antecedent of settings or models of care. The resulting synthesised antecedents of woman-centred were education, settings/models of care and the characteristics of the individual midwife.

Consequences of woman-centred care identified in Stage 1 were decision-making, protecting normal physiological birth, and navigating maternity care systems. The colloquial data from Stage 2 contributed additional consequences of improved health outcomes for both the woman and neonate. These improved health outcomes occurred with the provision of evidence-based information, so this data was synthesised with the consequence of improved health outcomes. As such, the synthesised consequences of woman-centred care were decision making, improved health outcomes and navigating maternity care systems. The synthesised findings of the consequences of woman-centred care from both the theoretical and colloquial stages showed similarities, implying that these findings were fit for purpose in the creation of a definition of woman-centred care for use in practice.

Identification of related concepts

Continuity of care is often used in the literature as analogous with woman-centred care requiring consideration of this as a related concept, particularly given the discrepant view of the concept in the theoretical and colloquial analysis. In the theoretical sample the studies included were conducted predominantly in higher income countries (Brady et al., 2019) where maternity care systems are evolving beyond the predominance of biomedical models of care to include models of care that offer opportunities for continuity of care. However, in the colloquial sample, expert midwives were drawn from all six International Confederation of Midwives (ICM) regions, including low-income countries, and these expert midwives did not rank continuity of care as a characteristic of woman-centred care (Brady et al., 2023). Women cared for in low-income countries may lack access to continuity of care (Renfrew et al., 2014). The model of care and maternity care systems are the context in which woman-centred care can occur, and these systems may or may not incorporate continuity of care. This identified that woman-centred care should not be defined by the model of care and maternity systems, but rather each individual woman should be entitled to the provision of woman-centred care by any healthcare professional in any model of care in any healthcare setting. Therefore, continuity of care and carer are related, but not central, to woman-centred care.

Table 3
Stage 3: Synthesis: Attributes, Antecedents and Consequences of Woman-Centred Care.

Concept	Stage1: Theoretical	Stage 2: Colloquial	Stage 3: Synthesis
Attributes	- Choice and control - Empowerment - Relationships	- Choice and control - Empowerment - Relationships - Meeting the woman's individual needs (includes family) - Respect - Holism (includes cultural, social, and spiritual care)	- Choice and control - Empowerment - Relationships
Antecedents	- Education - Continuity of Care - Midwife characteristics	- Education - Settings/Models of care (includes Continuity of care) - Midwife characteristics - Policy and procedure - Characteristics of care (time, quality)	- Education - Settings/Models of care - Midwife characteristics
Consequences	- Decision making - Protecting normal physiological birth - Navigating maternity care systems	- Decision-making (includes shared and informed) - Improved health outcomes - Evidence-based care/practice	- Decision-making - Improved health outcomes - Navigating maternity care systems

Definition development

The definition represents the contemporary understanding of woman-centred care in the empirical literature, synthesised with the consensus among the panel of international expert midwives on what woman-centred care is (Fig. 2). To develop the final definition of woman-centred care, the synthesised attributes of choice and control, empowerment and relationship were considered fundamental, so these terms appear in the first two sentences of the definition. Evidence-based shared and informed decision-making that assists the woman to navigate maternity care systems and ultimately improve health outcomes are the consequences of woman-centred care, and so anchor the definition in the final sentence.

Internationally informed evidence-based definition of woman-centred care

> "Woman-centred care ensures the woman has choice and control in her childbearing experience. Relationships built on reciprocal trust and respect foster empowerment, which recognises the woman's innate ability to meet her own needs. This is upheld through evidence-based shared and informed decision-making that supports the woman to navigate complex health systems and ultimately improves health outcomes for both the woman and neonate".

Discussion

This concept analysis identified the antecedents, attributes, and consequences of woman-centred care. Antecedents are education, models of care and midwife characteristics. Attributes are choice and control, empowerment, and relationships. Consequences are shared and informed decision making which supports the woman in navigating complex health systems, and ultimately improving health outcomes for both the woman and neonate. Existing literature (assessed in the first stage of this analysis) indicated that woman-centred care is multifaceted and interwoven in midwifery practice. However, there is not a shared understanding of this concept, making it difficult to identify and apply woman-centred care in practice. Woman-centred care is regarded as both a quality and as an intervention, yet each study appraised in the integrative literature review had only partially considered the concept and therefore the conceptualisation of woman-centred care was incomplete (Brady et al., 2019). Within the literature the concept woman-centred has only ever been considered from a theoretical perspective (Maputle, 2013; Fontein-Kuipers et al., 2018). This theoretical perspective aims to represent concepts as they appear in the scientific literature, rather than the colloquial perspective that represents the concept as used in practice. As a result, a gap is created between academic knowledge of the concept and the understanding of practitioners who use the concept in practice (Risjord, 2009).

Despite potential limitations associated with these published theoretical perspectives a theoretical concept analysis is a well-established

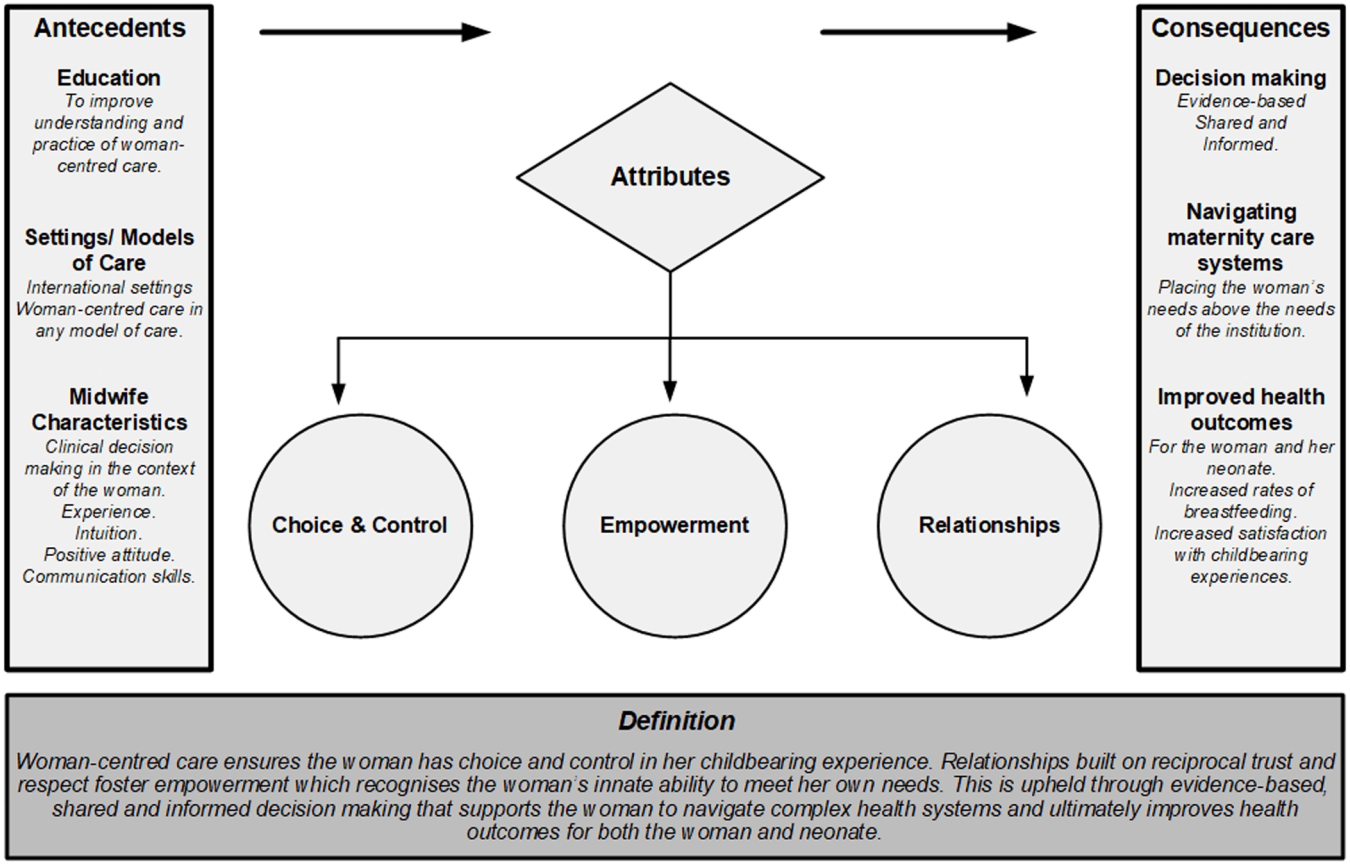

Fig. 2. Schematic Representation of the Concept of Woman-Centred Care.

method for analysing abstract ideas (Walker, 2011) and so has been used on two other occasions to analyse the concept of woman-centred care in midwifery. Firstly, in South African health services (Maputle, 2013) and secondly in developing an understanding of the concept of woman-centered care in preparation for research and education (Fontein-Kuipers et al., 2018).

Maputle's (2013) concept analysis was informed by two previous qualitative studies in which the concept of woman-centred care had emerged as a central idea (Maputle and Nolte, 2008; Maputle, 2010); the first, a qualitative study which investigated the experiences of childbirth for mothers cared for in a South African tertiary hospital (Maputle and Nolte, 2008). Findings from this investigation suggested the concept of woman-centred care as a central idea in the care experienced by women, and further identified attributes which the provision of woman-centred care was contingent upon. Maputle (2010) then conducted an exploratory, descriptive, contextual study using semi-structured interviews, to explore and describe the experiences of 12 midwives managing women during labour also in a tertiary care hospital in South Africa. Categories that prevented woman-centred care such as lack of mutual participation, information-sharing, decision making and informed choice options which in turn prevented empowerment and autonomy of the woman were identified. These authors concluded that these findings have implications for the provision of woman-centred care in South African maternity settings.

Maputle's (2013) concept analysis was subsequently conducted synthesising findings from these two qualitative studies (Maputle and Nolte, 2008; Maputle, 2010). While a strength of their concept analysis was the use of the robust methodological framework suggested by Walker and Avant (2005), a key limitation was the use of the definition of family-centred care proposed by Hutchfield (1999). This definition encompasses the idea that care is holistic and involves the professionals and family working collaboratively for a common outcome and was used as synonymous for woman-centred care when analysing the concept (Maputle, 2013). As such the proposed definition of woman-centred, care does not acknowledge the individual woman's autonomy in her care but rather regards the woman only in the context of the family unit.

The concept analysis on woman-centred care by Fontein-Kuipers et al. (2018) employed a principle-based method, reporting an in-depth understanding and a broad conceptual foundation of woman-centred care suggesting that this foundation could be used for research, educational purposes, and application to midwifery practice. The strength of this study was the principle-based evaluation of woman-centred care and the subsequent recommendation that in the provision of woman-centred care there is equal emphasis on both the woman's experiences and on clinical outcomes. Key findings implied that a multidisciplinary perspective of woman-centred care was investigated however, literature drawn from other disciplines such as medicine was excluded, affecting the multidisciplinary perspective of the search and thus the deeper understanding of the concept of woman-centred care proposed. Additionally, the analysis treated the terms "patient-centred", "person-centred", and "client-centred care" as synonymous with woman-centred care when sourcing literature for the analysis. The use of this varying nomenclature fails to acknowledge the childbearing woman as undergoing a normal physiological process with the potential to dehumanise the woman. Merely replacing terms with different words as if they are synonyms can also make healthcare communication confusing and inaccurate (Gribble et al., 2022).

Furthermore, although the researchers claim to have included both qualitative and quantitative studies in their selection, original research in woman-centred care, such as the development and piloting of the woman-centred care scale published by Brady, Bogossian and Gibbons (Brady et al., 2017), was not included despite this study defining woman-centred care, its attributes, antecedents, boundaries, and outcomes. Regardless, the definition of woman-centred care offered in the

Dutch study (Fontein-Kuipers et al., 2018) has some similarities with the findings of this study that woman-centred care relies on a collaborative relationship between the woman and the midwife and incorporates consideration of each woman's individual experiences.

To gain an international insight into woman-centred care, our study used an adapted theoretical and colloquial evolutionary model of concept analysis developed by Rodgers (2000), incorporating underpinnings offered by Risjord (2009). Theoretical findings in our study showed similar outcomes to those identified by the preceding studies. However, synthesis of the theoretical and colloquial data, and the final synthesis stage, that analysed each of the attributes, antecedents, and consequences of woman-centred care strengthens the understanding of the concept from an international perspective. Further, the definition of woman-centred care in practice developed from our concept analysis used statements directly sought from the participants in Stage 2: Colloquial Analysis and, combined with the data from Stage 1: Theoretical Analysis and culminating in Stage 3: Synthesis, has applicability to both the theory and practice of midwifery.

Common attributes of woman-centred care revealed in Stage 3 were those of choice and control, empowerment, and relationships. Attributes of woman-centred care identified by Maputle (2013) are those of mutual participation facilitating choice and control, empowering the woman through information-sharing, and relationships that supported interdependence and collaboration through accommodative midwifery actions. Fontein-Kuipers et al. (2018) stress that woman-centred care is characterised by the dynamic and reciprocal character of the woman–midwife relationship. The similarities of the findings in these studies with our study and the common identified attributes of choice and control, empowerment, and relationships confirm the fittingness of the chosen attributes to the formulated definition of woman-centred care.

Antecedents of woman-centred care were identified in our study as education, settings and models of care that support the provision of woman-centred care, and midwife characteristics. There is a gap in the literature about how to develop midwifery students' knowledge of woman-centred care and foster its application in practice. Frequently the development of woman-centred care behaviours in midwifery students is linked with the midwifery program requirements of a certain number of continuity of care experiences. Fontein-Kuipers and Romeijn (2017) conducted an evaluation of their woman-centred care education and research project and concluded that undertaking continuity of care experiences supported midwifery students' learning about providing woman-centred care. Yanti et al. (2015) undertook a quasi-experimental study of Indonesian midwifery students and their development of woman-centred care. They suggested that a continuity of care clinical learning model promotes and increases understanding of the philosophy of woman-centred care. Further, while continuity of care and carer are seen as important to midwifery practice and midwifery-led models of care (Sandall et al., 2016), outcomes of our study demonstrate that woman-centred care is not restricted to midwifery or to continuity of care models and so should be provided by all healthcare providers in all healthcare settings.

In this study the characteristics of the midwife were also identified as an antecedent to the provision of woman-centred care. Fontein-Kuipers et al. (2018) agree that the provision of woman-centred care is a conscious choice and a deliberate act by the care provider rather than the concept being applied by default. Outcomes of our study further contribute that to provide woman-centred care the midwife needs to have knowledge in clinical decision-making and an understanding of the application of woman-centred care practices gained through education. Descriptive behaviours of woman-centred care practices were used by Brady et al. (2017) to develop an instrument to articulate and measure care behaviours that are specifically woman-centred. The developed woman-centred care scale (WCSS) was proven to be a pragmatic and reliable tool to measure woman-centred care behaviours in midwifery students performing skills in a simulated environment. Davis et al. (2021) subsequently built on this work in developing the Woman-Centred Care Scale- Midwife Self-Report designed to measure woman-centred care behaviours in registered midwives. This scale was psychometrically tested in a large sample population of Australian and New Zealand midwives, with results confirming what we found in this study- that woman-centred care is demonstrated when, in the context of the maternity service, the midwife meets the unique needs of the individual woman. Davis et al. (2021) also suggest that when midwives have understanding and awareness of practice behaviours that constitute woman-centred care this ensures this midwifery philosophy underpins practice.

Consequences of woman-centred care were identified in our study as decision-making, assisting the woman to navigate maternity care systems, and improved health outcomes for both the woman and neonate. Fontein-Kuipers et al. (2018) also found that when woman-centred care is missing, care is dehumanised and coincides with increased medicalisation of birth and a decrease in quality of care. Outcomes of our study contribute that if women are consulted in all aspects of policy creation, then care provided would meet the needs of the woman and her family rather than the needs of the institution. And that this in turn would provide a mechanism for women to navigate the current biomedically dominated maternity care systems in many countries.

This concept analysis of woman-centred care facilitated deep emersion, exploration and clarification of the concept which underpins midwifery philosophy and practice making it a valuable contribution to midwifery theory and practice. This concept analysis supports the view that the way midwives demonstrate woman-centred care in their individual practice is distinct and associated with particular attributes, and antecedents. The resulting internationally informed definition of woman-centred care provides the first evidence-based definition which can be used to further translate this desired concept into care provision providing positive consequences of improved maternal and neonatal outcomes in today's complex maternity care systems. This work is not complete however, because although this work makes a valuable contribution to midwifery theory and practice, the voices of women who are the recipients of woman-centred care are yet to be explored.

Strengths and limitations

Using the adapted theoretical and colloquial evolutionary model of concept analysis proposed by Rodgers (2000) and Risjord (2009) is a strength of this study. In this approach, both theoretical and colloquial understandings of the concept were incorporated, ensuring that this definition contributes to the evolving understanding of the concept of woman-centred care. Additionally, the data used in this concept analysis were gained from an international perspective which makes this definition globally contextualised. This research enquiry also required a real-life contextual understanding of woman-centred care, and this was achieved with the midwifery experience of the researchers, and from the different perspectives gained in this study.

Although the term "woman-centred care" is used frequently in clinical practice, maternity services, education, and research, the initial review of the empirical literature showed that there is no single shared understanding of the concept. To mitigate this, the expert midwifery participants in the Delphi study (Brady et al., 2023) were asked to describe what woman-centred care meant to them and how they applied it in their individual midwifery practice. The re-examination of the data in Stages 1 and 2 of this concept analysis, and the synthesis process conducted in Stage 3 were utilised in developing the definition, making this definition of woman-centred care the first to use the input of both the academic literature and of an international group of practising midwives linking both theory and practice.

A concept analysis, however, is by nature largely an interpretative analysis, and what in this study was considered an attribute, antecedent and consequence of woman-centred care may be interpreted differently by others. Temporal and causal relationships between attributes, antecedents and consequences may also vary in different contexts. This could

be seen as a limitation of this study.

This study also did not specifically address the use of gendered terms and suggests that future research on woman-centred care should include clarification of this for example- this research uses the term "woman" when referring to woman-centred care. The term woman is not intended to be exclusionary to those who give birth and do not identify as women (Gribble et al., 2022), and this could be perceived as a limitation.

Conclusion

For the first time, this study has developed an evidence-based, internationally informed definition of woman-centred care by synthesising theoretical data representing woman-centred care as it appears in the empirical literature, and colloquial data that considers the concept as used by international practicing midwives. The resulting definition is that woman-centred care ensures the woman has choice and control in her childbearing experience. Relationships built on reciprocal trust and respect foster empowerment, which recognises the woman's innate ability to meet her own needs. This is upheld through evidence-based shared and informed decision-making that supports the woman to navigate complex health systems and ultimately improves health outcomes for both the woman and neonate.

The findings from this study also suggest that whilst important to midwifery practice and midwifery-led models of care, continuity of care is not a core essential element of woman-centred care. As such woman-centred care could and should be provided by any healthcare practitioner in any healthcare setting. The three-stage approach makes this concept analysis of woman-centred care robust and original and attempts to close the gap between theory and practice, ultimately improving healthcare for childbearing women.

Author contributions

The authors Susannah Brady, Fiona Bogossian, and Kristen Gibbons were involved in all levels of the research, conception and design of the project, analysis of the data and drafting, critique and review of the findings and each of the authors have reviewed and approved the final transcript for submission. This article is our original work and has not been published elsewhere, nor is it under consideration for publication elsewhere. There are no notable conflicts of interest to declare, and the authors agree to abide by the copyright terms and conditions of Elsevier.

All authors made substantial contributions to the paper. SB, FB, KG were involved in the conception and design of the concept analysis and interpretation of the data. SB drafted the article and FB, and KG critically revised it. SB, FB, and KG provided the final approval of the version to be submitted.

Declaration of competing interest

The Authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the research reported in this paper.

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