

This file is part of the following work:

Cheer, Karen Diane (2019) *Balancing it out: the process by which midwifery students provide care to women following stillbirth in Papua New Guinea*. PhD Thesis, James Cook University.

Access to this file is available from:

<https://doi.org/10.25903/5d4a750c7d880>

Copyright © 2019 Karen Diane Cheer.

The author has certified to JCU that they have made a reasonable effort to gain permission and acknowledge the owners of any third party copyright material included in this document. If you believe that this is not the case, please email

researchonline@jcu.edu.au

Balancing it out: The process by which midwifery students provide care to women following stillbirth in Papua New Guinea

Karen Diane Cheer

BA (Lib&InfoSci), GCertResMeth

A thesis submitted for the degree of Doctor of Philosophy

in the College of Arts, Society and Education

January 2019

James Cook University

Declaration

I declare that this thesis is my own work and has not been submitted in any form for another degree or diploma at any university; and to the best of my knowledge and belief this thesis does not contain any material previously published or written by another person except where due reference is made in the text.

I acknowledge that an electronic copy of my thesis must be lodged with the University Library and subject to the General Award Rules of James Cook University, immediately made available for research and study in accordance with the *Copyright Act 1968 (Cth)*.

Statement of the Contributions of Others

Intellectual support

My advisory team provided advice and guidance on study design, analysis and reporting within the remit of their roles. Associate Professor Lalen Simeon, Rachael Tommbe and Lester Asugeni provided cultural mentoring.

Jointly authored works contained in the thesis

Co-authors of this publication have given their permission for the publication to be included in this thesis:

Thesis Chapter	Details of the publication	Nature and extent of the intellectual input of each author
3	Cheer, K., MacLaren, D., & Tsey, K. (2016). The use of grounded theory in studies of nurses and midwives' coping processes: A systematic literature search. <i>Contemporary Nurse, 51</i> (2–3), 200–219.	KC, KT and DM conceived of the study and participated in the study design. KC carried out database search, literature review, data extraction and analysis and quality assessment of publications and drafted the paper. All authors edited and revised the draft paper and approved the final manuscript.

Financial support

I gratefully acknowledge financial support from the following sources:

- Australian Government Australian Postgraduate Award
- Australian Government Research Training Scholarship
- Far North Queensland Hospital Foundation
- Joan Hardy Scholarship for Postgraduate Nursing Studies, National Tertiary Education Union
- College of Arts, Society and Education, James Cook University

Editorial assistance

This thesis was edited by Elite Editing. Editorial intervention was restricted to Standards D and E of the Australian Standards for Editing Practice.

Published works by author relevant to the thesis but not forming part of it

Cheer, K. (2016). Asia-Pacific women's experiences of stillbirth: A metasynthesis of qualitative literature. *Health Care for Women International*, 37(8), 889–905.

doi:10.1080/07399332.2015.1080261

Acknowledgements

I would like to thank my advisors Professor Komla Tsey, Associate Professor David MacLaren and Dr Jenny Kelly for their patience, support and guidance throughout the research process. I value the different perspectives you each brought to the research. You always challenged me to do better. Thank you for your steadfast faith in me. I will be forever grateful to you for sharing your experience and wisdom.

This research could not have happened without the support of Pacific Adventist University (PAU). There are too many people in the PAU community to list individually. However, I wish to acknowledge a number of staff who made significant contributions. I am indebted to the members of my cultural reference group: Deputy Vice Chancellor, Associate Professor Lalen Simeon (formerly Director of Research and Postgraduate Studies), Rachael Tommbe and Lester Asugeni. Thank you for providing Melanesian perspective and generously sharing your knowledge. My thanks to the Asugeni family for welcoming me into your home when I had nowhere else to stay. To Clare Kokinai, for your personal support and together with Lalen, helping to facilitate ethics and visa applications, thank you.

I gratefully acknowledge the support of the staff of the PAU School of Health Science. You made me welcome and assisted this research in various ways. My special thanks to midwifery lecturers Annie-Rose So-Onguku and Ellie Korave, and tutors Esther Koski and Ellen Baibuni for your continued interest and support of my research. I look forward to further collaborations with you.

I would also like to thank colleagues at James Cook University who have supported me in conducting this study. Associate Professor Wendy Earles, you instilled in me the belief

that I could ‘do research’; Dr Michelle Redman-MacLaren, you trod the path before me and inspired me to achieve; Nalisa Neuendorf and Russel Kitau, my PNG *wantoks*, for sharing your cultural insight and translating *Tok Pisin* for me. Thank you also to friends who shared the PhD experience with me. Fiona Oates, together we experienced the highs and lows of researching our respective theses and your encouragement since our undergraduate days has been invaluable; Ben Menadue, thank you for challenging discussions about research methodologies, data analysis and the universe.

I am especially grateful to the midwifery students who participated in this study. Thank you for sharing your stories with me. Without you giving so generously of your time and of yourselves, there would be no thesis.

My greatest appreciation goes to my husband Daryl and daughters Belinda and Larissa. Thank you for your enduring love and support in all things. I could not have achieved this without you.

Abstract

Stillbirth is a paradox of life and death. Each year, 3 million women worldwide experience stillbirth. As frontline providers of maternal health care, midwifery students and midwives are often with the woman when stillbirth occurs. The support midwifery staff provide during and after the birth contributes to how a woman recovers from her loss. Stillbirth significantly affects the wellbeing of midwifery staff, particularly midwifery students who may have little experience of stillbirth. Papua New Guinea (PNG) has one of the highest stillbirth rates in the Pacific, yet midwifery students' experiences as regards stillbirth in PNG have not been documented. This thesis helps address this gap, to inform strategies to help midwifery students cope with this often-challenging aspect of their work, thereby helping improve the provision of maternal health care in PNG.

PNG is a Pacific Island nation of 8 million people. Most of the population live a subsistence lifestyle in rural and remote village communities. With an unevenly resourced health care system, a shortage of registered midwives and inadequate infrastructure, women have limited access to maternal health care facilities and skilled care during delivery. Women typically have lower social status than men and thus have limited abilities to make individual decisions, notably in relation to their reproductive health.

This qualitative study employed constructivist grounded theory and decolonising methodologies consistent with the PNG context in which the research was conducted. Purposive sampling was used to recruit participants from a cohort of midwifery students enrolled at a PNG university. A three-phase approach was utilised over a 12-month period. Focus group discussions (n = 3) with midwifery students explored socially shared knowledge and beliefs about pregnancy, birth and stillbirth to generate initial concepts. Next, rich, semi-

structured interviews (n = 11) with nine female and two male students expanded on key issues and concepts raised in the focus group discussions. A workshop with eight female students was then conducted to discuss the ‘big ideas’ from data analysis and conceive how ideas fit together. Transcribed audio files and workshop diagrams were analysed using constructivist grounded theory methods of initial and focused coding and categorisation to inform a developing grounded theory. The theory was presented at the study site in PNG and authenticated by people involved in the research and its outcomes.

Students’ narratives show how social, cultural and religious elements of PNG life influenced the creation of meaning and determined individual and community behaviour. Students described transitioning to midwifery and their philosophical approach to care for women following stillbirth. Male students explained the challenges they faced working as student midwives when pregnancy and birth are considered women’s business. In a country with diverse customs and beliefs, stillbirth is attributed to various causes. Students revealed the personal and professional consequences of caring that affected their own health and wellbeing.

‘Balancing It Out’ is the core category emerging from the contextual environment in which the study participants live and work. The theory describes the processes the students used in (i) ‘Becoming a midwife’, (ii) ‘Traversing different belief systems’ and (iii) ‘Dealing with feelings’ to achieve their aim of providing the best possible care to women following stillbirth. Providing quality midwifery care means students taking into account difficult conversations about religion, culture and social issues. Students need communication skills to have layered discussions to improve health outcomes for the women and their families.

This is the first study of midwifery students' experiences of providing care to women following stillbirth in PNG. Every midwifery student at the study site had experienced providing care to women following stillbirth prior to becoming a midwifery student. This ubiquitous experience exemplifies the need for ongoing research into interconnected social, cultural, spiritual and systemic factors that influence concepts of stillbirth and the provision of care in the PNG context.

This study is unique and there are no comparable studies from other Pacific countries, despite the high stillbirth rates across the region. However, many of the elements identified within this study correspond with findings from research investigating the provision of care to women after stillbirth by nursing students internationally. These include the psychological effects of stillbirth on students and the challenges of supporting the woman following a stillbirth delivery with holistic care that meets her social and cultural needs. The emergent themes from this study emphasise the importance of social and emotional aspects of health, and not just the biophysical. The concepts emphasise the importance of holistic care that reflects the founding principles of the World Health Organization (WHO) definition of health as 'a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity' (2014, p.1). The major findings of this study offer practical insights into WHO frameworks, such as the Declaration of Alma-Ata (1978) and the Ottawa Charter for Health Promotion (1986), which highlight that attaining good health requires addressing the social determinants of health. This study also offers insights into the realities of providing holistic care to women following stillbirth and the importance of advocating, enabling and mediating across health, social and economic sectors to attain the best outcomes for women following stillbirth and the midwifery staff who provide them with maternity care. Findings from this study exemplify the operational reality of these broad international documents and

the importance of this unrecognised issue of care. The experiences of the midwifery students at this university demonstrate the reality for health staff, not only in PNG but also in other similar settings. The findings have practical implications for informing midwifery education and practice in PNG and provide a platform for maternal and child health research in PNG and the wider Pacific region.

As a recommendation for action, students requested specific modules in midwifery education for providing care to women experiencing stillbirth, which incorporate not only biomedical but social, cultural and spiritual aspects. Teaching of bereavement care skills would assist midwifery students in their practice and provide a balance between clinical management and social and emotional support for women. This action has begun.

Recommendations from this study have informed midwifery educators who now discuss psychosocial care for women experiencing stillbirth in course content. The new postgraduate midwifery curriculum under development will include a discrete unit on stillbirth and appropriate care for women. Self-care modules for midwifery students to build coping mechanisms to deal with the emotions they experience are also needed. Professional support and supervision for midwifery students following a critical event have the potential to reduce the effects of negative emotions on their health and wellbeing. Ongoing research is needed to assess the suitability and sustainability of these modules in the care of these women.

Table of Contents

Declaration.....	i
Statement of the Contributions of Others	ii
Intellectual support.....	ii
Jointly authored works contained in the thesis.....	ii
Financial support.....	iii
Editorial assistance.....	iii
Published works by author relevant to the thesis but not forming part of it	iii
Acknowledgements.....	iv
Abstract.....	vi
Table of Contents.....	x
List of Figures.....	xiv
List of Tables.....	xv
Index of Acronyms.....	xv
Prologue.....	1
Chapter 1: Introduction.....	6
1.1 Chapter outline.....	6
1.2 Stillbirth and the global call for action.....	6
1.3 Midwives providing care to women following stillbirth.....	9
1.4 Bereavement care programmes for midwifery students and midwives	11
1.5 Midwifery practice in postcolonial settings	12
1.6 Rationale for this research.....	13
1.7 Substantive area of inquiry and study aims.....	15
1.8 Thesis style.....	15
1.9 Thesis structure	16
1.10 Summary	17
Chapter 2: The Research Setting.....	19
2.1 Chapter outline.....	19
2.2 Papua New Guinea.....	19
2.3 Christianity in Papua New Guinea.....	20
2.4 Health care in Papua New Guinea.....	22
2.5 Maternal health care and stillbirth in Papua New Guinea.....	23
2.6 The development of midwifery in Papua New Guinea.....	24
2.7 Strengthening midwifery capacity in Papua New Guinea	26
2.8 Location of the study.....	27

2.9	The Pacific Adventist University Bachelor of Midwifery programme.....	29
2.10	Summary	32
Chapter 3: A Methodological Journey		33
3.1	Chapter outline	33
3.2	Exploring experiences of stillbirth.....	33
3.3	Philosophy and research paradigms	35
3.4	Coming to a philosophical standpoint.....	37
3.4.1	Critical realism.....	38
3.5	Qualitative research.....	40
3.6	Qualitative methodologies.....	42
3.6.1	Narrative research	43
3.6.2	Case study research.....	44
3.6.3	Ethnography	45
3.6.4	Phenomenology.....	45
3.7	Grounded theory.....	47
3.8	Nurses' and midwives' coping processes in grounded theory studies	50
3.9	Summary	70
Chapter 4: A Methodological Journey Continued		71
4.1	Chapter outline	71
4.2	Constructivist grounded theory	71
4.3	Research in the postcolonial space.....	73
4.4	Decolonising methodologies	74
4.5	Constructivist grounded theory + decolonising methodologies.....	76
4.6	Summary	77
Chapter 5: 'Doing' the Research.....		79
5.1	Chapter outline	79
5.2	Engaging with the Pacific Adventist University community.....	80
5.2.1	Working with the PAU cultural reference group.....	81
5.2.2	Ethical considerations	83
5.2.3	Data storage and management	85
5.3	Collecting the data.....	85
5.3.1	Focus group pilot	93
5.3.2	Stage one: Focus groups	95
5.3.3	Stage two: Individual interviews	99
5.3.4	Stage three: Workshop.....	104
5.3.5	Theoretical sampling and saturation in the Papua New Guinea context	105
5.4	Analysing the data.....	107

5.4.1	The act of transcription and theoretical sensitivity	108
5.4.2	Coding, categorisation and constant comparison.....	109
5.4.3	Memos, maps and diagrams.....	111
5.5	Returning to the field.....	115
5.6	Engaging with the literature in grounded theory research	117
5.7	Summary	118
Chapter 6:	Findings—Part 1	119
6.1	Chapter outline	119
6.2	Conceptual overview of the theory	120
6.3	The contextual environment.....	121
6.4	Who controls reproduction?	122
6.4.1	Power relationships	123
6.4.2	Women are childbearing people	125
6.5	Who presents with the woman?	127
6.5.1	Expecting women’s support.....	127
6.5.2	Inviting male support	129
6.6	How accessible is health care?	131
6.6.1	Service disparity.....	132
6.6.2	Confronting geography	134
6.6.3	Finding the money	135
6.7	Summary	136
Chapter 7:	Findings—Part 2	138
7.1	Chapter outline	138
7.2	Becoming a midwife	138
7.2.1	Preparing to care	141
7.2.2	Practising care	152
7.2.3	Being a male midwifery student	163
7.3	Traversing different belief systems	169
7.3.1	Traditional truths.....	171
7.3.2	Religious rationalising	184
7.3.3	Blaming the midwife.....	189
7.4	Dealing with feelings	193
7.4.1	Consequences of caring	195
7.4.2	Capacity for coping.....	206
7.5	Summary	211
Chapter 8:	Discussion	212
8.1	Chapter outline	212

8.2	Locating the findings within the literature	212
8.3	Acknowledgement of the Papua New Guinea context.....	213
8.4	Becoming a midwife	218
8.5	Traversing different belief systems	228
8.6	Dealing with feelings	239
8.7	Global health frameworks	245
8.8	Philosophical concepts in research.....	250
8.9	Ensuring research quality	254
8.10	Limitations of the study.....	260
8.11	Summary	262
Chapter 9: Recommendations and Conclusion		263
9.1	Chapter outline	263
9.2	Where I began the study.....	263
9.3	What I did along the way	264
9.4	What I found at the end of the study	266
9.5	Recommendations for action.....	267
9.6	Recommendations for future research.....	269
Epilogue		271
References.....		274
Appendices.....		321
Appendix A: Asia-Pacific women’s experiences of stillbirth.....		321
Appendix B: Ethics approvals.....		339
Appendix C: Unpublished manuscript: Use of interviews and focus group discussions in constructivist grounded theory health care studies		341
Appendix D: Coding examples		364

List of Figures

Figure 2.1 Papua New Guinea and its provinces	20
Figure 2.2 Estimated stillbirth rates for Pacific countries 2015.....	23
Figure 2.3 International Confederation of Midwives midwifery scope of practice.....	30
Figure 2.4 Conceptual framework reflecting midwife/woman relationship.....	31
Figure 3.1 The three study aims.....	46
Figure 4.1. Philosophy underpinning this research.....	77
Figure 5.1. Data collection and analysis	80
Figure 5.2. Workshop diagrams.....	105
Figure 5.3. Analytical maps and diagrams.....	113
Figure 6.1. Theoretical model: How to provide the best possible care to women following stillbirth by ‘Balancing it Out’	121
Figure 6.2. The contextual environment and its dimensions	122
Figure 6.3. The dimension of ‘Who controls reproduction?’ and attributes.....	123
Figure 6.4. The dimension of ‘Who presents with the woman?’ and attributes	127
Figure 6.5. The dimension of ‘How accessible is health care?’ and attributes.....	131
Figure 7.1. The dimension of ‘Becoming a midwife’ and attributes	139
Figure 7.2. Workshop: importance of midwifery knowledge.....	143
Figure 7.3. Workshop: include practice with counselling	150
Figure 7.4. Workshop: a topic of its own.....	152
Figure 7.5. Workshop: we only wrap it up	157
Figure 7.6. The dimension of ‘Traversing different belief systems’ and attributes...	171
Figure 7.7. Workshop: falling into customs and beliefs	179
Figure 7.8. Workshop: face the consequences.....	187
Figure 7.9. Workshop: connection through prayer	188

Figure 7.10. Workshop: awareness of legal implications	192
Figure 7.11. The dimension of ‘Dealing with feelings’ and attributes	194
Figure 8.1. Holistic approach to welfare for School of Health Science students	222
Figure 8.2. School of Health Science office: reminder to pray	236
Figure Epilogue 1. PAU 2017 Graduation Ceremony	272

List of Tables

Table 5.1 Participant demographic information	101
Table 8.1. Criteria for grounded theory studies	256

Index of Acronyms

CASP	Critical Appraisal Skills Programme
CHW	Community health worker
CINAHL	Cumulative Index to Nursing and Allied Health Literature
CRG	Cultural reference group
FDIU	Fetal death in utero
ICM	International Confederation of Midwives
MCHI	Maternal and Child Health Initiative
JCU	James Cook University
LMICs	Low- and middle-income countries
PAU	Pacific Adventist University
PNG	Papua New Guinea
SDA	Seventh-day Adventist

SOHS

School of Health Science

WHO

World Health Organization

Prologue

I had a baby, but she died...

I am an Australian woman living in Cairns, Far North Queensland, Australia, located on the shores of the Coral Sea. Cairns is in close proximity to Papua New Guinea (PNG) and other Pacific Island nations and has several thousand residents of Pacific Island origin. James Cook University has ongoing research collaborations with institutions and other universities across the Pacific. My interest in the countries and peoples of the Pacific began in childhood from listening to my father's stories of his World War II service in PNG.

I have English, Irish, Scottish and Asian heritage. My ancestors came to Australia in the 1800s as economic migrants. I am the younger of two daughters born to middle-class, working parents. During my childhood in the 1960s, my family lived in a multicultural suburb in Sydney, New South Wales. I was aware my surname indicated my 'foreign' heritage but in the place where I lived, I was no different from my friends whose families had migrated to Australia from across the globe. When I was about 12 years old, my parents decided we would leave the hustle and bustle of Sydney for a quieter life a few hours north on the New South Wales Central Coast, where the population at the time was predominantly Anglo-Celtic. I was an unmotivated student with an unusual surname, and although I had absolutely no idea of what I really wanted 'to be' when I left high school, I was positive that marriage and a family were in my future. In my girlhood dreams, I had four children, two boys and two girls, and had already chosen their names.

In 1988, I was married and expecting my first child. I was so excited I was going to be a mum! After an unremarkable pregnancy during which I had regular medical check-ups, I unexpectedly went into labour at 37 weeks. I had already booked into the district hospital for the birth, so when my husband and I arrived at the labour ward, staff took us to a delivery room. After a normal labour with no indications of what was to come, I gave birth to a stillborn daughter we named Courtney. Although my experience happened many years ago, I can remember the staff trying desperately to resuscitate Courtney on a bench to the side of the room. I was confused and worried, unsure of what was happening with my baby. Some minutes passed, and then my doctor told me my baby had died. Understandably, Courtney's death was deeply distressing for my family and me, and for the medical staff who provided care—my family doctor and the attending nurses and midwives. I recall I did not cry at that time; I only asked what would happen now. I do remember a nurse saying I was in shock. I know my husband was near but have no recollection of how he reacted.

Later, I transferred from the labour ward to the postnatal ward. The room I was given was located between the nurses' station and the verandah section of the ward. It was common for staff to use the room as a corridor as they attended to the women with live babies on the verandah. At all times of the day and night, I could hear the sounds of happy families and crying babies as I lay on the bed in my room with the blinds drawn. I shed many tears. I had few visitors, and no one appeared to know what to say, except for one midwife who shared her own personal story of stillbirth with me. I was able to see and hold Courtney twice while in the hospital, and one of the midwives gave me a grainy Polaroid photo she had taken of Courtney shortly after she was born. Forty-eight hours after Courtney's birth, I was sent home with kind wishes from the staff and instructions to return to my family doctor in a few weeks' time for a check-up. Someone gave me a pamphlet about a recently formed

organisation, the Sudden Infant Death Association, known as SIDS, that I could contact if I felt I needed ‘help’. I returned to a house full of baby clothes and equipment, and my thoughts of what life should have been like with my baby. A post-mortem reported Courtney had died from acute intrapartum asphyxia and abruptio placenta. My doctor explained this to me as a ‘calcified placenta’. While I was 37 weeks pregnant when I went into labour, the placenta was ‘aged about 42 weeks’ and could not provide Courtney with sufficient oxygen during labour.

We buried Courtney one week after her birth. My parents, sister and several close friends attended the funeral. In the weeks after Courtney’s stillbirth, I felt lost and alone. My husband was working long hours. We did not talk to each other about what had happened and dealt separately with our grief. Our families did not discuss our shared loss with us, perhaps because they themselves felt uncomfortable or feared causing us further distress. I had no job to which I could return, having resigned in the third trimester of my pregnancy. Friends were either working or at home caring for their own babies and small children—spending time with them brought back the painful reality of my loss. It was distressing to have to explain to people unaware of what had happened that I had a baby, but she had died. Some people made well-intentioned comments such as, ‘It was meant to be’; ‘You never know, if she’d have lived she might have been disabled’; or ‘You’ll have another one.’ Those comments seemed to minimise my loss and Courtney’s existence. Once, when driving, I fleetingly wondered whether life was worth living. I did not contact the SIDS association and never received a follow-up call from the local health service. Then, on Christmas Eve, four months after my stillbirth, I experienced an ectopic pregnancy¹. I was admitted to the district hospital for

¹ Pregnancy situated outside of the uterus, commonly in the uterine (fallopian) tube (Fraser, Cooper, & Myles, 2009).

emergency surgery and subsequently had one of my fallopian tubes removed. My doctor advised I should give my body a rest and use family planning for a year. My dream of motherhood, once again delayed.

I worked part-time and got on with my life. While the pain of losing Courtney subsided, the memories remained. Two years later, I was pregnant again. It was a stressful yet happy time for me. My doctor considered the pregnancy high risk and closely monitored my baby and me: regular antenatal appointments, multiple ultrasound scans and kick charts to complete twice daily to check the baby's movements. I had day surgery to insert a Shirodkar suture following diagnosis of an incompetent cervix². Owing to my stillbirth history and the suture, my doctor decided the best option was to deliver my baby by elective caesarean section before term. I was fearful of having another stillbirth and trusted his judgement; he was a doctor after all. At 37 weeks, I gave birth by caesarean section to my second daughter. There were no complications, and she was a healthy baby. Family, friends and my doctor were relieved the birth had gone well. Finally, I was a mum.

Two years later, I was expecting another child. My fear of stillbirth lingered. My family doctor had since retired, and I was under the care of a well-regarded local obstetrician. He explained to me that my scar could rupture if I had a vaginal birth following my previous caesarean. Once again, I did not ask questions but trusted in the doctor's expert knowledge and experience. My third daughter arrived healthy, via elective caesarean section, again at 37 weeks—just to be safe. Two years later, feeling thankful for my two beautiful girls and

² A stitch to close the cervix (neck of the womb) to avoid cervical dilation leading to spontaneous rupture of the membranes and premature birth (Fraser et al., 2009).

unwilling to risk another stillbirth, I decided to undergo tubal ligation as a permanent contraceptive measure.

Today, I am not only a mother of three daughters but also a stepmother to three sons. Over the years, I have occasionally looked at the grainy photo taken by that midwife almost 30 years ago and wondered what Courtney would have been like, as a child, a teenager and as an adult woman, the eldest of my daughters. Remembering Courtney is no longer painful, but I will never forget the short time I spent with my firstborn child.

When my daughters were young, I needed to return to the workforce. While working part-time, I commenced university studies as a mature aged student and did well, having found the motivation I had lacked as a teenager. I embraced the concept of lifelong learning and went on to complete undergraduate and postgraduate study.

My family background and my work as a librarian supporting biomedical and health science research influenced my interest in the social and cultural determinants of health for people in the Asia-Pacific. My personal interests and stillbirth experience led me to undertake the current study.

Chapter 1: Introduction

This thesis examines the phenomenon of stillbirth from the perspective of a cohort of midwifery students at one university in Papua New Guinea (PNG). This study employed grounded theory and decolonising methodologies to explore and document social, cultural, spiritual and professional factors that inform the provision of care to women experiencing stillbirth from the perspective of midwifery students.

1.1 Chapter outline

In this chapter, I provide an overview of the research context. I describe the current challenges of stillbirth prevention globally. The role of midwives and midwifery students in the provision of care to women following stillbirth is introduced. I describe the importance of bereavement care programmes for midwifery staff. Midwifery practice in postcolonial nations is explored. The rationale for this doctoral research, the substantive area of inquiry and the aims of the study are provided. I discuss the style and the structure of the thesis.

1.2 Stillbirth and the global call for action

Childbirth is a time of significant risk, not only for women but also for their unborn babies (World Health Organization [WHO], 2016a). Globally, there are over 2.6 million stillbirths each year, with 98% occurring in low- and middle-income countries (LMICs; Horton & Samarasekera, 2016). The burden of stillbirth on families and nations is both psychosocial and economic (Heazell et al., 2016; PricewaterhouseCoopers (Australia) & Stillbirth Foundation Australia, 2016). While action is being taken to improve maternal health

and reduce infant mortality, particularly in LMICs, stillbirth has only recently been integrated into national and international health agendas (P. E. Bailey et al., 2017). At the time of writing this thesis, the Australian parliament had established the Senate Committee on Stillbirth Research and Education to consider the future of stillbirth research and education in Australia (Parliament of Australia, 2018). The major impetus for action has been the 2011 *Lancet Stillbirths Series* that brought worldwide attention to stillbirth. Research highlighted the rates and causes of stillbirth globally, explored interventions to prevent stillbirths and set key actions to halve stillbirth rates by 2020 (Lawn & Kinney, 2011). The follow-up 2016 *Lancet Stillbirths Series* provided updates on the state of stillbirths, missed opportunities and priority action to accelerate progress towards ending preventable stillbirths, particularly in LMICs (The Lancet Ending Preventable Stillbirths Study Group, 2016). An expanding network of global agencies engages in stillbirth issues; however, matters of funding, utilisation, poor governance structure and a lack of leadership from leading maternal and child health organisations, such the United Nations and the WHO impede efficacy (Frøen et al., 2016).

The lack of recognition of stillbirth may be partly attributed to the absence of a standard global definition. The WHO definition used for international comparisons is the birth of a baby born at 28 weeks or more gestation, weighing 1,000 g or more, showing no evidence of life (Frøen et al., 2011). However, many countries lack reporting mechanisms or do not count stillbirths in national data, reporting instead on information provided from household surveys (Haws et al., 2010; Lawn et al., 2010; Roos et al., 2016). To blur statistical reporting even further, stillbirth and neonatal³ death data are often combined to provide perinatal mortality rates (Lawn et al., 2011; WHO, 2015a). The perinatal period is defined by

³ Deaths occurring in the first 28 days after birth (Lawn et al., 2014).

the WHO as the period from 22 weeks gestation ending seven days after birth (WHO, 2015a). Knowledge of the real burden of stillbirth would create awareness of the issues and allow for analysis within health care systems and beyond to identify areas where improvements can be implemented (Roos et al., 2016). Although improvement in data collection will not alone save lives, it provides a means to target interventions daily worldwide that can reach those women who experience stillbirth (Lawn et al., 2016).

Stillbirth, neonatal and maternal mortality are closely related (Lawn et al., 2011; Save the Children, 2014). Three major contributing factors to stillbirth are poor maternal health, childbirth complications and poor obstetric care (Lawn et al., 2011; Save the Children, 2014). Globally, 1.3 million stillbirths occur during the high-risk time of labour (Lawn et al., 2016). Most of these are full-term babies whose deaths are avoidable with the provision of skilled care during labour, estimated to reduce stillbirths by 45% (Lawn et al., 2011; Save the Children, 2014). Meta-analysis of empirical studies of women's lived experiences of stillbirth in Asia-Pacific countries concluded that stillbirth experiences are complex and interconnected, with individual aspects of experience influencing, and being influenced by, others (Cheer, 2016). The social and cultural context in which the women live shapes their experiences. The quality of health care they receive contributes to the meaning attributed to the overall experience of stillbirth for women (Cheer, 2016). Positive or negative interactions within health care systems are contributing factors to how women manage and reconcile childbirth loss (Ellis et al., 2016; Geller, Psaros, & Kornfield, 2010; Gold, 2007).

1.3 Midwives providing care to women following stillbirth

Midwives provide support, care and advice to mothers throughout the antenatal⁴, birthing and early postnatal⁵ periods. The introduction of antenatal screening has led to the belief that any problems encountered in pregnancy and childbirth can be solved by medical intervention (Mitchell, 2005). However, not all childbirths result in a live infant and midwives are often the frontline providers of care to women following a perinatal death (Fenwick, Jennings, Downie, Butt, & Okanaga, 2007; Homer, Malata, & ten Hoop-Bender, 2016). The word midwife derives from the Old English ‘with woman’ (Australian College of Midwives, 2018). Being intimately involved with women and their families as they experience stillbirth requires midwives to be open to intense emotions and the grieving process (Fenwick et al., 2007). Much literature on the etiology of stillbirth and the clinical care of mothers exists (e.g., see Flenady et al., 2011; Fretts, 2005). To date, studies focusing on the experiences of stillbirth for nurses, midwives or midwifery students have mostly been undertaken in Western, industrialised countries, where research has demonstrated the mental, physical, social and emotional wellbeing of these professionals is affected by this major event (L. McKenna & Rolls, 2011; Wallbank & Robertson, 2013).

At some time in their career, every midwife is required to provide midwifery care to women following a perinatal death (Mitchell, 2005). Midwives may feel unprepared to deal with the sensitive issues surrounding stillbirth and perinatal⁶ death (Nallen, 2006). They may find caring for a bereaved woman challenging, both professionally and personally (Fenwick

⁴ During or related to pregnancy (Fraser et al., 2009).

⁵ Also called the puerperium or the postpartum period, defined as the first six weeks after delivery (Fraser et al., 2009).

⁶ Refers to death occurring within the first seven days of life (Fraser et al., 2009).

et al., 2007; Homer et al., 2016). Midwives and midwifery students have described this area of practice as ‘emotionally overwhelming’, ‘exhausting’ and ‘challenging’ (Fenwick et al., 2007; Mitchell, 2005). Staff may be simultaneously providing bereavement support to parents, clinical care to mothers, assisting with funeral arrangements and finalising paperwork (Nallen, 2006; Wallbank & Robertson, 2013). In the aftermath of dealing with perinatal loss, midwives and midwifery students have reported mixed emotions. Feelings of distress, guilt and inadequacy conflict with feeling a sense of purpose, and/or pride in the quality of care provided to the bereaved and an awareness of personal and professional growth (Cartwright & Read, 2005; Fenwick et al., 2007; Homer et al., 2016; L. McKenna & Rolls, 2011; Mitchell, 2005; Wallbank & Robertson, 2013).

Personal and practical support from colleagues was deemed an important factor in midwives and midwifery students’ abilities to cope with a perinatal death event (Nallen, 2007). Being able to discuss matters with empathetic colleagues and receive guidance, support and advice following an event allowed midwives to release internalised emotions (Nallen, 2007; Wallbank & Robertson, 2013). Yet, researchers found the levels of collegial and organisational support varied, resulting in the needs of midwives being unmet (Nallen, 2007; Wallbank & Robertson, 2013). A study of midwives in Israel described how stressful childbirth situations affected professional relationships, with the reactions of colleagues a contributing factor to the midwives’ experiences of the event. Positive interaction with colleagues provided much-needed emotional support, enabled midwives to process the stressful event and confirmed their professional identity. Negative or disrespectful comments caused midwives to feel belittled and rejected, thereby affecting their capacity to function in the workplace (Halperin et al., 2011).

1.4 Bereavement care programmes for midwifery students and midwives

There is consensus throughout the literature that midwifery students and midwives need formal training to develop the knowledge and skills required to provide optimal bereavement care to women following stillbirth (Cartwright & Read, 2005; Homer et al., 2016; Mitchell, 2005; Nallen, 2007). Training also enables positive coping mechanisms for midwives' personal processing of perinatal death (Homer et al., 2016; Mitchell, 2005; Nallen, 2007). Bereavement training is essential for midwifery students, who, owing to their inexperience, are often protected from providing care to women following stillbirth (Homer et al., 2016). However, training programmes alone might not be enough to prepare staff to respond to, and cope with, the distress of perinatal loss (Wallbank & Robertson, 2013). Because training implies that feelings may be controlled, it could be detrimental to the validation of the emotional responses of staff to a death, leading to their physical and/or mental isolation (Wallbank & Robertson, 2013). Therefore, researchers have concluded that the combination of education, training and a supportive environment provides staff with the foundation to develop adaptive coping mechanisms in response to stressful events, primarily life-and-death concerns for mothers and newborns (Jonas-Simpson, Pilkington, MacDonald, & McMahon, 2013). Education and training programmes operate in different environments and cultural settings and should therefore be specifically designed to ensure they are fit for purpose and tailored to the needs of the midwives involved (Pezaro, Clyne, Turner, Fulton, & Gerada, 2016).

1.5 Midwifery practice in postcolonial settings

Postcolonial nations face the challenge of developing and maintaining health care systems with limited financial, material and human resources, within an environment where cultural beliefs and values juxtapose with inherited Western attitudes and aspirations that often underpin biomedicine and ‘modern’ health care systems operated or regulated by national governments (Barclay, 2008). Davis-Floyd saw a continuum between traditional midwives and birth attendants—those who practice according to community traditions, without formal certification—and professional midwives, who have successfully completed accredited education programmes and are registered to practice in relation to health systems based on Western biomedical concepts (2007). Conceiving the term ‘postmodern midwife’, Davis-Floyd aimed to describe a contemporary, professional midwife as one who possesses ‘an informed relativism that encompasses science, traditional midwifery knowledge, professional midwifery knowledge, and complementary or alternative practice systems’ (2007, p. 707).

Theoretically, postmodern midwives have the ability to move between the colonialist, structured biomedical model and cultural traditions of birth to deliver woman-centred, holistic care to women (Davis-Floyd, 2008). The biomedical model of health focuses on the physical or biological aspects of disease and illness. The model is associated with concepts of assessment, diagnosis, prescription and treatment (H. P. McKenna, Pajnkihar, & Murphy, 2014). Women-centred care focuses on the woman’s unique needs rather than institutional or professional requirements (Homer, Brodie, & Leap, 2008). However, the ability of midwives to negotiate successfully between multiple worlds of care depends on local, regional and national contexts, including the interaction of historical, political, economic and sociocultural

factors (Hsu, 2001). Pacific nations are attempting to balance these issues. The Samoan health system aims to balance cultural beliefs and customs about childbirth with Western medicine. Traditional birth attendants and midwives form working partnerships in health care provision, where contemporary medical services complement a system of social birth support valued by the community (Barclay, 2008). In 2006, a memorandum of understanding was signed by the New Zealand College of Midwives and *Ngā Māia* Maori midwives, introducing the principles of *Turanga Kaupapa*, a contextual, cultural framework to guide midwifery practice (Kenney, 2011). In urban, regional and remote settings across Australia, *Birthing on Country* approaches provide Aboriginal and Torres Strait Islander women with continuity of culturally safe midwifery care and foster connection to country. *Birthing on Country* models incorporate Indigenous knowledge and oversight, and the support and development of the Indigenous maternal and child health workforce (Congress of Aboriginal and Torres Strait Islander Nurses and Midwives, Australian College of Midwives, & CRANaplus, 2016). In remote Indigenous communities in Australia's Northern Territory, senior Indigenous women working in the *Strong women, strong babies, strong culture* programme are experienced traditional midwives who assist women giving birth. The programme acknowledges the valuable cultural knowledge senior women provide to pregnant women and their families through participation in activities aimed at improving maternal and child health (Kildea, Tracy, Sherwood, Magick-Dennis, & Barclay, 2016; Lowell, Kildea, Liddle, Cox, & Paterson, 2015).

1.6 Rationale for this research

To date, research has focused on the experiences of village health volunteers and village birth attendants and their contribution to antenatal and childbirth care provision in

PNG (see, e.g., Bettiol, Griffin, Hogan, & Heard, 2004; Cox & Hendrickson, 2003; O'Keefe, Davis, Yakuna, Van Gemert, & Morgan, 2011). Recent studies explored PNG midwifery education, employment and practice issues for midwifery graduates (Moores et al., 2016). The issues surrounding the provision of midwifery care in PNG to women following stillbirth remain to be explored. During the development of this research proposal, no studies examining midwifery students and midwives' experiences of providing care to women following stillbirth in PNG were located, indicating this is an unexplored area of research. The dearth of studies examining the impact of stillbirth on midwifery students and midwives in Pacific countries, such as PNG, limits our understanding of its effects in this region. Research is needed to address this knowledge gap, to contribute to the body of literature and to inform strategies to assist PNG midwives and midwifery students in coping with this often-challenging aspect of their work, thereby helping improve the provision of care to women following stillbirth in PNG. When combined with my personal experience of stillbirth, this lack of empirical research on this important health issue provided the justification for me to undertake this project.

The Pacific Adventist University (PAU) Bachelor of Midwifery is a 12-month degree funded by the governments of Australia and PNG, which aims to increase the PNG midwifery workforce. As an emerging university, PAU seeks to strengthen its research capacity and researchers from James Cook University (JCU) and PAU have a history of collaboration on a variety of projects. Within this context, I contacted PAU about undertaking this doctoral research, to which they agreed. Further detail is provided in Chapter 2.

1.7 Substantive area of inquiry and study aims

The substantive area of inquiry for this grounded theory study was to explore, describe and theorise how midwifery students at a PNG university understand, experience and manage the provision of care to women following stillbirth. The aims of the study were to:

1. explore and describe midwifery students' understanding of stillbirth and their experiences of providing care to women following stillbirth
2. in partnership with midwifery students, describe and construct a theoretical model of the processes used by the midwifery students to manage the provision of care to women following stillbirth
3. identify the implications of the research findings for the university's midwifery programme and the provision of maternal health care in PNG.

1.8 Thesis style

The concepts of reflexivity and theoretical sensitivity are fundamental to the interpretative process in grounded theory studies, and therefore, I have written this thesis in the first person to position myself and reflect my subjectivity.

Respect for the study participants underpinned my decision regarding the style in which to present their words. Throughout the thesis, I refer to the participants as midwifery

students, or students. To maintain confidentiality when reporting findings, I gave each student a pseudonym. The words of the students who participated in this study provide supporting evidence of the findings throughout this thesis and are emphasised in italicised text. Although the students were proficient English speakers, English was not their first language and their verbatim responses often contained repetitive words and fillers such as um, ah and like. I removed most of these for ease of reading when reporting the findings; however, I retained other speech irregularities to preserve the detail of the student responses. I apologise for any inconsistencies of style and thank the reader for their patience.

1.9 Thesis structure

This thesis contains nine chapters. Following this introductory chapter, in Chapter 2, I situate the study in the PNG setting, where faith-based organisations play a critical role in delivering health service provision to a diverse and dispersed population. A comparison of the estimated stillbirth rates in Pacific nations highlights the scale of stillbirths occurring in PNG. I discuss the state of midwifery and midwifery education in PNG, with specific reference to the midwifery programme offered at the PNG university where this research was undertaken.

In Chapters 3 and 4, I outline my methodological journey: how I identified my personal philosophical standpoint and the decision-making steps that lead to the selection of a research design most appropriate for the study. I discuss issues regarding researching in a postcolonial space. In Chapter 5, I discuss the practicalities of conducting the research, including project establishment, engagement with the host community and the processes I

used for data collection and analysis. Ethical and culturally appropriate practice issues are discussed.

In Chapters 6 and 7, I present the major findings in the form of a grounded theory. The core concern of the midwifery students was how to provide the best possible care to women following stillbirth. Students used the process of ‘Balancing it Out’ to provide this care. Balance was the core construct that emerged through my analysis of the data. In Chapter 6, I describe the contextual environment from which the theoretical model emerges, with evidence from the data. In Chapter 7, I present the second part of the theory, identifying the three interconnected, central dimensions and their attributes with further data evidence.

In Chapter 8, I situate the findings in relation to the literature. I position the findings under global health frameworks and use philosophical paradigms to consider the theoretical contribution of the study. I evaluate the quality of the doctoral research against established criteria and address the limitations of the study.

In the final chapter, Chapter 9, I summarise the thesis, make recommendations for action and provide suggestions for future research. I conclude the thesis in an epilogue.

1.10 Summary

In this chapter, I have:

- described the current challenges of stillbirth prevention globally
- introduced the role of midwifery students and midwives in the provision of

care to women following stillbirth

- described the importance of bereavement care programmes for midwifery staff
- explored midwifery practice in postcolonial nations
- provided the rationale for the research, the substantive area of inquiry and the aims of the study
- discussed the style and the structure of the thesis.

In the following chapter, I will:

- provide a brief introduction to PNG
- describe how Christianity influences PNG social and political life
- discuss the PNG health system, maternal health care and stillbirth in PNG
- discuss the state of midwifery in PNG
- describe the location of the study
- introduce the midwifery degree programme and requirements.

Chapter 2: The Research Setting

2.1 Chapter outline

In this chapter, I provide an overview of the setting in which the research takes place. I describe the country of PNG, the influence of Christianity on PNG social and political life and the role of faith-based organisations in health service provision. Health system performance, maternal health care and stillbirth in PNG are discussed. I briefly examine the development of midwifery in PNG and strengthening of the national midwifery capacity. I describe the location of the study along with an overview of the Bachelor of Midwifery programme at the time this study was conducted.

2.2 Papua New Guinea

Australia's closest neighbour, PNG, is a country of 7.5 million people located in the southwest Pacific. First colonised by Britain and Germany in the late 1800s, PNG was later under the administration of the Australian Government and became an independent constitutional monarchy in 1975 (High Commission of Papua New Guinea Canberra, 2001). PNG has a landmass of 463,000 square kilometres and comprises 600 islands (Figure 2.1). Over 800 languages are spoken, and there is sociocultural divergence between and within regions. While approximately 20% of the population live in urban areas, most people live a subsistence lifestyle in village communities reliant on hunting, gathering, agriculture and livestock production and consumption (Department of Foreign Affairs and Trade, 2017). Where roads exist, the majority (97%) are unpaved. Many villages are accessible only by sea, air or on foot (Ascroft, Sweeney, Samei, Semos, & Morgan, 2011). The capital city, Port

Moresby, is one of the world’s least liveable cities, according to the 2018 Global Liveability Report that evaluates living conditions of cities around the world across five factors: stability, health care, culture and environment, education and infrastructure (Economist Intelligence Unit, 2018).

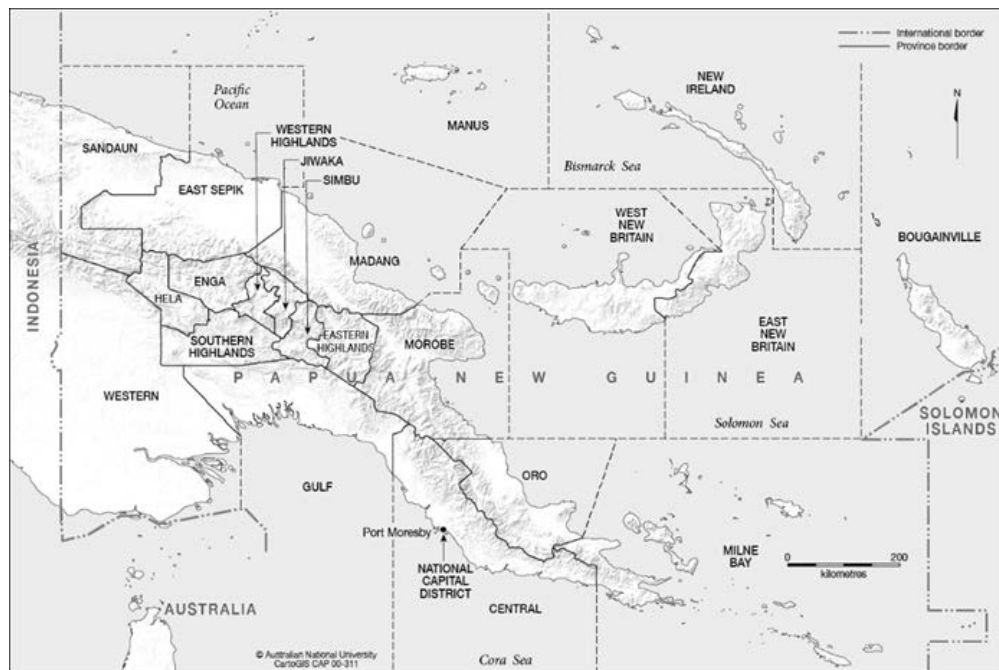


Figure 2.1 Papua New Guinea and its provinces

Source:http://asiapacific.anu.edu.au/maponline/system/files_force/maps/bitmap/elevation/2016/09/00-311_PNG_provinces_2016.png?download=1 Accessed 2 November 2018

2.3 Christianity in Papua New Guinea

While most (98%) of the population identify as Christian, many combine this introduced faith with traditional Indigenous spirituality (Street, 2010; United States Department of State, 2017). The four main groupings of religious entities in PNG are: (i) mainline denominations of Anglican, Catholic, Lutheran and United churches; (ii) the Evangelical Alliance of Apostolic, Baptist Nazarene and Salvation Army churches; (iii) the

Pentecostal churches including Assemblies of God, Christian Revival Crusade and the Four Square Gospel Mission; and (iv) the Seventh-day Adventist (SDA) Church (Anderson, 2015; Asian Development Bank, 2015). Faith-based organisations play a significant role in providing basic social services and leadership in communities, particularly in rural and remote areas (Hauck, 2010; Shih, Worth, Travaglia, & Kelly-Hanku, 2017). These organisations deliver services through various systems, including divisional offices, affiliated international agencies or in partnership with non-government organisations (Asian Development Bank, 2015). Thus, faith-based organisations wield considerable material and spiritual authority in nation building and in the daily lives of PNG citizens (Anderson, 2015). An example of this authority is that the defeat of the incumbent government in the 1997 PNG general election was attributed to the power of prayer during a national prayer rally against corruption (Douglas, 2000). The SDA Church is considered to have the greatest political influence of all religious denominations in PNG, because a disproportionate number of politicians identify as its members (Hauck, 2010). The Preamble to the Constitution of 1975 is evidence of the interconnected relationship between traditional beliefs and introduced Christian religion in PNG. The Preamble states:

We, the people of Papua New Guinea... acknowledge the worthy customs and traditional wisdoms of our people – which have come down to us from generation to generation [and] pledge ourselves to guard and pass on to those who come after us our noble traditions and the Christian principles that are ours now. (Government of Papua New Guinea, 2017, p. 1)

2.4 Health care in Papua New Guinea

The PNG government has determined to provide citizens with universal health coverage (General Assembly of the United Nations, 2017). The total expenditure on health per capita in PNG in 2014 was USD\$92, compared with Australia at USD\$6,031 (WHO, 2014b). The PNG National Department of Health Sector Performance Annual Report (SPAR) is a monitoring tool that annually measures progress of the PNG health sector and compares trends over a five-year period (National Department of Health Papua New Guinea, 2017). The 2016 SPAR indicated an overall decline in health system performance compared with that in previous years, and a decrease in the health budget allocation per capita from PGK227 in 2011 to PGK183 in 2014 (National Department of Health Papua New Guinea, 2017). Of particular note, the report indicated the rate of supervised births and antenatal care coverage continued a downward trend (National Department of Health Papua New Guinea, 2017).

Health care in PNG is delivered through a hierarchical system of services, from the village rural aid post, to the largest and best-resourced national referral hospital (Andrew et al., 2014; WHO, 2016b). Fundamental to health care provision in PNG are facilities operated by the faith-based organisations, which comprise approximately 45% (50% in rural areas) of health care services (Andrew et al., 2014; WHO, 2016b). Other health care providers throughout PNG include non-government and community organisations and commercial entities, such as factories, mines and plantations (WHO, 2012, 2016b). Village health volunteers or *Marasin Meri/Men* (medicine women/men) provide health education and basic medical care in areas without formal health care services (WHO, 2012).

2.5 Maternal health care and stillbirth in Papua New Guinea

PNG has one of the lowest reporting rates of registered births in the Pacific (United Nations Children’s Fund [UNICEF], 2013). Few births occur at health facilities, with only 43% of births attended by a skilled health professional: The Western Pacific regional rate is 93% (WHO, 2015b). In 2015, the reported rate of midwifery personnel in PNG was 1:10000, the lowest density of midwives to population in the Pacific (Homer, Turkmani, & Rumsey, 2017). Among Pacific countries, PNG has the fourth highest rate of stillbirth, estimated at 15.9 per 1000 births (Blencowe et al., 2016; Figure 2.2). Higher stillbirth rates have been reported, with Port Moresby General Hospital registering 16.6 stillbirths per 1000 births and ANGAU Memorial Hospital, Lae, registering 28.5 stillbirths per 1000 births (Amoa, 2017; Dumo, 2017).

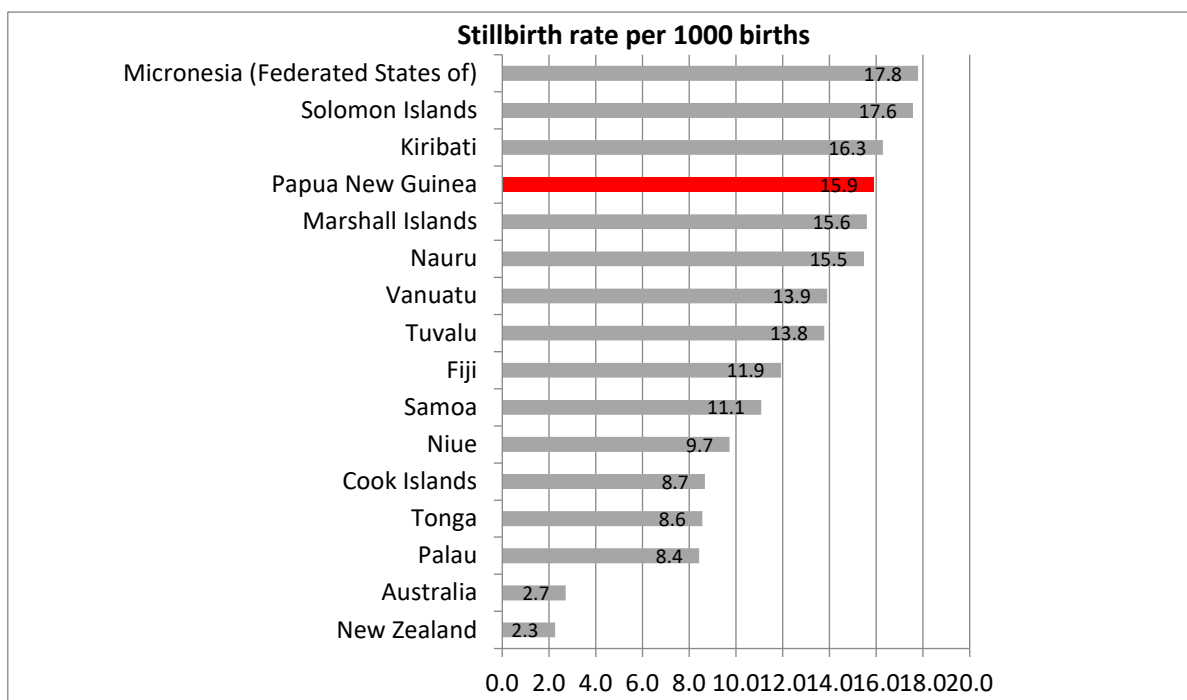


Figure 2.2 Estimated stillbirth rates for Pacific countries 2015

Source: <http://datacompass.lshtm.ac.uk/115/>. Accessed 2 November 2018

Women and their families in PNG recognise that receiving antenatal care and having a supervised birth at a health facility is important for the health of both mother and baby (Andrew et al., 2014; Larsen, Lupiwa, Kave, Gillieatt, & Alpers, 2004; L. M. Vallely et al., 2013). However, the decision to seek care is influenced by interconnected financial, cultural and systemic factors, particularly for women living in remote and geographically isolated areas. The cost of transport to facilities, social obligations, cultural beliefs and practices and the demeaning attitudes of health care workers towards expectant mothers are barriers to accessing services (Andrew et al., 2014; Larsen et al., 2004; L. M. Vallely et al., 2013).

2.6 The development of midwifery in Papua New Guinea

Western medicine arrived in PNG in the late 1800s when European missionaries, traders and government administrators brought health workers to care for the health needs of the expatriate community and the PNG workers they employed (Frankel & Lewis, 1989; Voigt, 2001). Demand for Western-style health care grew as missions and government offices were established, creating a need for trained health workers (Voigt, 2001). Colonial governments gradually accepted responsibility for the health of the PNG population but recognised the substantial human and economic costs of providing services to dispersed communities (Frankel & Lewis, 1989). Colonial administrators decided to train village men to act as ‘native medical and hygiene assistants’ to government medical officers and to provide simple medical treatments in their communities (Frankel & Lewis, 1989, p. 7). Health care services were generally operated by, and catered to, men, with the care of women and children largely undertaken by missions (Frankel & Lewis, 1989). It was not until 1920 that the first nurse training school opened at the Salamo Hospital in Milne Bay province, teaching basic nursing skills (Voigt, 2001). As medical knowledge and techniques developed,

so too did nursing and midwifery education. In 1952, the first nurses graduated with the Maternal, Child Health and Midwifery certificate, a three-year course (Voigt, 2001). Initiatives for maternal health nursing continued during the 1960s and included midwifery subjects in the Territorial Nurse (T-nurse) programme at the Port Moresby Nursing School, and from 1961–1979, a post-basic certificate course in Midwifery in Rabaul (Voigt, 2001; WHO, 2013b).

In 1995, the first midwifery post-basic programme educated registered nurses to work in obstetrics and gynaecology units and antenatal and family planning clinics in urban and rural health care services. In their midwifery role, the nurses aimed to improve maternal health by educating communities and following standard protocols (Kamblijambi & Holroyd, 2017). Similar to midwifery training programmes in other countries, registered nurses undertook apprentice-style training in hospitals to gain specialist midwifery education. In the late 1990s, midwifery education was transferred to the tertiary sector, specifically the University of Papua New Guinea, resulting in decreased numbers of new midwives (Pacific Adventist University, 2014). By 2005, other tertiary institutions were providing combined majors in midwifery and child health but only the Lutheran School of Nursing conducted a midwifery programme (WHO, 2013b). At the time of writing, five PNG institutions provide registered nurses from PNG and other Pacific nations with midwifery qualifications through an accredited, 12-month Bachelor of Midwifery degree. These are St Mary's School of Nursing at Divine Word University, Vunapope; Lutheran School of Nursing, Madang; Pacific Adventist University (PAU), Port Moresby; University of Goroka, Goroka; and University of Papua New Guinea, Port Moresby (Australia Awards Pacific Scholarships Papua New Guinea: Bachelor of Midwifery, 2015).

The PNG Nursing Specialist Competency Standards (Midwifery), the Code of Ethics and the Code of Professional Conduct guide midwifery practice in PNG (Papua New Guinea Nursing Council, 2003–2014). The PNG Midwifery Society is the professional organisation that represents midwives from across the country and a member of the International Confederation of Midwives (ICM). This Society is in an ICM twinning partnership with the Australian College of Midwives whereby midwifery knowledge and resources are shared (Lockey, 2011).

2.7 Strengthening midwifery capacity in Papua New Guinea

At the time of writing, the Australian and PNG governments made major investments to fund programmes aimed at strengthening the capacity of maternal health services to increase the number of births supervised by skilled professionals, specifically the specialised training of local registered nurses to become midwives. The PNG National Health Plan 2011–2020 identified poor maternal health as the nation’s most significant health issue (Government of Papua New Guinea, 2010). The PNG government has since taken significant action to increase the number of qualified midwives and build midwifery education capacity to help address the high rates of maternal and infant mortality (West, Dawson, & Homer, 2017).

The Maternal and Child Health Initiative (MCHI) was developed by the PNG National Department of Health in 2011, with advice from the WHO (PNG) and support from the World Health Organization Collaborating Centre for Nursing, Midwifery and Health Development, University of Technology Sydney (Dawson et al., 2016). The MCHI, funded

by the Australian government's AusAid⁷ programme, aimed to improve the quality of midwifery education and strengthen the capacity of midwives to provide essential maternal and newborn health care (Dawson et al., 2016). As part of the initiative, international clinical midwifery facilitators were situated at four PNG training institutions to supervise and mentor midwifery educators and students and assist in midwifery clinical teaching and practice. AusAid funding provided textbooks and teaching resources to each institution, while also providing PNG midwifery scholarships, including a 12-month stipend to cover living expenses for the duration of the midwifery course (Dawson et al., 2016). Although the MCHI concluded in 2015, there are calls for the Australian government to reconsider the decision to end the programme and for continued collaboration with PNG midwives to improve their capacity to deliver effective maternal and child health services (J. Bailey, 2016, October 17; Neill, Homer, Rumsey, Kililo, & WHO Collaborating Centre for Nursing Midwifery and Health Development University of Technology Sydney, 2016). However, levels of future funding from the Australian government are uncertain, with the trend of decreased official development assistance to PNG over the past five years (Davies, 2017, May 16; WHO, 2016b).

2.8 Location of the study

Pacific Adventist University (PAU) is a small, faith-based university owned and operated by the South Pacific Division of the Seventh-day Adventist Church. The Koiari campus, named in honour of the traditional landowners, the Koiari people, is located approximately 22 kilometres from the capital of PNG, Port Moresby. The campus has

⁷ Until 2013, the autonomous Australian Agency for International Development delivering Australia's aid programme. It has since been integrated into the Department of Foreign Affairs and Trade.

pleasant landscaped gardens surrounding water-lily lakes, and the internationally acclaimed bird sanctuary attracts local and overseas visitors.

PAU offers a range of certificate and diploma courses, bachelor and master degrees and postgraduate diplomas in disciplines including arts and humanities, business, education, health science, science and theology. While most students at PAU are from PNG, others are from many Pacific Island countries and territories. Teaching staff are from PNG, other Pacific nations and territories, Asia, Australia, New Zealand and the Americas. The majority of staff and students live and work on the campus, which promotes a culture of community through shared participation in religious, social and cultural activities. In contrast to other areas of Port Moresby, residents and visitors are able to move safely around the campus owing to gated access, a 3 m high electrified fence and 24-hour security patrols.

Service is a multifaceted concept at PAU, as evidenced in its mission statement to ‘prepare graduates who are equipped and willing to serve their Community, their Country, their Church and their God’ (Pacific Adventist University, n.d.). Christian beliefs and ethics underpin the educational philosophy of PAU, and all staff and students identify as having a strong Christian faith. Its Code of Conduct outlines regulations, standards and expected behaviours for staff and students, including regular attendance at religious services and spiritual enrichment programmes. Prohibitions include smoking tobacco or other drugs, alcohol consumption, chewing of betel nut and explicit violation of literalist biblical teachings regarding sexual mores, such as sexual intimacy before marriage (Pacific Adventist University, 2012). Staff or students found to engage in these activities may have disciplinary action brought against them or be dismissed from PAU.

In recent years, PAU committed to strengthening its research capacity. Following the establishment of the Office of Research and Postgraduate Studies in 2007, PAU entered into collaborative partnerships with other national and international research institutions, including JCU. The success of numerous research projects between the two universities resulted in a Memorandum of Understanding formalising the links between the two universities in 2015 (Gray et al., 2014; MacLaren et al., 2013; Redman-MacLaren, Mills, & Tommbe, 2014; Redman-MacLaren et al., 2017; Redman-MacLaren, Api, et al., 2014; Redman-MacLaren & Mills, 2015; Redman-MacLaren, 2015a; Tommbe et al., 2013; A. J. Vallely et al., 2017).

2.9 The Pacific Adventist University Bachelor of Midwifery programme

PAU is one of the five PNG institutions that offers a midwifery degree that educates registered nurses to become midwives and to deliver professional midwifery care at all levels of the health care system, in both urban and rural settings. PAU received AUD\$2.8 million from the Australian government to upgrade its midwifery school facilities, including new classrooms and computer labs that were opened in 2014 (Bishop, 2014, May 18). The PAU midwifery programme aims to ‘produce graduates who will contribute to the reduction of maternal and perinatal mortality and morbidity through the provision of safe, timely, evidence based care’ (Pacific Adventist University, 2014, p. 6). Clinical and theoretical components of the course are designed to meet the competency standards of the PNG Nursing Council. The PAU Bachelor of Midwifery curriculum document indicates that while the Christian principles of the PAU form the basis of the programme’s ethical framework, the ICM *International Definition of the Midwife* (2017) defines the scope of midwifery practice used in the curriculum (Figure 2.3).

International Definition of the Midwife scope of practice

The midwife is recognised as a responsible and accountable professional who works in partnership with women to give the necessary support, care and advice during pregnancy, labour and the postpartum period, to conduct births on the midwife's own responsibility and to provide care for the newborn and the infant. This care includes preventative measures, the promotion of normal birth, the detection of complications in mother and child, the accessing of medical care or other appropriate assistance and the carrying out of emergency measures.

The midwife has an important task in health counselling and education, not only for the woman, but also within the family and the community. This work should involve antenatal education and preparation for parenthood and may extend to women's health, sexual or reproductive health and child care.

A midwife may practise in any setting including the home, community, hospitals, clinics or health units.

Figure 2.3 International Confederation of Midwives midwifery scope of practice

The PAU Bachelor of Midwifery curriculum document includes a conceptual framework that acknowledges the relationship between midwife and woman, and describes the factors that may influence this relationship (Figure 2.4).

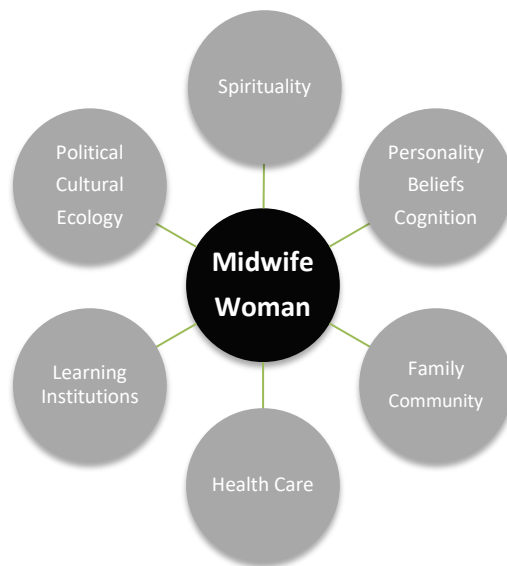


Figure 2.4 Conceptual framework reflecting midwife/woman relationship

(Pacific Adventist University, 2014, p. 12)

PAU midwifery students undertake nine subjects in a prescribed order over the 12-month programme. The subjects taught in semester one are: (i) Foundations of Midwifery Practice; (ii) Midwifery Practice; (iii) Emergency Obstetric Care (EmOC) 1; (iv) Socio-cultural influences on Maternal Health in PNG; and (v) Principles of Christian Ethics. Semester two subjects are: (i) The Neonate; (ii) Midwifery Practice 2; (iii) Public Health and Reproduction; and (iv) Planning and Implementing for Health. Clinical placements occur in a variety of venues related to midwifery across central, highland and coastal provinces. Students are graded on clinical skills and 20 clinical competencies during the 32 weeks of clinical practicum, including a checklist of essential skills based on the PNG competency standards for midwives. Students are expected to achieve midwifery competency, evidenced by the completion of clinical skill competency assessments, midwifery experience and completed clinical goals recorded in the student's clinical logbook during clinical learning activities and placements.

2.10 Summary

In this chapter, I have:

- provided a brief introduction to PNG
- described how Christianity influences PNG social and political life
- discussed the PNG health system, maternal health care and stillbirth in PNG
- discussed the state of midwifery in PNG
- described the location of the study
- introduced the PAU midwifery programme and requirements.

In the following chapter, I will:

- describe the methodological decision-making process for the research
- detail a metasynthesis of qualitative research literature undertaken to identify sensitising concepts
- describe the connection between philosophy and research and the philosophical standpoint informing this research
- explore qualitative approaches and discuss the selection of grounded theory methodology.

Chapter 3: A Methodological Journey

3.1 Chapter outline

Accounts of the decision-making processes undertaken in the formative stages of a project are missing from many published research studies. Morse introduced the concept of ‘the armchair walkthrough’ (1999, p. 435) as a technique of critically contemplating each step of a research project. Using this concept, in this chapter and the next chapter I provide a reflective walk through the methodological decision-making journey I undertook as an emerging researcher. This chapter has three sections. I provide a summary of how I synthesised qualitative literature relating to women’s experiences of stillbirth to become familiar with the broader topic and identify aspects for possible consideration in the research process. I describe the philosophy/research connect, the importance of research paradigms and the way in which I came to a personal philosophical standpoint that informed my research design. I describe my exploration of qualitative methodologies that led to my selection of grounded theory as the overarching methodology for the study. Together, these methodological tasks helped me to arrive at a research design that was most appropriate to answer my research question and therefore achieve the aims of my study.

3.2 Exploring experiences of stillbirth

As I prepared to embark on my PhD journey, I strengthened my academic writing skills and engagement with the literature regarding stillbirth by undertaking a metasynthesis of qualitative research literature to explore Asia-Pacific women’s experiences of stillbirth. Additional to my own experience of stillbirth, this would allow me to develop sensitising

concepts in the broader research topic for inclusion in the analytic process (Ramalho, Adams, Huggard, & Hoare, 2015). A mentor suggested metaethnography as a method to produce new understanding of previously translated research (Noblit & Hare, 1988). Metaethnography synthesises and transcends the findings from individual studies, yet retains each study's distinctiveness by mapping key themes or concepts and translating these into one another for novel interpretation of original findings (Noblit & Hare, 1988). The metasynthesis I conducted, 'Asia-Pacific women's experiences of stillbirth: A metasynthesis of qualitative literature' was published in the journal, *Health Care for Women International* (Cheer, 2016) (Appendix A).

Undertaking the metasynthesis, I explored the question, 'What are Asia-Pacific women's experiences of stillbirth?' I conducted a systematic database search employing combinations of relevant keywords, selecting seven papers from six empirical studies for analysis. These studies met three selection criteria: They were located in the Asia-Pacific region, related to women's experiences of stillbirth and qualitative in approach. While the question posed for the metasynthesis included studies from the Pacific, few papers located from this region met the selection criteria; hence, only studies from Asia were included. Using a modified Critical Appraisal Skills Programme (CASP) Qualitative Research Checklist (Campbell et al., 2011), I assessed each paper for quality. I then used reciprocal translation, coding from the voices of the women participants, with comparison and interpretation to develop themes. Finally, I presented a model of the construct.

The metasynthesis revealed that stillbirth resulted in complex and interconnected experiences for the women, influenced by cultural and systemic factors. Four experiential themes emerged from the translation process: 'Acts of Accusation', 'Rocky Relationships',

‘Entangled Emotions’ and ‘Routines of Reconciliation’. Two systemic factors, ‘Contexts of Culture’ and ‘Health Care Matters’ influenced these themes. The sociocultural experiences of women and their interaction with health care systems shaped how they managed and reconciled their loss. Social and cultural expectations and women’s engagement with health care services and staff were a major determinant in how women experienced stillbirth, and formed a contextual frame around the developed themes. Women experiencing stillbirth were identified as different from those delivering a live baby—they were m/others, women without a baby at the end of their pregnancy and thus, subject to differential treatment by others within their life environments, which further aggravated relationship issues with partners, family and the community. Undertaking the metasynthesis gave me a better understanding of my stillbirth experience and those of other women and provided a solid foundation for my future research. Yet, I had more to contemplate before I could launch myself into my project.

3.3 Philosophy and research paradigms

My advisors reminded me throughout the process that undertaking a PhD was akin to being an apprentice learning the craft of research. One part of this apprenticeship required that I contemplate my own view of the world and my place within it—in other words, to consider the philosophical aspect of undertaking a Doctor of Philosophy degree. The following sections, comprising the second section of this chapter, describe how I arrived at my own personal philosophy that subsequently influenced the research design and practice.

Birks and Mills (2015) suggested one objective of a doctoral programme is to inculcate in students the knowledge of various philosophical schools and their related methodologies. Prior to my PhD journey, I had never given much thought to philosophical

assumptions: If asked what they were, I would not have been able to provide a reasoned answer. I faced a steep learning curve!

Philosophy derives from the Greek *philos* (loving) and *sophia* (wisdom) and at its most fundamental is the study of the nature of knowledge (Trusted, 1997). Birks provides a contemporary definition of philosophy as ‘a view of the world encompassing the questions and mechanisms for finding answers that inform that view’ (2014, p. 18). British philosopher Bertrand Russell posited that philosophy emerges from ‘an unusually obstinate attempt to arrive at real knowledge’ (1970, p. 1). Arrival at knowledge occurs through research attempts; thus, philosophy and research are inextricably linked (Birks, 2014).

Researchers come to a study (consciously or not) with a particular worldview that comprises their beliefs and assumptions about the nature of reality, the definition of self and the relationships that occur within the world (Guba & Lincoln, 1994). Known as research paradigms, these ways of thinking about the world act as a guide to inform the design and conduct of a research project (Creswell, 2014; Wahyuni, 2012). Explication of the underlying philosophical assumptions supports a strong research design and valid and convincing outcomes of research (Crotty, 1998).

Research paradigms consist of four philosophical elements: axiology, ontology, epistemology and methodology (Creswell, 2013). Axiology is concerned with the nature of ethics and relates to the values the researcher brings to the study that guide the pursuit of knowledge (Creswell, 2013; Wilson, 2008). Ontology is the study of being and describes how the researcher perceives reality and the nature of human engagement in the world (Crotty, 1998; Scotland, 2012). Epistemology studies the ways knowledge about reality is created,

understood and utilised (Wahyuni, 2012). Epistemological assumptions question the justification for knowledge claims, and explore the relationship between the researcher and that being researched (Creswell, 2013; Petty, Thomson, & Stew, 2012). Different research paradigms typically hold divergent ontological and epistemological views with varying assumptions of reality and knowledge that form the basis of their specific research approach, reflected in their methodology and methods (Scotland, 2012). Methodology is the strategy or action plan that informs the choice and use of particular methods within the context of a particular research paradigm (Crotty, 1998; Wahyuni, 2012), and it asks the question: ‘How do I find out more about this reality?’ (Wilson, 2008, p. 34). As I read the literature, the pieces of the philosophical puzzle slowly began to make sense to me.

3.4 Coming to a philosophical standpoint

Researchers’ differing philosophical positions can lead to diverse views and approaches to the same phenomena (Grix, 2010). It was clear that as part of the research process, I needed to identify my own philosophical stance to ensure a strong research design. I explored a variety of research paradigms and perspectives, each providing a lens through which to view the world and the way things work within that world. These included: (a) positivism: reality is apprehendable and absolute; (b) postpositivism: reality is imperfectly apprehendable and tentative; (c) postmodernism: reality is subjective and socially constructed; (d) critical theory: reality is shaped by relationships of power that are social and historically situated; and (e) constructivism: multiple realities exist, constructed through lived experiences and social interaction (Birks, 2014; Kincheloe, McLaren, & Steinberg, 2011; Lincoln, Lynham, & Guba, 2011).

3.4.1 Critical realism

Now able to put together the pieces of the philosophical puzzle, I recognised that a critical realist perspective would inform my study. Critical realism integrates ontological realism—the existence of a real world external to human cognition and action, with epistemological constructivism—all understandings about this real world are socially constructed (Danermark, Ekström, Jakobsen, & Karlsson, 2001). Claims of reality cannot be certain, because, as Maxwell explains, ‘[A]ll theories about the world are seen as grounded in a particular perspective and worldview, and all knowledge is partial, incomplete, and fallible’ (2012, p. 5).

Critical realism emerged in the post-positivist era of the 1970s, representing an alliance of researchers with differing theoretical perspectives, who sought to develop a meta-theoretical position, ‘providing a philosophically informed account of science and social science which can in turn inform our empirical investigations’ (Archer et al., 2016, 23 December). Critical realism scholarship is associated with philosopher Roy Bhaskar (1978, 1989). Bhaskar viewed reality as complex and comprising three layers: the real, actual and empirical. The real refers to whatever exists: natural or social objects, structures or ‘mechanisms’ that have both causal power to affect change and causal liability to undergo change. This layer of reality is intransitive: Things are as they are, independent of our perceptions, beliefs and asserted knowledge. The actual layer refers to events generated by mechanisms, whether or not they are experienced or interpreted. The empirical layer refers to theory and experience or observation of events, understood through human interpretation. This layer of reality is transitive: Our perceptions, beliefs and asserted knowledge are fallible and subject to change (Bhaskar, 1978; Fletcher, 2017; Potter & Lopez, 2001; Sayer, 1999).

Critical realism is epistemologically cautious with respect to scientific knowledge (Potter & Lopez, 2001). Critical realists accept the cultural and historical positioning of knowledge and posit that our understanding of the world is mediated through discourse (Oliver, 2012; Potter & Lopez, 2001; Sayer, 1999). Therefore, one true or valid interpretation is non-existent: There are only interpretations that are useful in some way (Creswell, 2013; Crotty, 1998). The practical usefulness of socially constructed knowledge varies because of the differentiated, layered and structured nature of reality (Danermark et al., 2001; Hockey, 2010). Scholars often use the terms constructivism and constructionism interchangeably, but there is an important distinction between the two: Constructivism emphasises each individual's experience of meaning making, whereas social constructionism investigates the ways individuals and groups, influenced by language and other social processes, collectively perceive reality (Cheung-Judge & Holbeche, 2015; Crotty, 1998). Social constructionists recognise cultural reality can deliver both liberty and limitations of rights and actions (Crotty, 1998). They also view constructed reality as dynamic, changeable by introducing alternative dialogues and narratives into the system (Cheung-Judge & Holbeche, 2015). Social constructionists make one or more of these assumptions:

- A critical stance towards taken-for-granted knowledge
- Historical and cultural specificity
- Knowledge is sustained by social processes
- Knowledge and social action go together

(Burr, 2015, pp. 2–5).

Researchers working from the critical realist perspective operate across the intransitive and transitive dimensions to better understand the world and create knowledge for

positive change (Redman-MacLaren & Mills, 2015). Critical realism does not preclude any methodology, yet asserts selection should be appropriate to the research question and the level of knowledge that already exists about the topic (Krauss, 2005; Sayer, 1999). Reflecting on my personal worldview and considering the social focus of my research topic, I decided a qualitative approach was most appropriate to investigate my area of study. The following sections, comprising the third part of this chapter, describe the characteristics I believe make qualitative research most appropriate for this study. I outline my investigation of various qualitative approaches and my rationale for choosing constructivist grounded theory.

3.5 Qualitative research

Qualitative research aims to learn the what, why and how of human behaviour, thought and meaning making (Ambert, Adler, Adler, & Detzner, 1995; Kuper, Reeves, & Levinson, 2008). Creswell asserted that qualitative research is ‘an inquiry process of understanding based on a distinct methodological approach to inquiry that explores a social or human problem’ (2013, p. 300). It is the focus on understanding the processes that lead to outcomes, rather than the outcomes alone, which is a strength of the qualitative research approach (Maxwell, 2013). Being exploratory in nature, qualitative research is particularly suitable for investigating research topics where little knowledge exists (Creswell, 2014). Qualitative research allows the researcher to obtain rich description of a phenomenon from the viewpoint of the people who experience it (Mills & Birks, 2014). Using a qualitative approach, the researcher can gain insight into the contextual and structural elements of participants’ lives, as well as the ‘bits of reality’—peoples’ thoughts, feelings, intentions and actions—to provide a holistic account of a phenomenon (Charmaz, 2014; Holliday, 2016, p. 6). The researcher becomes the key instrument for collecting, analysing and interpreting data,

to develop a multifaceted representation of the research topic from the perspective of participants (Creswell, 2013).

Unlike quantitative research, qualitative research has inbuilt flexibility that allows researchers to modify their design and focus, in response to events as they occur in the research setting (Maxwell, 2013; Jane Ritchie & Lewis, 2003). A flexible research design is particularly important when exploring sensitive areas of research, enabling the researcher to be responsive to the individual's particular circumstances as they bring to light feelings that may distress, or personal information that has not previously been shared with others (Liamputtong, 2013; Jane Ritchie & Lewis, 2003).

Research is typically a continuous, and often intensive, relationship between the researcher and participants, requiring an 'investment of the self' by the researcher (Birks, 2014, p. 26; Creswell, 2014). This deep engagement in the research process may potentially shape the interpretation of data. However, qualitative research includes the element of reflexivity, where researchers can identify the beliefs, values, bias and personal experiences that influence their interpretation throughout the study (Creswell, 2013; Maxwell, 2012). Qualitative research reports may take different formats, yet all provide 'for the voices of participants, a reflexivity of the researchers, a complex description and interpretation of the problem, and a study that adds to the literature or provides a call for action' (Creswell, 2013, p. 44).

3.6 Qualitative methodologies

The research question guides the selection of methodology (Birks & Mills, 2015). After choosing to use qualitative inquiry for my study, I needed to investigate qualitative methodologies. Wahyuni defines methodology as ‘the theoretical and ideological foundation of a method’ (2012, p. 72). Researchers often overlook this important foundation, which limits our understanding of the research findings (Cheek, Onslow, & Cream, 2009). P. L. Rice and Ezzy (1999) propose three questions to guide the choice of methodology and methods:

What is the theoretical framework underpinning the study?

What is the substantive area of research?

What are the desired outcomes of the research?

As described above, a critical realism framework informs this study. P. L. Rice and Ezzy note that the ‘Theoretical framework fundamentally shapes the sorts of things that the research focuses on and, therefore, also fundamentally shapes the method and techniques required for the research’ (1999, p. 11). The substantive area of my research is how a cohort of midwifery students at a university in PNG understand, experience and manage the provision of care to women following stillbirth. The desired outcomes are to theorise how the midwifery students experienced the provision of care to women following stillbirth and identify the implications for midwifery education and maternal health care provision in PNG, to provide evidence to inform the programme and public health research.

Creswell (2013) lists five approaches to qualitative inquiry: narrative research, case study research, ethnography, phenomenology and grounded theory. There are commonalities between the approaches: the general process of data gathering, analysis and reporting, as well as utilisation of similar data collection methods of observation, interviewing, text, audiovisual and images (Creswell, 2013). The differences lay in the contrasting characteristics each approach offers to meet the focus of the research, the ways of thinking about the data and the manipulation of methods to achieve research goals (Creswell, 2013; Richards & Morse, 2013). With the research aim and objectives of my study in mind, I explored each approach to identify the one most suitable to my research needs.

3.6.1 Narrative research

Storytelling is ‘a portal through which a person enters the world and by which their experience of the world is interpreted and made personally meaningful’ (Clandinin & Rosiek, 2007, p. 38). Using a narrative approach, the researcher invites an individual to tell their story of the experience under study, and then re-stories the account to present an in-depth understanding of that experience (Haydon, Browne, & van der Riet, 2018). A narrative researcher asks questions aimed to help interpret and understand the participant’s world, not to provide an explanation of that world (Wang & Geale, 2015). Narrative research acknowledges the dynamic nature of human experiences (Wang & Geale, 2015, p. 196). It not only focuses on the experience of the individual but also seeks to understand the cultural, social and institutional influences that link the narrative to a specific context (Clandinin & Rosiek, 2007; Wang, 2017). The relational elements of narrative research (temporal, social and spatial) include the collaborative researcher–participant relationship (Haydon et al., 2018). Together, the researcher and the participant negotiate the meaning applied to the

stories to clearly comprehend and re-present the experience in the context of the individual's life (Creswell, 2013).

3.6.2 Case study research

Case study research shares many similarities with narrative research but differs in that its focus is on issues, not individuals and their story, and in the methods of analysis (Creswell, Hanson, Plano Clark, & Morales, 2007). Yin defined a case study as an '[investigation of] a contemporary phenomenon within its real-world context, especially when the boundaries between phenomena and context are not clearly evident' (2014, p. 2). Case study research is most suitable for answering questions about how and why a contemporary phenomenon occurs, providing an in-depth perspective of the phenomenon from the viewpoint of participants (Harrison, Birks, Franklin, & Mills, 2017; Hentz, 2016). The researcher situates each case, or multiple cases, within specific boundaries, such as conditions of time and place, activity, definition and context, to define the scope of the research (Baxter & Jack, 2008; Creswell, 2013). The case to be analysed can range from an individual to an organisation, simple to complex processes, interventions, programmes or relationships, enabling researchers to deconstruct and then reconstruct the phenomenon under study (Baxter & Jack, 2008). Unlike other methodologies, case study research does not align to a particular philosophical position, providing researchers the flexibility to customise the research design to meet specific research requirements (Casey & Houghton, 2010). Case studies may be explanatory, exploratory or descriptive, with the final interpretation often including the researcher's conclusions of the lessons learned from investigating the case (Creswell, 2013; Yin, 2014).

3.6.3 Ethnography

Ethnography describes the ‘cultural ways of human life’ (Liamputtong, 2013, p. 7). An ethnographic approach involves the study of culture-sharing or social group, to understand and interpret shared behaviour, values, beliefs and language (Creswell, 2013). Ethnographic research requires the researcher be immersed in the daily lives of the participants for an extended period, to gain an insider’s view on social interaction within the group and the meaning people attribute to their experiences (Liamputtong, 2013). This ongoing interaction provides the data to identify cultural patterns and themes from which the researcher can create a complex, holistic account of the activities and practices of the cultural group (Creswell, 2013; Liamputtong, 2013).

3.6.4 Phenomenology

A phenomenological approach focuses on the lived experiences of a phenomenon, as a concept or idea, by one or more individuals (Creswell, 2013). Phenomenological research aims to describe and reduce numerous individual experiences to a ‘composite description of the essence of the experience’ for participants (Creswell, 2013, p. 76). With the phenomenon as the central concern, researchers attempt to understand the ‘object’ of the experience by studying the meaning ascribed to the phenomenon by the individual (Wilding & Whiteford, 2005). There are two main phenomenological approaches. In descriptive phenomenology, the researcher sets aside, or brackets, any preconceptions or biases, and ignores existing knowledge of the phenomenon to provide a ‘pure’ description of participant experiences (Matua & Van Der Wal, 2015; Wilding & Whiteford, 2005). In interpretive phenomenology, researchers focus on gaining an in-depth understanding of a phenomenon, illuminating the

'hidden' meanings and structural conditions relating to the phenomenon, as experienced in the context of the participants' lifeworlds (Creswell, 2013; Matua & Van Der Wal, 2015).

Each of the above methodologies would enable me to address the first aim of the study: to explore the topic of stillbirth with midwifery students; gain an understanding of the phenomenon from their perspective; and an opportunity to provide my interpretative description of the import of stillbirth for the students as they provided care to women experiencing stillbirth. However, I required a methodology that would also allow me to construct a theoretical model to explain the processes used by the students to manage care in the context of their practice, and subsequently identify the implications for the university midwifery programme and inform practical actions. Grounded theory was the methodology I selected as the most appropriate to address all three study aims (Figure 3.1). The intent of grounded theory is to go beyond descriptions to generate a theory explaining the underlying social process or action related to a phenomenon, presented as new knowledge that may be used by practitioners to inform action (Birks & Mills, 2015; Creswell, 2013).

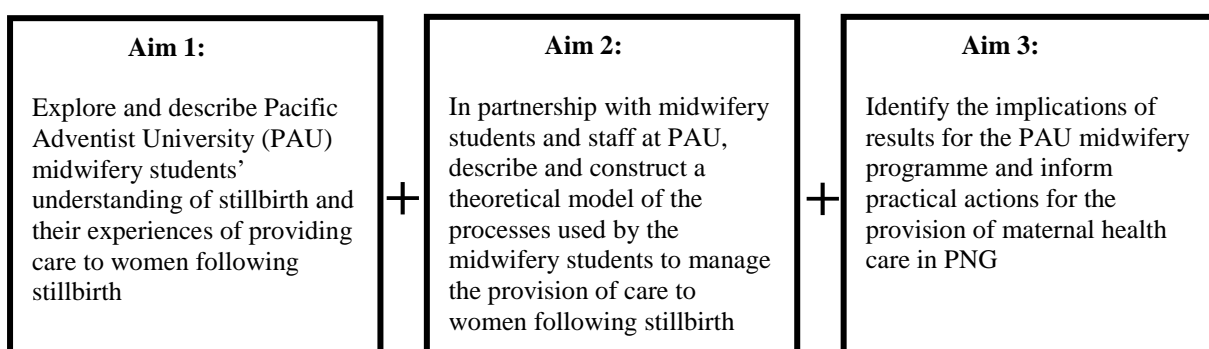


Figure 3.1 The three study aims

3.7 Grounded theory

Barney Glaser and Anselm Strauss introduced grounded theory methodology in 1967 as a response to the positivist nature of social research of the era, combining the strengths of both quantitative and qualitative inquiry (Walker & Myrick, 2006). Grounded theory involves a nonlinear, iterative process of data collection and analysis through coding and categorisation, memo writing, constant comparative analysis and the integrating relevant literature to generate theory (Birks & Mills, 2015; Charmaz, 2012). I found grounded theory attractive because it provides a systematic set of steps for assisting researchers to capture sociocultural contexts in the explanation of a phenomenon, particularly in areas with little existing knowledge (Bainbridge, Whiteside, & McCalman, 2013; Bryant & Charmaz, 2010; Strauss, 1987). Grounded theory enables the researcher to answer research questions about human relationships, including social and psychosocial processes, systematically and inductively (Redman-MacLaren & Mills, 2015).

I had identified grounded theory as the most appropriate method for meeting my research aims. However, as an emerging researcher, I had no experience of how to go about 'doing' grounded theory. How should I proceed? I needed to learn more about how researchers utilised grounded theory in their qualitative studies. Budget restraints meant I was not able to travel to attend training outside my local area, but I attended workshops and seminars run by expert grounded theorists at my university and participated in grounded theory webinars. To expand my knowledge of grounded theory and my reporting skills, I undertook a systematic literature search to investigate the use of grounded theory in empirical research studies. The following is a summary of the study, as published in the journal *Contemporary Nurse* (Cheer, MacLaren, & Tsey, 2016) and set out in Section 3.8. The study

describes the common grounded theory characteristics and research design quality in qualitative, grounded theory studies of nurses and midwives' coping processes.

Undertaking the systematic literature search, I explored the question: 'How have the authors utilised grounded theory methods to study how nurses or midwives cope with work-related experiences?' The question consisted of two parts: (a) 'How have grounded theory characteristics been applied in the studies?' (b) 'What is the qualitative design quality of the studies?' I conducted a systematic database search using a combination of relevant keywords and database-specific subject headings. I initially evaluated the retrieved papers by reviewing the title and abstract. Citation searching of the selected articles extended database searching. Inclusion and exclusion criteria were established and applied to retrieved studies. Papers in which a grounded theory approach was used, study participants were nurses or midwives and nurses or midwives' coping strategies were examined, and were published within a set timeframe in peer-reviewed journals and available in English were included. Excluded were papers focusing on health care workers other than nurses or midwives. I identified 16 papers from 15 studies for inclusion.

From each paper, I extracted and analysed methodological information informed by the common grounded theory characteristics of data collection methods, use of theoretical sampling, theoretical sensitivity, memo writing, constant comparison, theoretical saturation, coding processes and theory generation. I compared and contrasted the studies to examine how authors utilised these characteristics to generate theory in the context of nursing or midwifery. Again, I employed a modified version of the CASP Qualitative Research Checklist to determine the quality of the selected studies (Campbell et al., 2011). Criteria assessed for clarity of research aims, research design, methodological quality, recruitment

strategy and the researcher/participant relationship, data collection and analysis, ethical considerations, a clear statement of finding and the value of the research.

The systematic literature review revealed that researchers of nurses and midwives' coping processes employed varied grounded theory approaches. Authors selectively used grounded theory characteristics according to their specific research requirements or use of other methodological frameworks. Few studies indicated the use of all common grounded characteristics. The studies varied in accounts of research design and the use of grounded theory characteristics as defined in the CASP qualitative studies inclusion criteria. Only three of the studies met all criteria and had a rating of very strong. Studies with limited or no description of researcher positioning or data collection/analysis that did not fully meet the modified criteria were rated moderate to strong. Most researchers did not clarify the epistemological and theoretical perspectives underpinning their use of a grounded theory approach, nor explicate the relationship between themselves as researcher and the study participants. This has implications not only for research design but also for trustworthiness of the research. These findings alerted me to the steps I needed to take to develop a robust study design. Together with my co-authors, I concluded that to improve grounded theory research studies in nursing and midwifery, researchers should identify their theoretical stance and clearly articulate their use of grounded theory methodology and characteristics in research reporting. The published paper is set out below.

3.8 Nurses' and midwives' coping processes in grounded theory studies

Cheer, K., MacLaren, D., & Tsey, K. (2016). The use of grounded theory in studies of nurses and midwives' coping processes: A systematic literature search. *Contemporary Nurse*, 51(2–3), 200–219. doi:10.1080/10376178.2016.1157445



Contemporary Nurse



ISSN: 1037-6178 (Print) 1839-3535 (Online) Journal homepage: <http://www.tandfonline.com/loi/rcnj20>

The use of grounded theory in studies of nurses and midwives' coping processes: a systematic literature search

Karen Cheer, David MacLaren & Komla Tsey

To cite this article: Karen Cheer, David MacLaren & Komla Tsey (2015) The use of grounded theory in studies of nurses and midwives' coping processes: a systematic literature search, *Contemporary Nurse*, 51:2-3, 200-219, DOI: [10.1080/10376178.2016.1157445](https://doi.org/10.1080/10376178.2016.1157445)

To link to this article: <https://doi.org/10.1080/10376178.2016.1157445>



Accepted author version posted online: 24 Feb 2016.
Published online: 15 Mar 2016.



Submit your article to this journal [↗](#)



Article views: 285



View Crossmark data [↗](#)

The use of grounded theory in studies of nurses and midwives' coping processes: a systematic literature search

Karen Cheer^{a*} , David MacLaren^b and Komla Tsey^c

^aCollege of Arts, Education and Society, James Cook University, PO Box 6811, Cairns, Australia; ^bDivision of Tropical Health and Medicine, James Cook University, PO Box 6811, Cairns, Australia; ^cThe Cairns Institute, James Cook University, PO Box 6811, Cairns, Australia

(Received 14 September 2015; accepted 17 February 2016)

Background: Researchers are increasingly using grounded theory methodologies to study the professional experience of nurses and midwives.

Aim: To review common grounded theory characteristics and research design quality as described in grounded theory studies of coping strategies used by nurses and midwives.

Methods: A systematic database search for 2005–2015 identified and assessed grounded theory characteristics from 16 studies. Study quality was assessed using a modified Critical Appraisal Skills Programme tool.

Findings: Grounded theory was considered a methodology or a set of methods, able to be used within different nursing and midwifery contexts. Specific research requirements determined the common grounded theory characteristics used in different studies. Most researchers did not clarify their epistemological and theoretical perspectives.

Conclusion: To improve research design and trustworthiness of grounded theory studies in nursing and midwifery, researchers need to state their theoretical stance and clearly articulate their use of grounded theory methodology and characteristics in research reporting.

Keywords: grounded theory; qualitative research; research design; nurses; midwives; coping; strategies

Content has been removed
due to copyright restrictions

*Corresponding author. Email: karen.chcer@my.jcu.edu.au

Content has been removed
due to copyright restrictions

Content has been removed
due to copyright restrictions

Content has been removed
due to copyright restrictions

Content has been removed
due to copyright restrictions

Content has been removed
due to copyright restrictions

Content has been removed
due to copyright restrictions

Content has been removed
due to copyright restrictions

Content has been removed
due to copyright restrictions

Content has been removed
due to copyright restrictions

Content has been removed
due to copyright restrictions

Content has been removed
due to copyright restrictions

Content has been removed
due to copyright restrictions

Content has been removed
due to copyright restrictions

Content has been removed
due to copyright restrictions

Content has been removed
due to copyright restrictions

Content has been removed
due to copyright restrictions

Content has been removed
due to copyright restrictions

Content has been removed
due to copyright restrictions

Content has been removed
due to copyright restrictions

3.9 Summary

In this chapter, I have:

- recorded the methodological decision-making that informed the study design
- described a metasynthesis of qualitative research literature conducted to identify sensitising concepts (Appendix A)
- discussed research paradigms and explored the critical realist stance underpinning the study methodology
- discussed qualitative research and explored qualitative approaches
- described a systematic literature review conducted to identify the use of grounded theory methodology and the characteristics of good qualitative research design in a published article.

In the following chapter, I will:

- consider the methodological implications of undertaking research in the postcolonial nation of PNG and the role of decolonising methodologies.

Chapter 4: A Methodological Journey Continued

4.1 Chapter outline

In this chapter, I continue the reflective walk through the methodological decision-making journey I undertook for this study. I build upon the foundations of qualitative research approaches and grounded theory methodology discussed in the previous chapter. I provide the rationale for the selection of a constructivist grounded theory approach. I discuss the methodological implications of undertaking research in postcolonial countries and consider the impact of colonialism on my practice as a white Australian researcher working in PNG.

4.2 Constructivist grounded theory

Glaser and Strauss (1967), using a positivist approach, formulated their grounded theory in which there is an external reality to be discovered and researchers remain neutral, unbiased observers (Charmaz, 2014). Revisiting my own philosophical stance, I realised that a positivist, objective grounded theory approach was at odds with my ontological and epistemological perspectives. However, since its inception, grounded theory has evolved and diversified (Bryant & Charmaz, 2010). Second-generation theorists have continued to build on the foundations, taking the original approach in new ontological and epistemological directions (Mills, Bonner, & Francis, 2006). Further reading helped me identify the constructivist grounded theory approach of Charmaz (2014) as a suitable fit with my critical realist stance (Levers, 2013; Mills et al., 2006).

Oliver (2012) posits that contemporary grounded theory approaches meet the three requirements of a critical realist methodology. First, they can operate across epistemological paradigms, since the methodology has developed within multiple theoretical perspectives, thereby increasing ‘the scope of its generality because our various grounded theory allegiances have spawned differences in how we think and act toward data’ (Charmaz, 2009, p. 128; Oliver, 2012). Second, these approaches allow for conceptualisation and reconceptualisation, required by the critical realist’s belief that knowledge is fallible: Grounded theory approaches require the researcher to put aside preconceptions in the pursuit of leads defined from data, and a theory remains subject to refinement (Charmaz, 2000, 2014; Oliver, 2012). Third, grounded theory approaches embrace the critical realist concept of epistemic relativism (Oliver, 2012).

Constructivist grounded theory is a methodological approach that aims to explain and incorporate the underlying social processes related to a phenomenon through the researcher’s interactions with people, perspectives and research practices (Charmaz, 2014). Therefore, this theory is built on the theoretical position of symbolic interactionism and acknowledges multiple forms of knowledge and varying perspectives of reality in settings influenced by, but different from, the past (Charmaz, 2011, 2014). Theoretical representation is an interpretive act of the researcher, with theory constructed by situating events and behaviour within a broad social framework (Oliver, 2012). The flexible guidelines of constructivist grounded theory invite researchers with varying fundamental assumptions to be innovative in their use of the approach (Charmaz, 2000). Constructivist grounded theory methods would allow me to gain in-depth understanding of the phenomenon of stillbirth from the perspective of those who experienced it in the PNG setting, while complementing the holistic approach of midwifery (Australian College of Midwives, 2018; Mills & Birks, 2014).

4.3 Research in the postcolonial space

The power of the researcher in comparison to the research participant is widely discussed in methodological literature that emphasises both the power imbalance between parties and strategies by which the imbalance can be diminished (Råheim et al., 2016). In constructivist grounded theory, positions of power are made more equal by the participants' active involvement in the co-construction of data (Charmaz, 2008a). However, Redman-MacLaren & Mills (2015) question whether purposeful participation is sufficient. Researcher reflexivity regarding power differentials in the research relationship and planning for time spent in the field with participants are suggested strategies to affect a more equal sharing of power (Birks & Mills, 2015; Redman-MacLaren & Mills, 2015). I decided to examine critically my own position as a researcher and the nature of the relationship I would have with participants as co-creators of knowledge: What cultural, social and historical relationships did we share? Are there gender, economic and educational differences? Further, how will these factors affect data collection and theory construction? (Redman-MacLaren & Mills, 2015).

Charmaz posited that 'The shadows of post-colonialism persist in societies for which the domination of more powerful nations still shapes everyday life' (2014, p. 329). As an Australian woman, I am cognisant of the discourse surrounding PNG's colonial past and that my research might be seen to perpetuate the structures of colonial rule under German, British and Australian dominion. I also acknowledge my privileged upbringing, university education and comfortable living standard in a predominantly white society. Frankenberg (1993) discusses the issue of 'whiteness' as a social construct and argues whiteness has interconnected elements: a location of structural advantage, a standpoint from which white people view the world and position themselves and others, and a set of cultural practices,

unnamed yet dominant, in colonised/settler states, such as Australia. With personal experience of the unequal relationships of power between colonisers and the colonised, Fanon (1963, 1967) and Friere (1993) both challenged the structured inequality in colonised countries. Friere argued that the oppressed lived ‘inside’ the structures that minimised their opportunities and rights and reasoned that they needed to change the structures. For Fanon, decolonisation was not simply the eviction of colonisers from the land but required the formerly colonised to abandon Western ways of thinking, ‘the liquidation of all untruths implanted in his being by oppression’ (1963, p. 308). Fanon described the need to purge thought processes imbedded by the colonisers to enable the colonised to live according to their own ways. Engaging with the studies of Indigenous scholars, such as Fanon, impressed upon me the epistemological Eurocentrism existing in the academic pursuit of knowledge.

4.4 Decolonising methodologies

Chilisa reminds us of the power of research to ‘label, name, condemn, describe, or prescribe solutions’ to challenges in formerly colonised nations and those faced by the historically oppressed (2012, p. 7). As an emerging researcher entering the PNG research environment, I wanted to tread lightly to avoid the ‘intellectual arrogance’ often assumed by Western scholars undertaking research in the postcolonial space (L. T. Smith, 1999, p. 177). Conducting the metasynthesis of Asia-Pacific women’s experiences of stillbirth enhanced my understanding of the social process of othering. I determined that the voices of participants in my study would be heard, that students would have the opportunity to co-construct new knowledge—that they were not just ‘spoken for and theorized about’ (Denzin, 2010, p. 298). Exploration of the literature and discussions with advisors and mentors led me to examine decolonising methodologies for inclusion in my research design.

In response to the 'essentialism of Western thought pervading research' (Kovach, 2009, p. 28), Indigenous and non-Indigenous researchers alike have called for developing decolonising methodologies and strategies that acknowledge colonial histories, reject notions of Western ideological superiority and centralise Indigenous ways of knowing and being (Chilisa, 2012; Connell, 2007; Kovach, 2009; L. T. Smith, 1999; Wilson, 2008).

Decolonising methodologies require performing research in sensitive and culturally appropriate ways for both the decolonising researcher and participants, with research outcomes beneficial to research participants (Liamputtong, 2010). Enacting decolonising methodologies can empower participants through their direct involvement in the research process and active partnership in knowledge production (Redman-MacLaren & Mills, 2015).

The role of non-Indigenous researchers in Indigenous research is debated in the methodological literature (L. T. Smith, 1999; Wilson, 2013). In his discussion of the researcher/participant relationships, Hodkinson noted that identity is a multifaceted and fluid concept, and 'that the complexity of the selves of both researcher and researched makes the notion of being an absolute insider (or outsider) problematic... the prominence of particular elements of identity fluctuates back and forth according to context and audience' (2005, p. 133). Gair (2012) suggested the insider/outsider binary is simplistic, associated more with the epistemological foundations of a study than with the actual positioning of the researcher.

While it is important to acknowledge the past and recognise shared experiences, I do not assume to share the same experiences and worldview as the research participants. I agree with Aveling (2013) that even with the best of intentions, my understanding of participants' experiences of living in the shadow of colonialism will only ever be partial. However, I can be open to different ways of knowing and alternative views of reality, be empathetic and

maintain an awareness of ways in which I can improve my practice as a non-Indigenous researcher in the postcolonial PNG setting (Wilson, 2001).

4.5 Constructivist grounded theory + decolonising methodologies

A constructivist grounded theory approach helps authenticate Indigenous experiences as sources of knowledge and assists theory construction from the voices of participants (Bainbridge et al., 2013). The pragmatism that underpins constructivist grounded theory enables researchers to acknowledge their active role in the research process and to see the value of the constructed theory in terms of its usefulness for people in a specific context (Bryant, 2009). Charmaz posited that constructivist grounded theorists locate ‘both the grounded theory process and product in time, space, and social conditions’ (2008b, p. 469). I view this theory and decolonising methodologies as being complementary, since both centralise contextual social experiences and situations (Charmaz, 2014; Redman-MacLaren & Mills, 2015).

The researcher’s philosophical stance, research context and aims, and the selected methodological approach are interconnected elements of research design that, when in accordance, acquire methodological congruence (Birks & Mills, 2015; Richards & Morse, 2013). Methodological congruence does not preclude flexibility, and research design may evolve as a study progresses (Birks & Mills, 2015; Richards & Morse, 2013). What is important is that a researcher, even an emerging one like myself, ‘retains a coherent epistemological position and can justify the choices made, preferably in relation to both the theoretical context of the methodology and the impact of the change on method and the final research product’ (Carter & Little, 2007, p. 1326).

As a way of connecting the aspects of the methodological journey described in this chapter and the previous chapter, Figure 4.1 summarises the axiological, ontological, epistemological and methodological perspectives that inform this study.

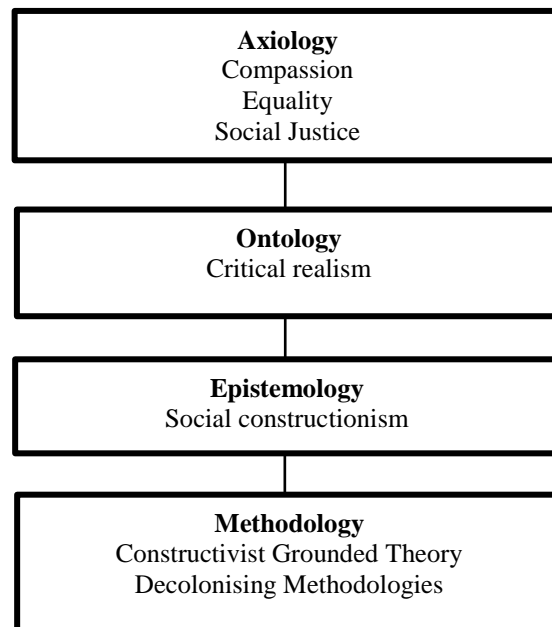


Figure 4.1. Philosophy underpinning this research

4.6 Summary

In this chapter, I have:

- explained the rationale for a constructive grounded theory approach
- explored the role of decolonising methodologies for research in postcolonial settings and as an adjunct to constructivist grounded theory.

In the following chapter, I will:

- link methodologies to the methods used in the research
- describe project establishment and working with a cultural reference group at PAU
- introduce and describe methods for data collection informed by a systematic scope of the literature
- provide an ethics statement and approvals
- discuss the application of constructivist grounded theory and decolonising methods during the four stages of the research
- discuss issues of transcription and theoretical sensitivity
- discuss coding, categorisation and constant comparison analysis, theoretical sampling and saturation
- discuss the use of memos and diagrams in analysis and theory construction.

Chapter 5: 'Doing' the Research

5.1 Chapter outline

Constructivist grounded theory and decolonising methodologies were appropriate to use in the PNG setting to construct a theory of the phenomenon of stillbirth from the perspective of a cohort of midwifery students. In this chapter, I discuss the practical application of the two methodologies in 'doing' the research. The chapter has five sections. In the first section, I outline how the project was established and describe how I engaged with the PAU community and cultural mentors who guided my research conduct. I consider ethical implications of the research. In the next two sections, I describe and reflect on the processes of data collection and analysis during the research project, consistent with constructivist grounded theory methodology (Figure 5.1). I then report how I authenticated the theory in the research setting. Finally, I discuss engagement with the literature in grounded theory research.

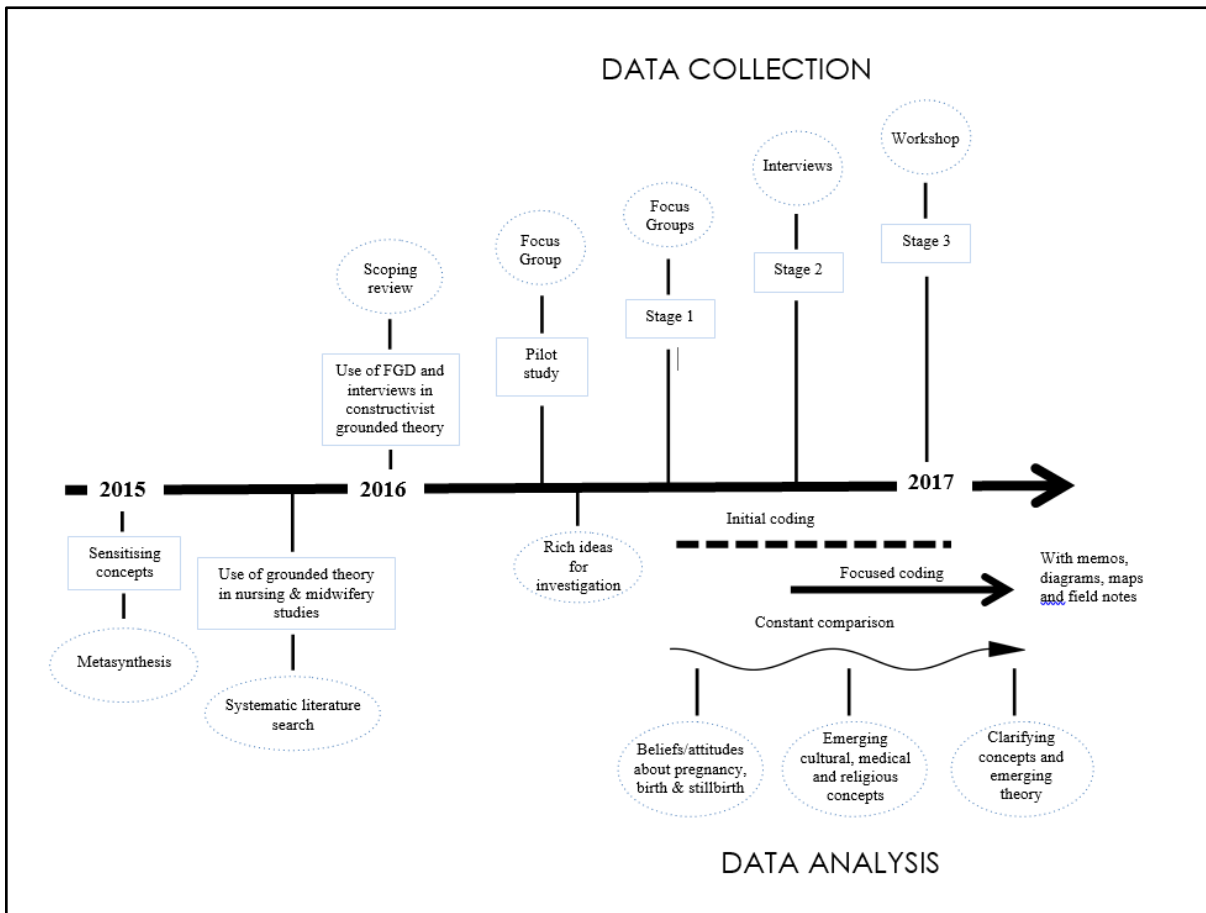


Figure 5.1. Data collection and analysis

5.2 Engaging with the Pacific Adventist University community

In October 2014, my advisor Associate Professor David MacLaren contacted the Director of Research and Postgraduate Studies and the Dean of the School of Health Science (SOHS) at PAU to inquire on my behalf whether the SOHS would be interested in working with me for my PhD project. This was an appropriate introduction for me to the university, because Associate Professor MacLaren holds adjunct status with PAU and has ongoing research projects at the university. Both indicated their support for my research project and believed findings would be valuable for informing the content of the midwifery programme (Director of Research, personal communication, May 2015; Dean of School, personal

communication, June 2015). In the context of the midwifery programme outlined in Section 2.9, I subsequently began to build a long-distance professional relationship with the PAU research and midwifery staff via email, providing updates on my progress in the early stages of my candidature. PAU midwifery lecturers and tutors viewed stillbirth as an important issue for research in PNG and were supportive of my intended project (Midwifery tutor, personal communication, May 2015). On their own initiative, midwifery lecturers surveyed the 21 students in the 2015 midwifery cohort regarding their experiences of providing care to women following stillbirth. Twelve students had either experienced stillbirth in the workplace or while studying at PAU (Dean of School, personal communication, August 2015).

5.2.1 Working with the PAU cultural reference group

Acknowledging that the research needed to be culturally respectful in the PNG setting, my advisors and the PAU Dean of Research supported me to connect with PAU mentors to form a cultural reference group (CRG). This group was to provide me valuable cultural insight throughout the research process. Several PAU staff had facilitated previous research collaboration between JCU and PAU, and they agreed to act as my cultural mentors. The Dean of Research and Postgraduate Studies Lalen Simeon and SOHS lecturers Rachael Tommbe and Lester Asugeni are of Melanesian origin, well-respected and senior researchers within the PAU community, each with experience of working within multinational, interdisciplinary teams. My CRG was on hand to observe and critique my practice and approach during the initial stage of the research process, for example through observation and feedback on my data collection technique, as well as provide their perspective on my interpretation of data. My CRG mentors also ensured I observed cultural protocols while in the field. I was mindful of the words of Aveling (2013), who noted ‘If we are not familiar

with cultural protocols or ignore them, we fall straight back into the intellectually arrogant trap of thinking that we know what we are doing' (p. 206).

Personal safety can be an issue in PNG, particularly for women. The Australian Department of Foreign Affairs and Trade advise Australians travelling in PNG to exercise a high degree of caution owing to high levels of crime and violence in major urban centres, such as Port Moresby. When I needed to leave the secure surrounds of the PAU campus during my field trips, my mentors ensured I travelled in secure vehicles and accompanied me to keep me safe from harm.

PAU was a teaching-intensive university until the mid-2000s but now has an increased focus on research capacity building. The Dean of Research asserted I could support research capacity building by presenting information sessions and workshops for PAU postgraduate students using my extensive experience as an academic librarian (personal communication, August 2015). While I was building my own research capability, I was also helping to develop research capabilities for health science staff and students through sharing my knowledge and skills and the opportunity to participate in active research. Although unknown to me at this stage of the research process, there would be many occasions to share my knowledge and experience: from showing SOHS staff how to embed images in PowerPoint presentations, to giving lectures on grounded theory methodology for undergraduate nursing students learning about research in nursing. I also facilitated practical exercises with students to help them learn about research, such as when we sorted pens and markers according to colour, shape, size and type to illustrate the multiple ways to code data. Postgraduate midwifery students requested my help to develop information literacy skills to

locate and evaluate literature on PAU library databases or via the Internet. I also taught midwifery staff about the different types of referencing styles used in published literature.

Forging friendships with highly regarded cultural mentors and the wider SOHS community aided in developing a relationship of trust between the participants and me as a non-PNG researcher, through ‘respect, reciprocation, collaboration and cooperation,’ concepts on which the protocols that guide this research are based (Aveling, 2013; Liamputtong, 2010, p. 23). Together with the social constructionist assumptions and pragmatism that informs constructivist grounded theory, this focus helped anchor the research within the local PNG setting and enabled me to use constructivist grounded theory as a decolonising tool (Denzin, 2010).

5.2.2 Ethical considerations

Before commencing the study, I received ethical approval from the JCU and PAU Human Research Ethics Committees (see Appendix B). A provision of the JCU approval was that I not take photographs of participants during the study. The team in the Office of Research and Postgraduate Studies at PAU assisted me in obtaining the necessary PNG research visa. At each stage of the research, I provided participants an information sheet to read and keep, and took time to explain the overall purpose of the research and the value of student contributions. I explained that participation in the study was voluntary. I outlined the ethical issues involved and reassured students regarding the confidentiality of our discussion. I advised I would assign each participant a pseudonym to ensure anonymity in reporting the research. I explained our discussions would be audio recorded with participant consent. Students signed a consent form indicating they understood their rights and agreed to

participate. The forms included details for the PAU Dean of Research, as well as my contact details and PNG mobile phone number, should participants wish to discuss ethical issues after I returned to Australia. Owing to the sensitive nature of discussing a topic such as stillbirth, the forms advised participants that assistance was available from PAU counselling service and the SOHS if they required support. I asked the participants to inform me if they experienced emotional distress, advising our meeting could end and if necessary, referral made to PAU counselling services.

Students were not given a cash payment for participating in the research. My CRG mentors explained to me that the Melanesian way of saying thank you is by giving a gift and sharing food. These are the details of my gifts to participants as a token of my appreciation:

- Students participating in focus group discussions and/or individual interviews were gifted a JCU pen, a small pocket notebook and a 5-kina⁸ phone charge card (useful for calling relatives and friends in the provinces). Following the discussion, I provided juice and biscuits and shared these with the students
- Students participating in the workshop were gifted a JCU tote bag (donated by the Centre for Nursing and Midwifery Research, JCU, Cairns campus), containing a JCU lanyard (much appreciated for use in the workplace), a 5-kina phone charge card and a hand towel (a sought after and useful household item). Following the workshop, I provided juice and a lunch of sandwiches and fresh fruit and shared these with the students

⁸ It is a unit of PNG currency equivalent to approximately USD0.30 or AUD0.40 (as at November 2018).

There were no complaints reported to PAU contacts and no complaints reported to the JCU or PAU ethics committees.

5.2.3 Data storage and management

In accordance with ethical approvals and commitments provided to JCU and PAU ethics committees, I downloaded audio files from the voice recorder I used in the field and securely stored these on a password-protected laptop computer. At JCU, the transcribed audio files and documents were stored on a password-protected computer and secure server. I kept the original hard copies of signed consent forms from focus group discussions, individual interviews and the workshop in a locked drawer at JCU.

5.3 Collecting the data

Methods for qualitative data collection are numerous—interviews, observations, documents, videos and photographs—to name but a few. I needed to decide on the best methods to collect rich data to help me answer the research question and ground the theory. Importantly, the data collection methods I selected needed to be culturally appropriate in the PNG context with the particular participants. I investigated methods previously used in the research environment. Focus group discussions and individual interviews were methods used by health researchers within the PNG research setting (see Redman-MacLaren et al., 2017; L. M. Vallely et al., 2013) and were congruent with my research question, the constructivist grounded theory approach and the type of data I required.

Individual interviews (interviews) are the most popular data collection method in qualitative research and in grounded theory studies (Charmaz, 2014; Mills, 2014). An interview is a purposeful, semi-structured conversation between a researcher and interviewee, where interaction enables knowledge construction (Brinkmann & Kvale, 2015). There are three types of interviews, and all rely on a degree of directed dialogue taking place: unstructured interviews, which begin with an open-ended question; semi-structured interviews, where the researcher has a guide or memory aid to prompt questioning; and structured interviews, where the researcher asks each participant a set of identical questions (Charmaz, 2014; Mills, 2014). Guided interviewing allows the researcher to direct the course of the interview. Early questions invite the participant into the discussion, to warm up and overcome the 'etiquette barrier' (Hiller & DiLuzio, 2004, p. 16). When trust develops, participants typically offer in-depth responses to focal questions about the research topic. Closing questions ask for further comments and give thanks for participation (Creswell & Poth, 2018). In grounded theory research, interviews that have less structure allow the researcher to follow leads that appear during conversation (Birks & Mills, 2015).

An extension of interview methods, focus group discussions (focus groups) are used to explore a specific topic or phenomenon among a group of two or more selected participants, with the researcher asking a series of open-ended questions to guide the discussion (Birks & Mills, 2015; Liamputtong, 2011). Participants provide individual responses to questions while being encouraged by the researcher to talk and interact with other group members. Interaction within the group encourages participants to explore and clarify both individual and shared viewpoints (Tong, Sainsbury, & Craig, 2007).

Interviews and focus groups share a similar structure of inquiry, in that they both seek to gain insight into the views, experiences, beliefs, understanding and knowledge of participants on a selected topic through conversation (Rosenthal, 2016). A difference between the two methods is the data collection procedure. Both methods involve interaction between the researcher and participants; however, focus groups rely on the interaction between group members (Liamputtong, 2011; Rosenthal, 2016). Focus groups seek consensus and/or divergent views from participant interplay, and interaction may 'produce data and insights that would be less accessible without the interaction found in a group' (Morgan, 1997, p. 2). By definition, interviews are unable to collect and discuss such opinions in real time.

I saw several advantages in employing focus groups for my study. Focus groups can reduce the power imbalance between researcher and participants in postcolonial settings such as PNG (Redman-MacLaren, Mills, & Tommbe, 2014). With me as researcher performing a facilitative role, participants would have more control of the discussion space, with the outcome a nuanced and deeper understanding of the research topic (Kamberelis & Dimitriadis, 2013). Focus groups would provide a safe and private space where participants had freedom to express their opinions and feelings and share personal concerns within a select group of people (Kamberelis & Dimitriadis, 2013; Liamputtong, 2011). The relaxed, collegial and supportive environment of focus groups would also make the sensitive topic of stillbirth less threatening for participants to discuss and encourage conversation, while providing the means for me as researcher to learn about the language and thought patterns of the participants within their social context (Liamputtong, 2011).

There were also advantages in data gathering using interviews in the PAU setting. For researchers working in the constructivist and decolonising space, interviews are interactions

that can help develop social bonds, empathy, understanding and validation of experience (Charmaz, 2014). Conducting interviews would provide an opportunity for students to disclose personal aspects of their stillbirth experiences that they may not wish to discuss in a group setting (Gill, Stewart, Treasure, & Chadwick, 2008). Interviews would allow students to more fully discuss their experiences in all their complexity, providing me with better insight into actions and behaviours related to the stillbirth event (Hiller & DiLuzio, 2004).

I wanted to learn more about the combination of focus groups and interviewing methods in constructivist grounded theory health studies. I systematically scoped the extant literature available on the Cumulative Index to Nursing and Allied Health Literature database to examine how researchers had sequenced these methods in previous health studies. I explored the question: ‘How have authors used focus groups and interviews in constructivist grounded theory studies?’ I established criteria to apply to the retrieved studies. Papers published between 2011 and 2016 were included where authors employed a constructivist grounded theory approach as the theoretical framework, and used focus groups and interviews exclusively as data collection methods. I excluded papers that used multiple qualitative approaches, qualitative data collection methods other than focus groups and interviews or additional quantitative data collection methods. I then evaluated the retrieved studies by reviewing the title and abstract, followed by a detailed reading of each article. I identified seven articles from six studies for inclusion. The PRISMA checklist (Moher, Liberati, Tetzlaff, & Altman, 2009) informed the data extraction from selected papers. Study characteristics were categorised by (1) author and publication year; (2) study focus; (3) study location; (4) study population; (5) sample size; (6) number of focus groups conducted and participants; (7) number of interviews conducted; (8) description of data collection methods; (9) reported rationale for combining focus groups and interviews; and (10) reported

outcomes. I compared and contrasted studies to examine how authors utilised interviews and focus groups in their research studies. The unpublished manuscript is included as Appendix C and summarised below.

The review evidenced that constructivist grounded theory researchers sequenced interviews and focus groups in varying order. Debate surrounds the order of method used: According to some, focus groups are best conducted after previous research; others state focus groups can be conducted at any stage of the research, or simultaneously with individual interviews (Peek & Fothergill, 2009). Reviewing the selected papers, I found the most common sequencing of data collection was focus groups prior to participant interviews. The review indicated that focus groups enabled researchers to explore the range of participant experiences, with subsequent interviews conducted to explore issues at depth. Preliminary use of focus groups can increase the efficacy of interviews by allowing the researcher to develop an interview guide grounded in participant views and understanding of the research topic (Barbour, 2007; Morgan & Spanish, 1984). Charmaz suggested that in constructivist grounded theory, focus groups are useful for initial sampling, ‘a point of departure’ directed by the research question: Subsequent interviews provide the opportunity for theoretical sampling to explicate categories and concepts (2006, p. 100). Important considerations in determining the number of focus groups to conduct include the number of participants invited, participant diversity and recruitment, group structure and the point at which data saturation occurs (Morgan, 1996).

The scoping review showed that interviews were commonly utilised as a data collection method in constructivist grounded theory studies because they allowed for open-ended, comprehensive exploration of a participant’s substantial experience in a given area

(Charmaz, 2014). In grounded theory research, focus groups may be used as the primary data collection method or as an adjunct with other qualitative methods (Birks & Mills, 2015). Despite Glaser's dictum that 'All is data' (1998, p. 8), the suitability of focus group data in theory development is debated in the literature. One criticism is that focus groups produce only fragmented data that fail to provide an in-depth narrative of participant experiences (Morse, 2001). Another criticism is that the strategy of collecting rich data through the interaction of focus group participants is incompatible with the grounded theory aim to generate theory validated through the systematic process of concurrent data collection and analysis, and constant comparison of data, obtained via methods including interviews, observation and documents (Jayasekara, 2012; Webb & Kevern, 2001). Yet other researchers have supported focus group use in grounded theory research, arguing that focus groups are a suitable method for understanding the broad range of participant experiences and viewpoints (Birks & Mills, 2015). From this understanding, focus groups allow researchers to develop sensitising concepts that may guide researchers to areas for further inquiry in the process of developing ideas and constructing theory (Charmaz, 2014).

The aim of multimethod studies is that each method should contribute in its own distinct way to the understanding of the studied phenomenon (Morgan, 1997). The use of multiple data methods in grounded theory studies can substantiate research findings, thus adding value to the grounded theory (Cheer et al., 2016). The selection of the most useful methods should originate from, but not be driven by, the research question and to where it leads (Charmaz, 2014). The peculiarities of the research setting and the level of researcher engagement within that setting help to shape the choice and use of data collection methods over the course of the research (Charmaz, 2014; Morgan, 1997).

In constructivist grounded theory studies, there are no rules governing data collection methods and the order in which they should be conducted. Researchers ‘take successively more analytical control over their data collection and emerging theoretical ideas’ (Charmaz, 2014, p. 85). Combinations of focus groups and individual interviews ‘have proven to be fertile ground for developing grounded theories’ when focus groups are used ‘strategically’ (Charmaz & Belgrave, 2012, p. 356): that is, when the tenets of grounded theory are respected and the methodological foundation of the methods fully discussed (Webb & Kevern, 2001). Individual interviews and focus groups provide researchers opportunities to collect raw data with the explicit aim to limit preconceived ideas or predetermined theories. Researchers can then use the inductive process to assign data to codes, categories and concepts using the constant comparative method (Denscombe, 2014). This approach enables researchers to more fully understand the phenomenon of study and build theory directly from the perspectives and experiences of study participants.

I found that none of the reviewed studies provided an explanation as to why authors chose both interviews and focus groups over other qualitative data collection methods. Justification of the selection of data collection methods to meet research aims—not just a description of their use in the research—together with references to supporting literature, assists readers in assessing overall research quality (Kuper, Lingard, & Levinson, 2008; Tobin & Begley, 2004; Webb & Kevern, 2001; White, Woodfield, & Ritchie, 2003). Explication may also be of pedagogical benefit for emerging researchers like me, or those seeking to build on existing studies or adapt research practices (Tracy, 2012). There are challenges and concerns surrounding the creation of appropriate standards for reporting across the range of methodological approaches used in qualitative research; nevertheless, reporting standards have been developed, including specifically for the use of focus groups

and interviews (e.g., Standards for Reporting Qualitative Research; Consolidated Criteria for Reporting Qualitative Research; Carter & Little, 2007; O'Brien, Harris, Beckman, Reed, & Cook, 2014; Tong et al., 2007). The reasons authors of the selected studies did not provide a rationale for the combination of data collection methods is unknown, but lack of detail has been attributed to limitations in manuscript submission or disengagement with concepts surrounding methodology and method use (Carter & Little, 2007; Hutchison, Johnston, & Breckon, 2011).

I used the findings from the systematic scope of the literature to inform my data collection approach. Focus groups were an appropriate method to explore my topic, where no published knowledge existed in the PNG setting. Together with the participants, I would explore socially shared knowledge and beliefs about pregnancy, birth and stillbirth to generate initial concepts (Birks & Mills, 2015). In discussion with my CRG mentors, we decided focus groups were a less threatening introduction to me as an outsider and to practical research methods for the participants. Individual interviews would be an appropriate method to re-examine and expand on key issues and concepts raised in the groups. I would use interviews with participants to elicit individual understandings of stillbirth and explore in greater depth how each student experienced and managed the provision of care to women following stillbirth and the effect on the student of a stillbirth event. Semi-structured interviews with open-ended questions would provide coverage of the same topics but allow participants to elaborate on any additional topics raised. Interviews would also foster relationship building and mutuality between participants and me. Adhering to the principles of decolonising research, I devised the focus group and interview guides with assistance from my cultural mentors to ensure relevancy and cultural appropriateness. Following constructivist grounded theory and decolonising principles, I planned to provide an

opportunity for participants to discuss ideas arising from my primary analysis of data from the focus groups and individual interviews in a workshop, where participants and I could co-construct concepts and potential theory.

Qualitative researchers rely on language to communicate with participants regarding the phenomenon of interest, with participant words comprising research data (Redman-MacLaren, 2015b). Participants use language to present an image of self and to describe and explain matters related to their culture, gender and other elements of identity (Squires, 2008). One decision I had to make was whether to conduct focus groups, individual interviews and the participant workshop in English or *Tok Pisin*, the lingua franca of PNG. English was the language of the British and Australian colonial powers and my only language. If I conducted focus groups and interviews in *Tok Pisin*, I would need the services of an interpreter. I was unsure how difficult this would be to arrange but recognised hiring an interpreter would be an additional cost for a project with a limited budget. English is the formal language used for government, business and education throughout PNG, although parliamentary debates and social conversation are mostly in *Tok Pisin* (Shelley, 2013). However, the study was located at a university campus where formal education is delivered in English. My CRG mentors informed me that potential participants were proficient English speakers and that I would be able to conduct focus groups and individual interviews in English.

5.3.1 Focus group pilot

In February 2016, while at PAU to meet with my CRG mentors and SOHS staff, I was advised to conduct a pilot focus group with graduating student midwives returning to PAU for the graduation ceremony. Although unexpected, the pilot focus group provided me the

chance to test my questions and develop my moderating skills. One of my cultural mentors had helped me develop focus group questions, which the CRG reviewed prior to the pilot group. The focus group was scheduled for the evening before graduation. My mentors were present to take notes and translate *Tok Pisin*, to notice any cultural nuances I did not yet recognise and to observe my facilitating technique.

Some students could not attend, and hence, midwifery tutors joined the focus group, which progressed with three students and three tutors. Employing Liamputtong's (2011) guidelines for conducting focus groups, I commenced by introducing myself, sharing my stillbirth experience and the reasons I was motivated to undertake the research. I invited all the participants to introduce and say something about themselves. This was a useful way to ensure all participants felt that they were contributing to the conversation from the outset (Liamputtong, 2011).

The focus group participants were female midwifery tutors and graduating midwifery students, aged 30–49 years, with 7 to 28 years professional experience. All had experienced stillbirth in the workplace. In hindsight, I should have gone ahead with only the three graduating student midwives participating in the focus group, since this would have enabled me to incorporate the student data into my study. This approach may have negated the power imbalance between tutors and students. However, I took advice from respected, senior PAU researchers. At the time, I was naïve about the intricacies of PNG life, with its foundation of cooperation in times of need. This was my first experience of the integral reciprocity of Melanesian society (Narokobi, 1983) and part of conducting research in PNG. Instead of coercion, participation was in reality a reciprocal gesture and a mark of respect for my CRG mentors and me. The pilot focus group lasted 74 minutes. According to custom, we shared

food, drink and conversation at the conclusion of the discussion, and I presented each participant with a phone credit card to the value of 5 kina. The data from the pilot focus group provided initial ideas for further investigation, such as the spiritual, social and cultural aspects about pregnancy and birth, and the ways midwifery staff respond when a stillbirth occurs. This also allowed me to reflect and review my facilitation technique and, together with my cultural mentors, revise the questions for focus groups in stage one.

5.3.2 Stage one: Focus groups

Midwifery students undertake theoretical and clinical practical course components during their midwifery studies, with practicums often taking place in remote locations. I liaised with SOHS CRG mentors and the midwifery course coordinators to schedule my field trips during the times students were attending the PAU campus. In May 2016, I travelled to the university to conduct focus groups in the first stage of my data collection.

During my time at PAU, I asked many questions of my CRG mentors and worked to ensure my practice and conduct were culturally appropriate. Following the pilot focus group, I worked with my advisors and CRG members to update the focus group guide. One of my SOHS mentors had arranged for a midwifery postgraduate student to be my assistant in organising the focus groups and to act as the liaison between the students and me. At the commencement of this field trip and according to protocol, my assistant introduced me to the midwifery student cohort. In semester one, 15 midwifery students were enrolled in the programme. I spent substantial time outlining my study and inviting the students to participate. I disclosed my personal experience of stillbirth some years ago and the reasons I was interested in learning about the students' experiences. I spoke of how the research

findings may inform the PAU midwifery programme and development of strategies to help midwifery students cope with the often-challenging aspect of stillbirth in their work. The midwifery students were interested to know more about my postgraduate studies and about me as researcher and outsider. They asked me many questions: Where did I live? What was it like there? Did I have a family? What was it like at my university? I regarded personal questions not as intrusive but as a way for students to situate my research and me and as part of the relationship-building process. I purposely worked each day within the school offices so I became a familiar face to the students.

Pregnancy and childbirth are traditionally women's business in PNG. With the possibility that male midwifery students would participate in the research, my CRG and I considered the need to conduct gendered focus groups and interviews, with a male mentor acting as facilitator. My mentors decided that separating genders was unnecessary because the students, both female and male, worked as one homogenous group in their studies. Although I wondered about gender imbalance, and whether the responses of the male participants would have differed when discussing maternal health care and stillbirth with another male, I trusted my mentors' cultural knowledge and followed their advice.

The focus groups provided the participants the opportunity to get to know me in a collective setting within the PNG cultural space. This was important in the PAU context, where the process of research is new and midwifery students are from many different provinces. I chose not to arrange participants into the focus groups. Students were instead able to self-nominate participation in a focus group with their peers. All groups opted to meet in the familiar setting of the midwifery rooms of the SOHS, at a time convenient to all members.

Conducting research is frequently messy, and things did not always go to plan. Expecting the unexpected became the norm and I needed to be patient and flexible following last-minute changes to meeting venues, or on finding that buildings supposed to be open were locked or when participants ran late or cancelled without notice. Such was the case with one focus group, first organised for a Sunday but when no participants arrived, rescheduled a further three times before occurring on the following Tuesday afternoon with a different student composition. As I waited in vain for participants on that Sunday afternoon, I recorded my thoughts:

What have I learned from this? PNG time is a flexible, non-specific thing. Saying you will be there at 2 o'clock doesn't mean you will come on time. Also, saying you will come does not mean you will be there at all. I have to be flexible and calm and just go with it. (30 May 2016)

Although I had hoped more students from the cohort would nominate, the final number of students recruited for focus groups was nine, (M = 2; F = 7) from the cohort of 15. Several students were taking a leave of absence owing to health or family matters. One student told her peers she was too scared to participate, while others indicated they were too busy with course work to participate. I conducted three focus groups lasting between 60 to 90 minutes. Prior to commencing each focus group, I reintroduced myself and took time to explain verbally the purpose of the research and the ethical issues involved. This was important since it was the first time most students from the cohort had participated in research. The Dean of Research had organised for a note taker to be present and translate *Tok Pisin* if necessary. Although known to many of the students, I introduced the note taker and explained the role in the focus groups. To build rapport with the participants, I disclosed that

I had personal experience of stillbirth some years ago and that midwives cared for me at that time: This was one reason I was interested in learning about the students' experiences. I also initiated an icebreaker activity before the questions to ensure that participants felt like a part of the discussion from the beginning (Liamputtong, 2011).

Students actively participated in the focus groups, providing insight about attitudes and beliefs about pregnancy, birth and stillbirth and discussing the maternal health services where they had lived and worked. Several students were initially hesitant in joining in the conversation; however, they became more comfortable as the discussion progressed and I consciously drew them into the conversation. The free-flowing discussion evoked personal memories and sharing of participants' experiences of caring for women following stillbirth—the circumstances surrounding the stillbirth and the response of students following the event. Although sharing stories of distress, students shared much laughter too. Focus group participants were proficient English speakers and easily conversed with me throughout the discussion. On a few occasions, participants and the note taker conferred about the translation of a word or phrase from *Tok Pisin* to English, for example when describing an animal the students first translated to English as a bird-bat, which they finally agreed to be a flying fox. I visited the midwifery classroom each day following a focus group to check the wellbeing of participating students, thank them for participating and remind them to contact me if they had any questions about the study or the focus group. I confirmed I could contact them if I had any follow-up questions. I also checked with the students when it was difficult to hear voices on the audio record and when I needed clarification of a word or phrase. According to Melanesian custom, before leaving PAU I presented a small gift to the note taker and postgraduate assistant as a token of my appreciation. Data analysis is described further in Section 5.4.

5.3.3 Stage two: Individual interviews

In October 2016, I returned to PAU to conduct individual interviews for the second stage of my data collection. Once again, I scheduled my field trip according to the midwifery programme timetable when students were on the campus. For the first weeks of my field trip, the students were on a clinical rotation working day or evening shifts at Port Moresby General Hospital. During the final week of my trip, students were in daytime classes.

Leading up to my arrival for this stage of the research, I continued to liaise via email with mentors, who acted as a conduit between the students, midwifery staff and me. As a respected PAU leader and researcher, one of my SOHS mentors visited the midwifery lab to inform students about the research project and invite students to participate, outlining the benefits to students in both research practice and capacity building. I intended to conduct purposive sampling of midwifery student participants from Stage 1 focus groups and other students in the cohort who identified as having been involved in a health care experience resulting in a stillbirth event. However, I learned that all students met this criteria, when each indicated they had experience providing care to women following stillbirth during their nursing careers or while midwifery students, or both. My mentor was instrumental in organising a list with contact details of the students who indicated an interest in participating.

When I arrived at PAU, I personally phoned or used the existing social structure of the cohort to contact students. I explained about this stage of the research, invited their attendance and arranged a suitable time and place to meet with participating students. Eleven students from the reduced cohort of 13 students elected to participate in semi-structured, individual interviews. From the original 15 students, two had withdrawn from the midwifery

programme and two had taken a leave of absence. Prior to commencing each interview, I asked students to complete a short questionnaire for demographic description, as shown in Table 5.1.

Table 5.1 Participant demographic information

Participant demographic information (n = 11)	
<i>Age (years)</i>	
Under 25	1
25–30	7
30–35	3
<i>Gender</i>	
Female	9
Male	2
<i>Nursing qualification</i>	
Bachelor of Nursing	4
Diploma in Nursing	7
<i>Additional qualifications</i>	
Diploma of Health Teaching	1
Certificate in Rural Health Administration	1
Certificate in Lay Ministry	1
<i>Duration since nursing qualification (years)</i>	
Less than 2	1
2–3	6
4–6	3
>7	1
<i>Most recent health care setting employment</i>	
Faith-based	3
Government	5
Private	3
<i>Religious denomination</i>	
Assemblies of God	1
Catholic	2
Lutheran	1
Nazarene	1
Seventh-day Adventist	6
<i>Location of home province</i>	
Coastal	7
Highlands	5

The duration of the individual interviews was between 50 and 110 minutes. I created the semi-structured interview guide in collaboration with mentors and my advisors, based on my analysis of the data collected during focus groups. I compared the ideas from the pilot focus group and stage one focus group data to identify similarities and differences, knowledge gaps or new areas and directions to explore. The questions asked depended on whether the student had participated in a focus group, the participant's gender, the identified gaps in the data and points of issue for further exploration. Examples of the questions used to guide the semi-structured interviews:

- Can you tell me about the maternal health services in the region where you come from? What is available for complicated deliveries?
- In the focus groups, we spoke about pregnancy and birth being seen in PNG as women's business. Can you tell me more about that in your community?
Or Can you tell me about what people in your community think about pregnancy and birth?
- Where you come from, culturally, what do people think about stillbirth?
Where you come from, spiritually, what do people think about stillbirth? In your role as a nurse and midwifery student, what is your view about these things?
- Think back to an occasion when as a nurse or midwifery student you were involved in the care for a woman experiencing a stillbirth. Can you tell me about that experience?

- Is there anything about the way you cared for her that you thought you did well? Is there anything you would like to have done differently? Is there anything you wanted to do for care but couldn't? Why?
- Tell me about your experience as a male midwifery student. What are the special things that you need to be aware of as a male? How does this make a difference in the way that you experience—or respond—to stillbirth?
- What sort of feelings did you have afterwards? What helps you manage those feelings?
- What education or training did you receive in your general nursing regarding stillbirth? What about in the Bachelor of Midwifery programme? Has this education or training helped prepare you for a stillbirth event?
- What suggestions do you have that might help other students in their experiences of caring for women experiencing stillbirth?
- Have we missed any issue or concern about stillbirth, and is there anything else you would like to add?

Over the course of my fieldwork, I had gradually built rapport with the students, who now enthusiastically participated in the interview stage of the study. Students trusted me enough to share stories, often intimate, of their experiences providing maternal health care during our discussions. In turn, I continued to answer questions and share details of my

experiences to help minimise the hierarchical relationship between me as researcher/outsider, and students as participants/insiders (Birks & Mills, 2015). Students often shared other personal information with me in the private interview space. I recorded this note in my journal about building relationships with the participants:

[She] said she doesn't feel confident when speaking English to others but feels confident speaking English with me for extended periods. This was nice to hear—but does this mean have I earned her trust or is it just about language proficiency? (11 October 2016)

Interviews were organised around the students' clinical shifts and assessment preparation. I recorded my observations and reflections after each focus group. I downloaded and listened to audio recordings when time between meetings allowed, noting new or significant points raised by each participant and reflecting on my technique. I used this initial analysis to inform the guide for the next interview.

5.3.4 Stage three: Workshop

I returned to PAU in February 2017 for stage three of my data collection, a workshop with the students returning for the Bachelor of Midwifery graduation ceremony. Once again, I used the social structure of the midwifery cohort to contact students as they returned from their home provinces. The workshop was held in the midwifery laboratory with nine of the 13 graduating students who had already arrived back on campus and had agreed to participate. All participants in the workshop were female. I explained the workshop was an opportunity for the students to discuss and provide feedback on my analysis of the focus group and

interview data and contribute to the theory construction. The duration of the workshop was 50 minutes.

Beginning the workshop, I presented diagrams outlining the ‘big ideas’ from preliminary data analysis to the students, discussing my emerging thoughts about three cultural spaces, namely (1) learned midwifery culture; (2) inherited PNG culture; and (3) introduced religious culture, and the ways in which midwifery students negotiated within and around these spaces depending on situational factors. Students discussed aspects of these cultural spaces, building on, combining or dismissing concepts and drawing their own diagrams (examples shown in Figure 5.2). Collectively, we conceived how ideas fit together. This emphasised the importance of cultural and spiritual aspects within the emerging theory and clarified concepts important to the students in care provision.

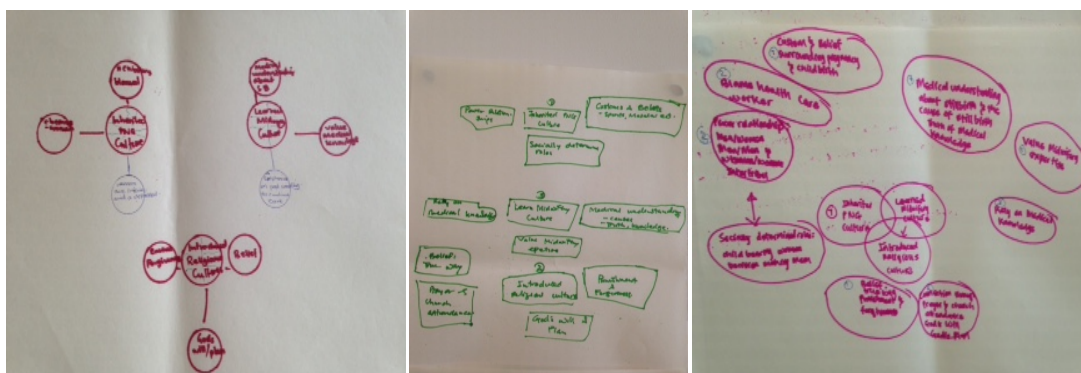


Figure 5.2. Workshop diagrams

5.3.5 Theoretical sampling and saturation in the Papua New Guinea context

Undertaking research in PNG requires a pragmatic approach that is often at odds with methodological ideals. Geographical constraints, participant availability and various other access issues limit researcher ability to conduct concurrent collection and analysis of data

(Birks & Mills, 2015). Theoretical sampling is a characteristic of the iterative process of concurrent collection and analysis of data, where the researcher decides on the type and location of data that will help meet analytical needs, saturate categories and construct theory (Birks & Mills, 2015; Charmaz, 2014; Glaser & Strauss, 1967).

Undertaking theoretical sampling in the latter stages of this study was difficult owing to the geographical dispersion of participants and issues with digital connectivity. Students were absent from the PAU campus for an extended period while on their final clinical placement, and then returned to their home provinces at the conclusion of the Bachelor of Midwifery programme. Thus, it was both logistically and financially impossible to arrange personal meetings. Email, Skype and social media connections are at best haphazard options in PNG, as is contact via mobile phone. With reciprocity an integral part of Melanesian life, being an absent outsider no longer in reciprocal relationships with the research participants added a layer of difficulty to access.

In grounded theory, data may include elicited material produced from researcher interaction with participants or extant material collected from external sources (Charmaz, 2014). For this study, I theoretically sampled data generated from the research process, including transcripts of focus groups and individual interviews, workshop texts, diagrams and memos, as well as relevant peer-reviewed texts to help fill knowledge gaps and aid in my theory construction. I am confident that the varying data I collected and analysed during the study inform the research findings.

5.4 Analysing the data

Grounded theory was designed as a ‘package’ of research methods (Glaser, 1998, p. 9). Similar to other variants of grounded theory, constructivist grounded theory involves a continuous cycle of sampling, data collection, coding and categorising, constant comparison, theoretical sensitivity, memo writing, analysis and interpretation (Charmaz, 2014). These elements are not undertaken in a linear fashion but iteratively throughout the research process.

In grounded theory, data collection and analysis ideally occur concurrently to inform the sampling process and develop new conceptual categories. However, this can be challenging to achieve in the real world and it was not always possible for me to transcribe and analyse each focus group or interview before I conducted the next. I recorded my observations and reflections after each focus group or interview. I downloaded and listened to audio recordings when time between meetings allowed, noting new or significant points raised by each participant and reflecting on my technique. I used this initial analysis to inform the guide for the next focus group or interview and to improve my practice. I wrote the following note about amending questions after the first focus group:

Reflecting upon the introductory question, the students spoke generally about ‘people’ rather than making distinctions between genders. I think this distinction is important to pursue, given how students later talked of the defined roles of men and women in the social structure. Amending the questions to ask specifically about women/men will (hopefully) elicit responses about similarities and differences in attitudes and beliefs of the genders. (15 May 2016)

5.4.1 The act of transcription and theoretical sensitivity

Transcription is an interpretive and representative process central to theory creation (Forbat & Henderson, 2005; Green, Franquiz, & Dixon, 1997). Transcription is also a selective process where particular characteristics of speech and interaction are recorded (Davidson, 2009). For several reasons, I decided to transcribe the audio recording of each focus group and individual interview myself although it was an extremely time-consuming process. First, the research budget did not allow for the use of transcription services. More importantly, there were methodological implications in employing a translator, whose epistemological role in the research process and potential effect on the data and analysis would need to be accounted for (Squires, 2008). As the researcher present at every recording event, I believed I was best placed to represent the nuances of participants' recorded voices, for example, whether a laugh was a humorous or nervous response, and could more accurately translate the verbal and non-verbal signals and interaction between the participants and me (Bird, 2005; Davidson, 2009; Markle, West, & Rich, 2011). Closely listening to the recordings multiple times during transcription heightened my familiarity with, and sensitivity to, the participants' views and emotions about the topic (Charmaz, 2014; Markle et al., 2011). As I transcribed the students' accounts of providing care to women following stillbirth, I reflected on my own experience of stillbirth. I wrote the following journal note:

Listening to the account of the how the doctor treated the mum with her milk coming in reminded me of when it happened to me after Courtney's birth. I remember feeling unsure of what to do, that tight feeling and the leaks and the sadness. The doctors didn't prescribe any meds for me, just said to wait it out and it would go away... And

how awful for the mum that the doctor suggested she feed other babies—I can empathise with her distress and anger. (18 May 2016)

Theoretical sensitivity incorporates the researcher’s personal and professional experiences and their intellectual history (Birks & Mills, 2015). Researchers additionally attain theoretical sensitivity through the analytical process as they interact with data (Strauss & Corbin, 1990). These theoretical activities ‘foster *seeing* possibilities, *establishing* connections, and *asking* questions’ (Charmaz, 2014, p. 244). The rich data generated from my transcription of participants’ voices provided me a firm foundation to begin the coding process.

5.4.2 Coding, categorisation and constant comparison

Coding requires a researcher to ask questions of the data, to better understand studied experiences and direct further data collection in the direction of the analytic issues being defined (Birks & Mills, 2015; Charmaz, 2014). I began analysis of the focus group transcripts by using grounded theory coding techniques. I studied fragments of the data—by line, sentence or paragraph—and coded for action, processes and belief (Charmaz, 2014; Saldaña, 2012).

As a first-time grounded theorist, I found my initial coding was overly descriptive. Reading published accounts of the coding and categorisation processes used to construct grounded theory by other researchers prompted me to review, and sometimes replace, my descriptive codes with gerunds to emphasise the sense of action in the data (Charmaz, 2014). When I hit a road bump in coding, I tried to remain close to the texts and view the data from

the participant perspective, using *in vivo* codes where possible (Charmaz, 2014). The following is a journal entry about my early struggles with coding:

I looked at my coding again from the perspective of the participants as per Charmaz, (2014): 'Begin analysis from their perspective ... starting from the words and actions of your respondents' (p. 20). This makes sense and should help me be less descriptive and more process oriented. (28 May 2016)

Constant comparative analysis is a cyclical process where new data are compared with existing data for coding and category development and theoretical sampling (Birks & Mills, 2015). I coded data, comparing codes to each other and identifying initial concepts and categories. Using the constant comparative method, I found similarities and differences in the data as well as knowledge gaps where I needed to find more information to help develop concepts and construct my theory (Birks & Mills, 2015; Charmaz, 2014). As I coded, I compared data within and between transcripts, sometimes combining similar codes, for example *keeping feelings inside* and *hiding emotions*. Analysing the data, I also considered the three components of Corbin and Strauss' (2008) coding paradigm: conditions; inter/actions and emotions; and consequences of inter/actions and emotions, for example the interaction between the midwifery student and the woman experiencing stillbirth. From the data, I identified a number of concepts for further investigation. These were often complex, such as the *collision* between medical practice and culture. At times, concepts seemed certain, but then, new data insights would make me re-evaluate my work. I created a conceptual mind map and reviewed my ideas with a fellow PhD student and my advisors. The process of explaining how the diagram worked required that I clearly capture my meanings and review some terms to allow better understanding. I used NVivo 11 qualitative analysis software in

the initial stages of coding and for managing the dataset. Beyond initial coding, human thought and framing were necessary to develop the theory.

5.4.3 Memos, maps and diagrams

Memo writing is an element of reflexivity fundamental to grounded theory development, containing insights into how the researcher reflects on, and analyses, data (Birks & Mills, 2015; Groenewald, 2008). Writing memos did not come naturally to me, and I initially felt uncomfortable recording my thoughts. Nevertheless, I persevered. Throughout this study, my journals were a repository where I recorded my feelings and ideas about the research and working in PNG. The following memo shows how I began to think about students' perceptions of differing knowledge sources:

Students often talk about knowledge of what is real and true, for themselves and the community. Truth and reality are related to different knowledge sources—cultural, medical and spiritual. Having knowledge or obtaining knowledge is very important to the students who rely on that knowledge to educate and provide holistic care and support. (Memo, 21 October 2016)

As shown in the memo below, I also reflected on my place in the research, and the effect of time and place on data collection:

Time, place and me as the researcher: Would the participant responses have been different if the interviews had taken place in a different cultural space? In Tok Pisin?

What can be known at this particular time and place with these participants? (Memo, 18 April 2017)

Groenewald stated, '[a] memo is purely an instrument to capture the outflow of ideas, insights, and observations' and as such, no rules for form or style of memos exist (2008, p. 506). As I continued to refine codes, my advisors encouraged me to create visual memos—diagrams—to aid theory integration. I found drawing diagrams and flowcharts invaluable in helping me to conceptualise links between developing categories and in identifying gaps. Diagrams assisted in communicating my ideas to my advisors, mentors and the student participants. I also used situational mapping (Clarke, 2003) to consider the complexity of the research situation. Situational maps are a supplement to traditional grounded theory analysis that outline the 'major human, nonhuman, discursive, historical, symbolic, cultural, political and other elements in the research situation of concern' (Clarke, 2003, p. xxxv). Ordering the pieces of the research into these different elements provided another way of thinking about the relationships between elements and the level of their situational importance. I found this activity particularly helpful since it reflected the dynamic social world of the participants with its connectivity, similarities, differences and tensions. Together with field notes and memos, these graphic artefacts of the research provide a record of how the theory developed over the course of the project. Example maps and diagrams are shown in Figure 5.3.

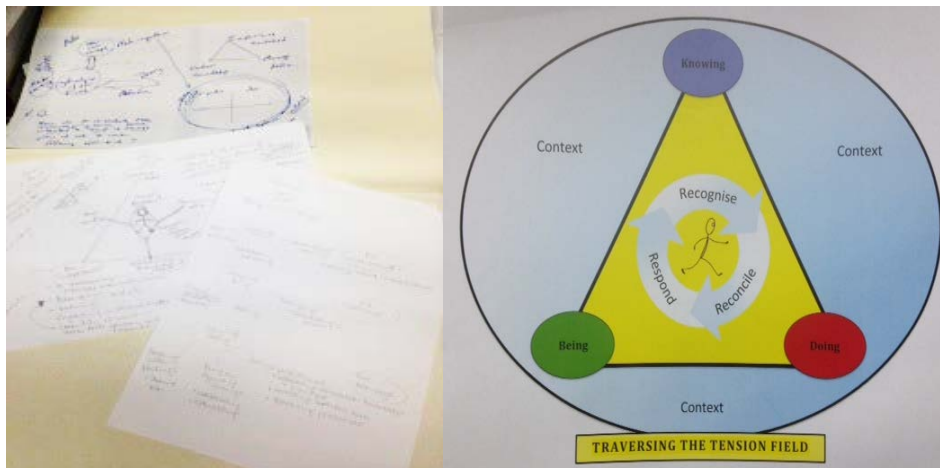
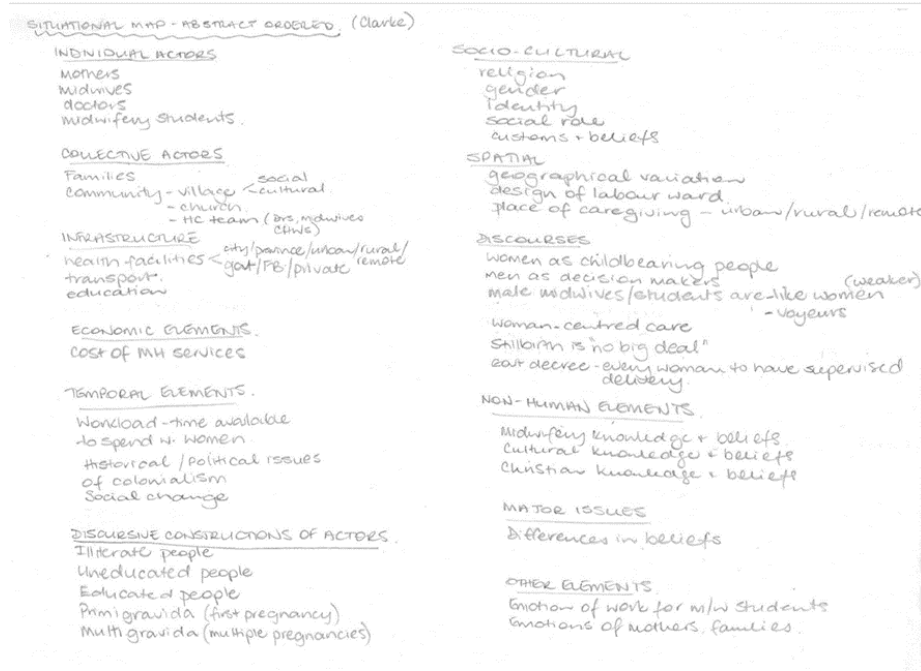


Figure 5.3. Analytical maps and diagrams

Analytic wrestling is part of the research process and growth as a researcher (Charmaz, 2014). Being new to grounded theory, I questioned my analytical skills—‘Did I miss something important’ or ‘Is my categorisation sufficiently robust?’ and, common among my fellow novice grounded theorists, ‘Am I doing it right?’ Charmaz (2017) maintains that doubt can inspire and sustain critical inquiry to help generate theory. I spent much time thinking, asking questions of the data and exploring analytical paths. When the themes of medical pluralism and spirituality emerged during analysis, I selectively read literature to gain better understanding of their context in the PNG setting. I continued to create memos,

diagrams and maps to explore relationships and processes. While I had used initial coding to break down the data, I subsequently used focused coding to ‘sift, sort, synthesize’ the codes that appeared often or made the most analytical sense to develop into categories for further testing and analysis (Charmaz, 2014, p. 138). This was an often-messy procedure as I reviewed and changed codes and categories to accommodate new data and ideas as they arose. Coding examples are shown in Appendix D. Finally, I integrated categories into a theoretical scheme (Corbin & Strauss, 2015).

Glaser (1998) discussed the danger of grounded theory researchers ‘forcing’ data into preconceived notions and theoretical frameworks. Glaser advised there was ‘no need to force meaning on a participant, but rather a need to listen to his genuine meanings, to grasp his perspectives, to study his concerns and to study his motivational drivers’ (1998, p. 32). Co-constructing and analysing data through interaction with the students in the workshop helped increase my theoretical sensitivity, reducing the likelihood that I would see things from ‘one angle’ or be limited to preconceived concepts (Glaser & Strauss, 1967, p. 46). I integrated the data from the workshop into existing codes created from the dataset. As with data collected from focus groups and interviews, I systematically analysed the data until no new insights or connections were revealed about the emerging theory (Charmaz, 2014).

Birks and Mills (2015) advanced the use of storyline as a mechanism to aid analysis and theoretical integration. The storyline is an abstract construct that illustrates the connection between concepts and explains theory (Birks & Mills, 2015). Glaser maintained the storyline should not be used as a framework to be imposed on data, but that the data should direct story development (Birks & Mills, 2015). I used a storyline to help understand what was happening in the data and weave the concepts emerging from analysis into theory

(Glaser, 1998). I also used it to communicate the developing theory with my advisors and CRG mentors.

Constant comparative analysis continued during the process of writing the thesis. Writing required I return to the data to confirm or revise my concepts. New ideas and connections often emerged as ‘thought happened in the writing’ (Richardson & St. Pierre, 2005, p. 970). I wrote this memo on one such occasion:

This is about more than just ‘valuing midwifery’—value is intrinsic, the students valued midwifery sure, but they took action to improve, they made the decision to enrol in midwifery because of their experiences where they didn’t have the expertise and that’s why specialisation was valued. (Memo, 2 February 2018)

5.5 Returning to the field

I returned to PAU in December 2017, the purpose of the trip being twofold. In the spirit of reciprocity, I was a member of a JCU team conducting a cross-disciplinary journal-writing workshop for PAU academic and research staff and postgraduate students. The workshop aimed to improve the academic writing skills of participants, with the strategic objective to increase PAU authorship of peer-reviewed journal articles and thereby increase the university’s international research profile.

I presented the key findings and grounded theory at an SOHS research symposium. In accordance with decolonising methodologies, this was an opportunity to authenticate the theory derived from the data with people involved in the research and its outcomes. I

provided a detailed account of my research findings and the grounded theory, with implications for teaching and learning in the midwifery programme, and more broadly, for maternal health care in PNG. Health science staff and the wider PAU teaching, research and student community attended the symposium, as well as community health workers (CHWs) from across PNG staying on the PAU campus for two weeks of professional development.

The audience mix of academics, researchers and health care workers from the field required my work be both intellectually and practically sound and engaging. I received positive feedback on my presentation and the grounded theory. The questions and comments contributed to final modifications to the theory. While a detailed evaluation of the grounded theory presented in this thesis is included in Chapter 8, audience comments demonstrated my theory met the criteria outlined by Glaser and Strauss (1967) and Glaser (1978): The theory was understandable, fit within the field of its intended use and had relevance for the PNG health care workers and researchers attending the symposium. One attendee remarked, ‘I was glad to see the model situated within a contextual environment, this is an important aspect—most ex-pat research omits context.’

Other comments indicated the theory had a level of modifiability to accommodate variation without losing relevance (Glaser, 1978). The Dean of Research stated the theory captured well the PNG lifestyle and envisaged using the model in projects across other disciplinary fields. A nursing lecturer suggested the model had application for nursing students. It was evident that the theory grounded in the data gathered and co-constructed with the student participants added to the audience understanding of stillbirth and the provision of care to women experiencing stillbirth in PNG by PAU midwifery students. This was the first step towards the implementation of recommendations in the midwifery curriculum. At the conclusion of my address, I presented a small gift to each of the midwifery lecturers, the

Dean of the SOHS and the Dean of Research, to show my appreciation for hosting me and for their generous assistance throughout the research project.

5.6 Engaging with the literature in grounded theory research

In most strategies of inquiry, engagement with the literature occurs prior to data collection to position the study within the existing body of knowledge (Creswell, 2013). The place of the literature in grounded theory studies is contentious, with debate focused on when and how to utilise relevant literature (Dunne, 2011). Glaser and Strauss (1967) advised that the researcher should undertake the literature review after data collection and analysis to avoid imposing extant concepts and frameworks on categorisation, thus ensuring theory derives from the data and the researcher's own ideas (Charmaz, 2014). While this may be a theoretically sound principle, engaging with the relevant literature during the later stages of the research process is impractical for many researchers (Dunne, 2011). In the ensuing years, grounded theorists have acknowledged that researchers bring their own theoretical and experiential knowledge to a study (Charmaz, 2014). Additionally, institutional requirements for research proposals and grant applications often necessitate knowledge of extant studies and theories in the researcher's chosen area of study (Charmaz, 2014). Adopting a pragmatic approach, constructive grounded theorists typically conduct a literature review during the early stages of the project, setting this aside while developing categories and the analytical relationships between these (Charmaz, 2014).

In this study, I engaged with the literature from the outset, reviewing the literature about stillbirth, midwifery staff and PNG for the purposes of university requirements and grant funding. As an emerging researcher, I used this first literature review to understand 'the

parameters of the conversation I hoped to enter' (Lempert, 2010, p. 254). I conducted several small literature reviews in the early stages of the project that helped develop my knowledge of grounded theory methodology, assisted my decision-making on how to combine data collection methods and enhanced my theoretical sensitivity. Following collection and co-generation of primary data, analysis and theory construction, I once again engaged with the literature, conducting a substantial review to position the theory in the extant body of knowledge.

5.7 Summary

In this chapter, I have:

- described the application of constructivist grounded theory and decolonising methods in the conduct of the research
- provided an ethics statement
- discussed the contribution of a cultural reference group (CRG) to the study
- described the process used to select data collection methods and their combination of use
- explained methods of sampling, data analysis and theory construction
- introduced and discussed my use of memos and diagrams as an analytical aid.

In the following chapter, I will:

- present a conceptual overview of the constructed grounded theory followed by an explanation of the contextual environment from which the theory emerges.

Chapter 6: Findings—Part 1

*My culture, it's social, we have socialising, understanding how we relate to each other, and then we have this spiritual belief as well, and then emotional aspect of the woman herself... when I want to **balance it out**, I go back to what's the cause of the stillbirth, sometimes it would be a medical condition, sometimes the woman can go through a lot of problems, social problems... As a nurse, it's good to find out too, to be holistic, if the woman is spiritually, because I come from a Christian background I have to know if she's got some problems with the husband or other problems that can contribute to the stillbirth. (Naomi)*

6.1 Chapter outline

In this and the following chapter, I present a theoretical model describing how midwifery students at a university in PNG understand, experience and manage the provision of care to women following stillbirth. The central concern for students was providing the best possible care to women following stillbirth in the setting in which they worked. The experiential process of 'Balancing It Out' incorporates three relational dimensions of 'Becoming a Midwife', 'Traversing Different Belief Systems' and 'Dealing with Feelings', which enables the students to provide the best possible care to women following stillbirth (see Figure 6.1). In this chapter, I present a conceptual overview of the theory followed by an explanation of the contextual environment from which the theory emerges. In the next chapter, I describe the three relational dimensions with supporting data. The grounded theory presented explains how midwifery students experience the phenomenon of stillbirth, including implications for the provision of midwifery care to women.

6.2 Conceptual overview of the theory

*I want to provide all **the best possible cares** to all the woman, from antenatal, intrapartum, in the delivery to postnatal. (Leah)*

The theoretical model emerges from a contextual environment in which the study participants live and work as they provide midwifery care. The key purpose of the students, and core concern of the theoretical model, was how to provide the best possible care to women following stillbirth. This was an in-vivo code gifted from a student during an interview. Commencing specialised study, students desired to become professional, competent midwives to provide optimal maternity care to women. The process by which the students were able to provide the best possible care to women following stillbirth was through balance, a recurring concept present throughout this constructivist grounded theory. ‘Balancing It Out’ was an experiential process used by students to manage tensions within and between the three dimensions of ‘Becoming a Midwife’, ‘Traversing Different Belief Systems’ and ‘Dealing with Feelings’ (and their attributes), to provide midwifery care to women following stillbirth.

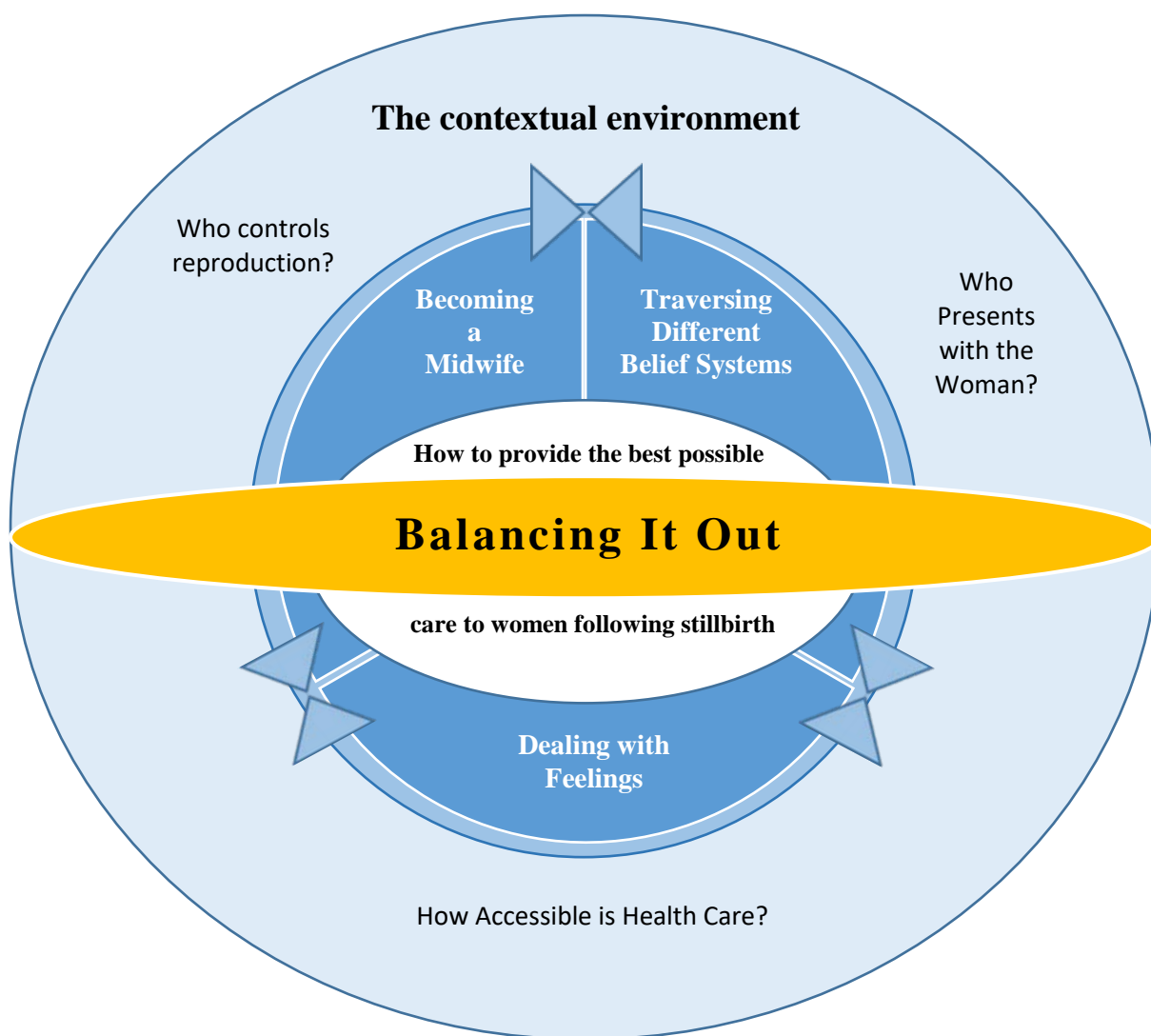


Figure 6.1. Theoretical model: How to provide the best possible care to women following stillbirth by ‘Balancing it Out’

6.3 The contextual environment

The theoretical model emerges from a broader contextual environment that includes the three dimensions of: (i) ‘Who controls reproduction?’; (ii) ‘Who presents with the woman’; and (iii) ‘How accessible is health care?’. These dimensions both enable and constrain how midwifery students experience and manage the provision of care to women in their communities (see Figure 6.2). The dimensions are not represented hierarchically in

terms of how they enable or constrain the provision of the best possible care to women following stillbirth but instead, detail interconnected social, cultural and professional factors that influence care provision. Students' stories demonstrated how their understanding and behaviour derive from the conditions of living in a particular place and time and from interactions with established systems and structures.

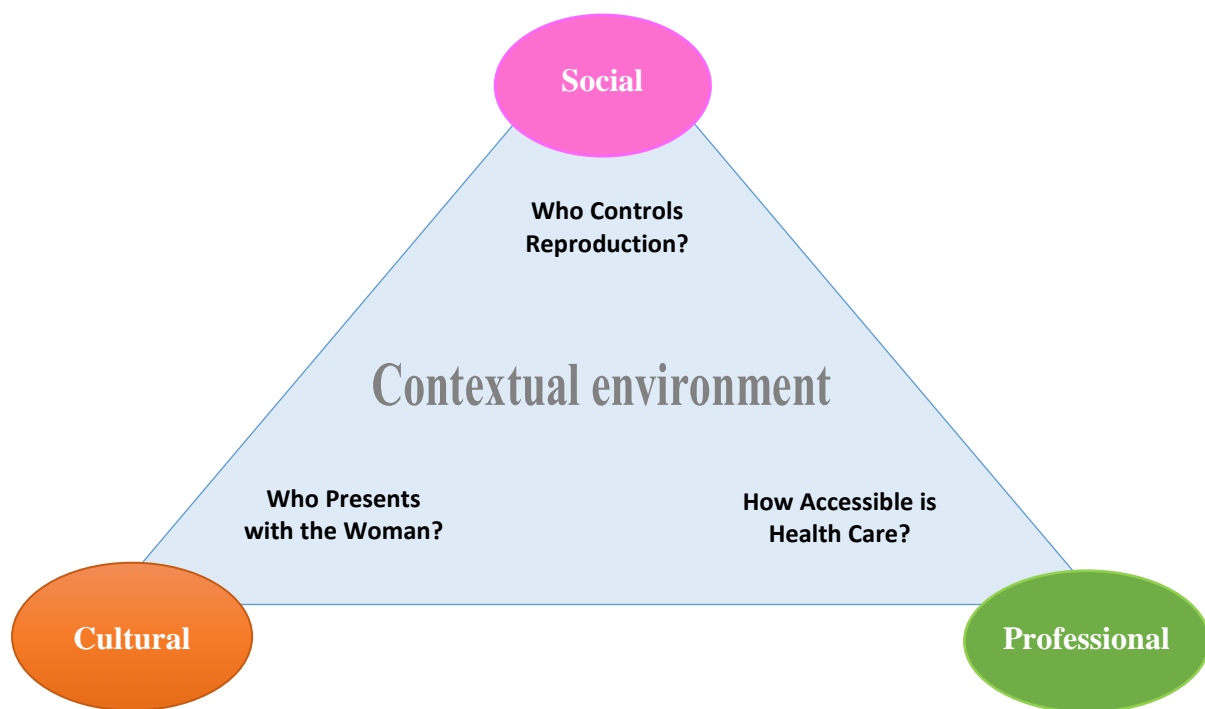


Figure 6.2. The contextual environment and its dimensions

6.4 Who controls reproduction?

‘Who controls reproduction?’ describes the social structure in which men seek to control the reproductive choices of women, attempting to deny a woman her reproductive autonomy. This involves the woman’s right to seek information regarding her reproductive health, the right to choose how many children she has, the right to family planning and the choice of contraceptive method. ‘Who controls reproduction?’ consists of the two related

attributes of ‘power relationships’ and ‘women are childbearing people’ emerging from the data (see Figure 6.3). The students spoke of power relationships that illustrate how deep-rooted notions of patriarchy diminish a woman’s capacity to exercise autonomy for her health and wellbeing. In ‘women are childbearing people’, an in-vivo code gifted from a student during a focus group discussion, students described how gender-defined roles within the family and community perpetuate the view that it is a woman’s duty to bear many children, even to the detriment of her own health.

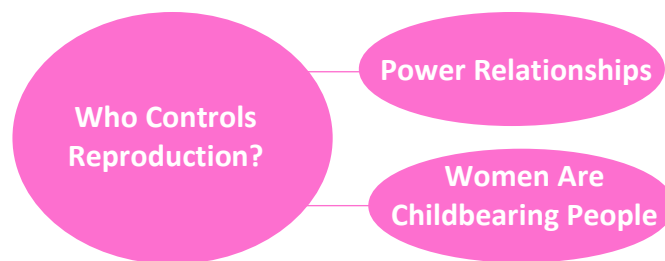


Figure 6.3. The dimension of ‘Who controls reproduction?’ and attributes

6.4.1 Power relationships

A hierarchy of power exists in many parts of PNG where men are often authority figures who desire to control familial and wider relationships in the community. This social construct undermines the autonomy of many PNG women in daily life. Most midwifery students came from regional areas within PNG where the social structure is patrilineal and largely clan based. In Rebecca’s place, *‘Men is regarded as super decision maker.’* Students had extensive information about the status of women in their communities through their lived experiences and observations. Women’s status was described as being low. Johanna said, *‘In my place, the men are more dominant over the woman... we see that the men are more*

superior than the woman.’ Nathan, providing a man’s perspective on relationships of power, agreed with his female peers, reporting, *‘In my community... the men is in charge... most rights of the womens are deprived.’* Women such as Naomi understood their limited capacity to participate in the decision-making process:

Sometimes the women don’t have the power to say no. Mostly it’s the men that they think that within the society, we think that men have the right to make all the decision... [Women] don’t have the choice because the man is in authority.

When discussing power relationships, several female students spoke about the custom of men paying bride price to a woman’s family upon marriage. Men are valued for their physical strength and because they remain culturally and socially connected to ancestral land, they said; however, in places where the bride price system operates, women are financially valuable. Marie explained that in these situations, families *‘will be happy they have more girls, coz there’s more money coming in’*. Students related that bride price included monetary payment but could also comprise livestock, such as pigs and chickens; garden foods, including staples, such as sago or *kau kau*⁹; and traditional woven *bilums*¹⁰. Once married, a husband expects a woman will be a compliant spouse. In Johanna’s place, *‘When the men pay bride price that’s it, the woman will have to submit to the husband’*. Following the payment and marriage, a woman is expected to leave her home village to begin a new life with her husband, living under his control. Eva clarified, *‘The husband will take over the woman and the woman will stay in his village and bear his children and become part of his family... sometimes she can be allowed to go and visit her family, her parents, her village’*.

⁹ Sweet potato.

¹⁰ A handmade, woven string bag.

Men seek to extend their authority over women in matters of reproductive health and family planning. Johanna explained, *'When it comes to contraception and pregnancy, the man decides whether the woman will continue to bear children or it's the time she will stop'*. Eva said the husband's authority was validated by his payment of the bride price, and the notion the woman was now the husband's property: *'The man makes the decision how many kids he want because he paid the woman already... in other words, he owns her so how many kids he wants, it's all up to him.'* In Eva's experience, if a woman had concerns about her reproductive health, she needed to seek her husband's permission prior to visiting a health care facility: *'They [men] don't consider the health of the mother... it's the man who is controlling the wife.'* Some women faced punishment for seeking family planning without their husband's consent. *'They go to the clinic to get help, but when the husband somehow caught them, he used to bash them up or ask them "Why you did not get the permission from me?"'* said Eva.

6.4.2 Women are childbearing people

Students explained about the socially accepted roles for men and women regarding pregnancy and birth. A man's sole role was to impregnate his partner, as Abby laughingly said, *'Men is just there to make the woman fall pregnant'*. Large families were desirable and earned parents respect from the community. *'We believe that the more children you have the more respect you will have... and the earlier you have children it will be better,'* explained Marie. In some areas, women gained a greater level of respect when they gave birth to a boy. Males in Hannah's province are valued because of their ability to fight in intertribal disputes, and therefore: *'For a woman to have a child, especially male, it's considered something good, so they can carry on and fight.'*

In many regions of PNG, it is a woman's duty to give birth. Naomi said, *'In my community they see women as childbearing people... regardless of how many children they have, there's the task to be pregnant and continue with the family'*. There were similar expectations along gender lines in Abby's community: *'Men, they are the head of the family and for the woman, ladies, our responsibility is to give birth.'* Students knew about societal expectations that women have large families and the associated risks of closely spaced, multiple pregnancies to mother and baby. Naomi recalled what villagers told her when she was on midwifery practicum in a rural area:

They said that a woman must continue to bear children because if they don't bear children then they are not strong... A strong woman gives bearing children for the man until he's got many children, at least 10 or more than 10, which is too much for the woman because she's got lots of household duties to do, gardening, looking after children, looking after the animals, pigs, it's too much for them... that's when mothers go into complication and things like stillbirth happens.

In addition, Marie spoke about the concept of strong women, and women's accordance with the notion in her community: *'They believe the more children you have, the more stronger you are, so woman just, they don't want to be left out so they have more children.'* Students admitted expectations surrounding pregnancy and reproductive health for women remained constant. As a male, Nathan acknowledged that, *'It's the role for woman to do most pregnancy, childbirth and all this, despite family planning we still have this influence in our society'*. Abby agreed, commenting, *'They say childbirth is part of a woman's job... our man, even though most of them are educated, I would say we still have this mentality within us'*.

6.5 Who presents with the woman?

‘Who presents with the woman?’ explains how cultural beliefs and practices establish who presents with a woman during her interactions with health care providers throughout pregnancy, labour and the postpartum period. ‘Who presents with the woman?’ consists of the two related attributes ‘expecting women’s support’ and ‘inviting men’s support’ (see Figure 6.4). In ‘expecting women’s support’, students described the notion of pregnancy and birth as women’s business, and the expectation for women to provide ongoing support to the woman and accompany her when she presents for care. ‘Inviting male support’ describes how hospital policies and practices deter men from being present to support their wives and be an active, informed partner in the care of mother and baby. Students saw this as a constraint to the increased participation of men in maternity care, yet identified opportunities to affect change through the care and education they provided.

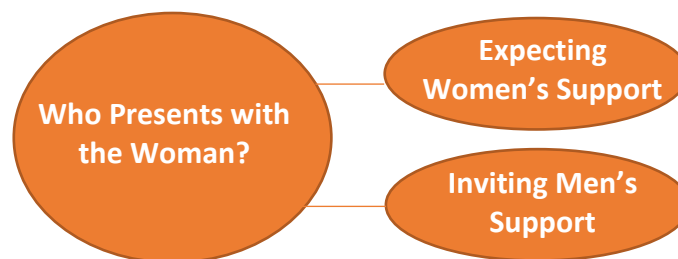


Figure 6.4. The dimension of ‘Who presents with the woman?’ and attributes

6.5.1 Expecting women’s support

Cultural norms vary from place to place and what is customary in one geographical area is not necessarily so in other areas. Yet, students reported most PNG cultures consider pregnancy and birth to be women’s business and that it is not customary for PNG men to

support their wives during labour. *'Men are not involved, it's against traditions, culture, yeah'*, Candace said. Many students knew about the belief that men lose their virility from coming into contact with women's blood when they support their wives during labour or during the postpartum period. Eva explained, *'The fresh blood and the fresh death of the delivery is still fresh on her hands... so the husband is not allowed to eat from her hands, that's what they believe'*. Students perceived peer pressure was a factor influencing a man's decision to present to the service with their wives. Abby revealed why she thought most men chose not to be involved:

They'd feel ashamed, people might laugh at them, they might tell them 'Hey, this is woman's business, you're not supposed to do that' or they gonna lose their strength... I would say most of the men are custom culture men; they wouldn't like to come into the labour ward, they would say, 'No, this is the woman's place, it's not for us men to enter that place'.

Students noted it is female family members who provide support to women during pregnancy, in the absence of male support, and present with the woman at the local health care facility. Support could be physical, financial or emotional. Nicole described the typical support she would provide:

Women sort of help each other when someone is pregnant, like if my sister is pregnant then I would be helping her, supporting her if she doesn't have money or if she needs something to be done I can help her do that... going to the garden or carrying heavy billum or things like that... going shopping, or I can bring her to the hospital, support

her when she delivers... after delivery too, mostly it's the woman that take cares of the woman who delivered.

Women giving birth in health care facilities are seldom there alone and at this time; the strongest bonds are between female family members. Leah explained:

In Papua New Guinea, we say during delivery time it's only the birth attendant and the guardian, which is supposed to be a female guardian, to come and witness the birth, and husbands are always waiting outside... it's going to be her mother, or sometimes the mother-in-law or sister... what sometimes we say, 'No, I feel comfortable with my mummy in the delivery room'.

6.5.2 Inviting male support

While students conveyed the common understanding of pregnancy and birth being women's business where women supported women, they also reported some men take a different stance. *'There's some good guys who would help their wives or sisters or daughters'*, Nicole said. Education was seen as a major influence on PNG men's approach to health care for their wives. In Abby's experience, men with a formal education often presented with their wives, *'Educated ones, they always come and stay with their wives'*. Naomi suggested, *'For [the] educated population, probably their husband help them to seek health services, whether it be antenatal or delivery or postnatal or family planning'*.

Hospital policy may determine whether men are able to be present during birth. In the labour ward of the hospital where Abby had worked, providing privacy for the women was a

concern for the staff, and therefore, *'When there's one mother in labour, we don't allow men to come in because of the privacy. That's the reason why we tell them to stay outside. Maybe I think partly it's our fault as well, we the health workers'*. Naomi explained that in her work place, the structure of the health facility affects men's participation in maternal health care:

Every services that are provided are woman centred... the man feel out of place, that's why they don't want to go... they don't provide something for the man, it's always the woman, so they feel that there is no need for them going in there with their woman, accompanying their woman to any health services.

Although aware of the challenges of changing longstanding cultural beliefs surrounding pregnancy and childbirth, students believed that they had a role to play in promoting men's involvement in maternal health care, to raise men's awareness of the process of pregnancy and birth. Naomi assumed, *'Probably through research we'll come up with some ways, we'll find out more about men in maternal health services'*, noting, *'As a student midwife, it's good to involve men more... so he knows what good and complication the woman probably go through'*. During antenatal clinics, Nathan encourages women to bring their husbands to their next clinic appointment:

Through health education and proper education during antenatal clinics, we see some of the men turning up during deliveries... I'll tell their wife and then they come back with the men... this employ a good idea we introduced to them and then most of the men they said, 'It's very nice, you are helpful'— it's working good for them.

6.6 How accessible is health care?

Students are experienced health practitioners working within the PNG health system. They are required to have nursing experience to enrol in a midwifery programme. They identified systemic issues they believed affected equitable, effective service delivery and health care access. ‘How accessible is health care?’ consists of the three attributes of ‘service disparity’, ‘finding the money’ and ‘confronting geography’ (see Figure 6.5). ‘Service disparity’ illustrates how an unevenly resourced health system affects the provision of quality maternity care. ‘Confronting geography’ outlines how the PNG landscape affects both maternity care provision and access to care. ‘Finding the money’ describes the financial barriers women face seeking care that may be accessible but not necessarily affordable. Students considered increased training in midwifery skills for nurses and other health care workers has limited impact when resources are deficient and most of the population face geographical and financial barriers to accessing skilled care during pregnancy and birth.

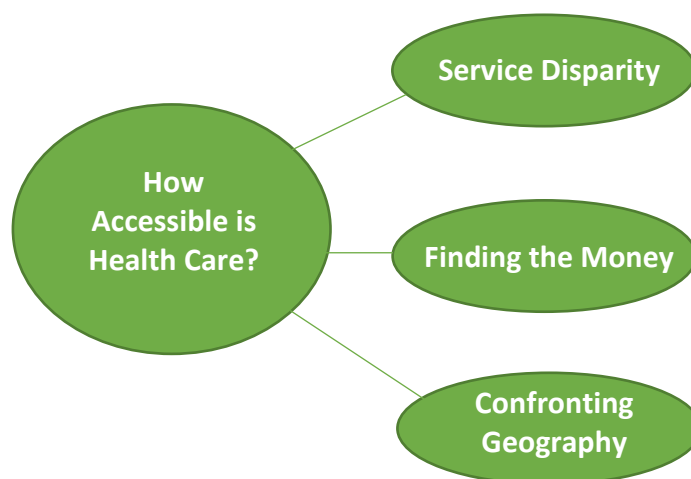


Figure 6.5. The dimension of ‘How accessible is health care?’ and attributes

6.6.1 Service disparity

Students described the health care facilities in which they had worked, and it was evident from their responses that the PNG health care system remains unevenly resourced in both human and material terms. This factor directly affects the provision of maternity care to women. Prior to enrolment in the midwifery programme, students worked in a variety of clinical settings, some in better-resourced regional hospitals with larger staff numbers, including overseas practitioners. Nathan stated at the hospital where he worked, *'Most of our doctors are internationals... the only nationals are we nurses'*. Students reported larger hospitals had better facilities, including designated obstetric and gynaecological operating theatres and medical equipment to manage complicated cases. Foreign specialist doctors often supervised and trained staff with various qualifications ranging from CHW to midwife, obstetricians and gynaecologists. In the hospital where Rebecca worked, an international gynaecologist conducted an in-house training programme: *'Upskilling midwifery for those CHWs, the community health workers, so they had courses for six months then they get certificates, so all of them are CHW midwives.'*

Rural and remote health services do not have the same level of resourcing as provincial hospitals. Universal health care does not exist in PNG and many communities have never had access to state-provided health care. In other areas, existing health facilities have deteriorated and not been replaced. Reuben recalled with a mix of sadness and frustration:

From my village, we do have one in the past when I was a small boy that I could remember, and that has gone, ceased from our community. No building or evidence of a facility existing. The people are disadvantaged, especially mothers.

Students told of the decline in regional public health services. Naomi provided a depressing portrayal of the problems she encountered working in the labour ward of a district hospital:

We lack some of the equipment that we need to use... even the manpower, qualified staff who can deal with complications... we don't have enough beds for the increasing number of women who are coming in, even the delivery bundles we use that consist of a kidney tray and forceps and suturing... then there's problem with the sterilizer... when the sterilizer is not working we can't use unsterile bundle on next woman.

Issues with material and human resources are not limited to government health care facilities. Reuben described the conditions at a faith-based centre where he worked:

There is no proper delivery bed for the mothers... it's like a first aid set up, even though it is called a health centre, it's not up to those standards to meet their requirement, to meet what the expectation of those patients or clients coming into their care.

Reuben noted CHWs staffed most health care facilities outside urban areas. He explained the challenge government and private health care providers face in attracting and retaining qualified staff to work in rural and remote areas:

Fewer nursing officers are seen there because some of them think of having easy access to life and they don't want to live in remote areas, so that's why the most of them just go in and come out for good and don't go there.

6.6.2 Confronting geography

Students spoke about the geographical barriers women face trying to access skilled midwifery care. In the province where Hannah worked, *'Due to the geography of the location, high mountains and all this, they usually come on choppers but most of others... they travel on vehicles and sometimes they walk'*. Marie regarded the situation for women living in rural communities in her province:

Those in the villages, they don't get much health care services unless they make it to town for delivery or they're referred... the health services, it doesn't reach everyone... very few have access to good health care facilities.

Time was an identified issue of life and death for many women living long distances from a health care centre, both for themselves and their babies. Abby described the standard procedure for air transfers of emergency obstetric cases at her hospital:

When there's an emergency, our doctors or our HEO, the Health Extension Officers, they call --- General Hospital, the provincial health people, they're the ones responsible to charter the plane... they call back telling us the plane will come on that time... then we got the patient on the ambulance and we transfer them to the airstrip and then they got on the plane and then they go.

Transferring women with pregnancy complications to larger health care facilities can be problematic, owing to not only great distance and rugged terrain but also staff knowledge

and abilities. Eva recalled she organised ambulance transfer for a woman in labour from her clinic to the nearest health centre. An hour later, the ambulance returned:

They came back to the clinic because she delivered on the road and the driver, they don't know how to do it and the baby is still hanging on the cord and they just turn and they ran back to the clinic.

Marie's comment regarding the clinical management of complicated cases in pregnancy highlights issues of maternal health care provision for women living in rural and remote areas of PNG:

We refer cases to the city... two hours by road, our ambulance service is there, some cases, we do have deaths on the road, some women die in the ambulance, or some women die in the facility because there wasn't enough medication or no proper management, so it needs some improvement when it comes to maternal health.

6.6.3 Finding the money

In addition to these geographical barriers, students acknowledged the financial barriers women faced in accessing maternal health care. People living a subsistence lifestyle have low financial incomes, with the situation made more difficult when living in a remote area. Reuben had lived and worked in remote areas and explained, *'To find 50 kina, it will take you two months because of the accessibility and the level of economic, or how the money is going in is very low. There's no market because of swampy areas... to find money is very hard'*.

Students reported private hospitals charge high fees for maternity services, particularly in areas where there are no other existing health facilities. Hannah detailed the fees for supervised deliveries and management of complicated deliveries at a regional private hospital:

There is only one health facility there and it is a privately runned – there is no government [run health facility]. And people all over the valley, they are usually crowded over this one hospital and they are charging them big money, like 250 [kina] for a normal delivery, and if they face any complication or that, and if they want to go for operation - we normally call it caesarean section to cut the baby - that is around 650 [kina].

Hannah went on to explain that while all women are able to access the private hospital facilities, only some women could afford the cost of a supervised delivery. Hannah identified this posed a health risk to mother and child for women without the necessary funds: *‘They usually delivers at home... later they come to the hospital when they face any problems to do with the delivery.’*

6.7 Summary

In this chapter, I have:

- presented a conceptual overview of the grounded theory of how midwifery students at a university in PNG provide the best possible care to women following stillbirth

- summarised the contextual environment from which the theory emerges with themes emerging from student focus groups and interviews
- described the social, cultural and systemic dimensions the midwifery students experience that enables and constrains how they manage the provision of care to women in their communities.

In the chapter that follows, I will:

- describe the three central dimensions of the experiential process of ‘Balancing It Out’
- describe the attributes of each dimension.

Chapter 7: Findings—Part 2

7.1 Chapter outline

In this chapter, I present the second part of the grounded theory. The experiential process of ‘Balancing It Out’ enables the students to provide the best possible care to women. ‘Balancing It Out’ incorporates three central dimensions: (i) ‘Becoming a midwife’; (ii) ‘Traversing different belief systems’; and (iii) ‘Dealing with feelings’. In this chapter, I describe each of the three dimensions and their attributes identified from the data. ‘Balancing It Out’ is a complex process with interconnected and dynamic dimensions and attributes. Students viewed ‘Becoming a Midwife’ as the means to balance nursing and specialist midwifery knowledge and skills to provide balanced maternity care to women following stillbirth. In seeking to provide respectful, balanced care to women and their families experiencing stillbirth, students were ‘Traversing different belief systems’ as they sought to make sense of the stillbirth event for themselves and the women in their care. Following their experiences of care provision, students took action in ‘Dealing with feelings’ to balance their own wellbeing for providing the best possible care to women following stillbirth.

7.2 Becoming a midwife

The Bachelor of Midwifery programme aims to prepare students to meet the needs of women during the antenatal, birth and postpartum periods through specialist education and clinical practice. ‘Becoming a midwife’ is a central dimension that explores how students were transitioning from being a nurse to being a midwife, seeking to provide optimal, balanced maternity care to women. ‘Becoming a midwife’ incorporates the attributes of

‘preparing to care’, ‘practising care’ and ‘being a male midwifery student’, as shown in Figure 7.1.

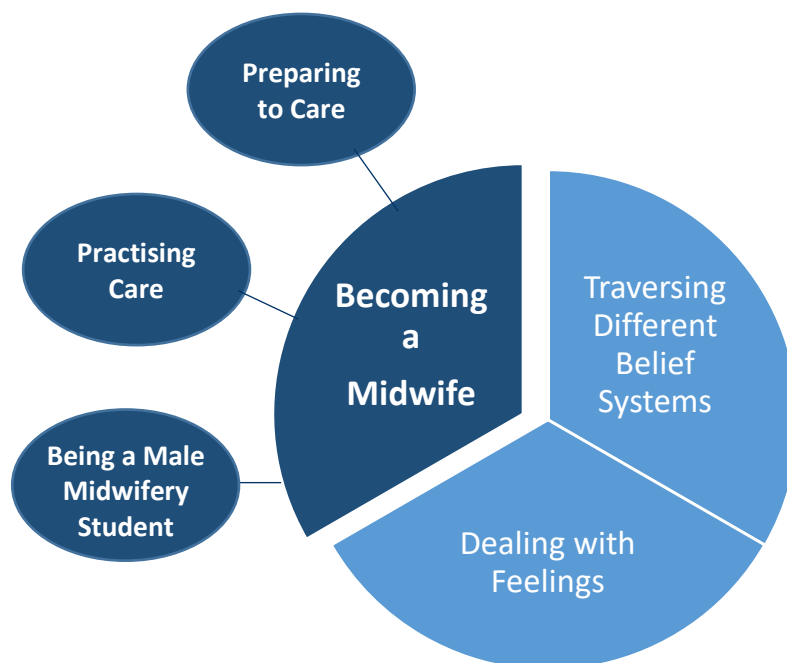


Figure 7.1. The dimension of ‘Becoming a midwife’ and attributes

‘Preparing to care’ begins with students making the decision to become a midwife and enrol in the PAU Bachelor of Midwifery degree programme. Students, on undertaking specialist studies, were learning more about stillbirth as they progressed through the programme, gradually gaining confidence in their ability to provide clinical care to women with pregnancy complications, including stillbirth. Transitioning into their new roles as midwives, students felt they would be making a difference by helping women avoid the risk factors contributing to stillbirth. With their increased knowledge and newfound confidence, students were able to offer suggestions for improving the PAU curriculum, with inclusion of a module on stillbirth, which they saw as a means to improve midwifery care for women.

Clinical placements and practicums during the midwifery programme provided students the opportunity to apply theory to practise. 'Practising care' introduces the concept of holistic care and illustrates aspects of midwifery care in PNG health care settings for women experiencing stillbirth. Despite the emphasis on providing holistic care to women, students were focusing on the physical when providing care to women experiencing stillbirth. Caring for the stillborn baby was a low priority, with the level of care dependent on staff attitudes and the type of clinical setting. Students with a strong Christian faith viewed that supporting the woman spiritually was an important aspect in their care provision. In recognising the emotional impact of stillbirth, students tried to be empathetic in effecting emotional care, at the same time addressing social issues within the limits of their professional practise.

'Being a male midwifery student' describes the experiences of the male midwifery students who participated in this study and the challenges they faced as men balancing their care for women in cultures with strong beliefs about the roles of men in the pregnancy, birth and the postnatal period. Community perceptions that male students were becoming similar to a woman because of their intimate physical care to women during childbirth juxtaposed with the view that male students are vagina voyeurs when the nature of midwifery care is sexualised. As PNG men studying and working in a predominantly female profession, male students were conscious of managing their masculinity to minimise gender issues when providing care. Studying midwifery resulted in the male students changing perspective about issues of gender equality in PNG society and the role of gender in customs surrounding pregnancy and birth.

7.2.1 Preparing to care

Students had nursing experience prior to undertaking midwifery studies and did not always self-identify as midwifery students or midwives, commonly referring to themselves as nurses or health workers providing nursing care. After graduation as nurses, they were often responsible for women's maternity care without the required knowledge and expertise to deal with pregnancy complications, such as stillbirth. This was especially the case for those students working as nurses in rural and remote settings. Eva worked as the nursing officer in a company clinic prior to midwifery studies, assisted by a CHW. The company operated at multiple sites, each with a clinic providing basic health care to employees and their families. Eva lived and worked in one clinic providing on-call care: *'So there's no escape from the patients, they come in the middle of the night and call for me.'* For pregnant women, Eva provided, *'Routine antenatal care... giving them the anti-malarials and Fefol [iron supplement]... We used to refer our critical cases or any other case that we cannot handle to [the doctor or nursing superintendent], then they refer to ---- General Hospital'*. Reuben previously worked as a nursing officer in charge of a small team, delivering health care to a geographically dispersed population. Reuben described how demanding a task this could be:

There are four of us; we took care of a total population of 15,000, that's our facility alone. It is made up of almost 25 to 30 communities, they are scattered around the region... we have mobile, we have static and we have patrols. Patrols is we do foot walking, where there's no way for car to travel, we have to travel in and sleep with the people... we do integrated approach, when we go for immunisation for babies, we do also maternal health.

Making the decision

Students enrolled in the midwifery programme because they wanted to learn specialist midwifery knowledge and skills to help save the lives of women and their babies. Students had provided care for the mother of a stillborn child while employed as nurses in urban, regional or remote settings; however, not all had experienced caring for a mother following stillbirth while a midwifery student. It was evident that students placed great value on gaining specialised midwifery knowledge and skills. For some students, this value stemmed from their experience of a maternal death or stillbirth while nursing and an understanding that their lack of specialist midwifery skills contributed to a death. Abby recounted that following one delivery, *'The baby wasn't making any noise, he was born flat'*. She explained further:

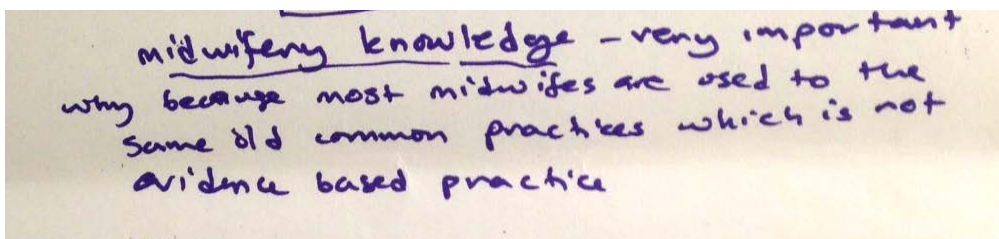
That time, I did not have any idea about how to resuscitate, I'm just a general nursing officer, but I don't have an in-depth knowledge about midwifery and then after that I came here, I realised my mistake.

Candace was motivated to become a midwife after her experience caring for a woman following stillbirth: *'I wish at that time I had more midwifery, I was specialised so I can counsel her and do everything for her.'* Reuben reflected on how his own experiences of maternal death and stillbirth while nursing influenced his decision to become a midwife:

When I sit down, I always look back and it's when, during this time I am here, I am regretting that if I have this knowledge, I could have helped this mother... Last year I lost three lives ... it wasn't my fault because of the knowledge I have... That made me

to have life midwifery. I didn't have a choice... because of these issues, I had to get the paper and apply for midwifery.

Many students had made personal sacrifices to come to PAU, leaving behind young children and family in the provinces. Some students had resigned from their nursing roles, while others had taken a leave of absence from their substantive nursing positions to undertake midwifery studies. Upon graduation, these students would return as qualified midwives to boost the number of staff providing skilled assistance, as Abby explained: *'Midwives, you've got two midwives, and I'll be the three, the number three when I go back.'* Reuben felt honoured to be a student on the course and had high expectations of what he would learn during the programme: *'I'm very privileged that I'm currently here to do my midwifery education and going back I know that all those unanswered questions in that health service will be answered through this knowledge that I'm gaining.'* Students acknowledged the importance of evidenced-based practice in midwifery care. During the stage three workshop, a student noted, *'Midwifery knowledge—very important. Why? Because most midwives are used to the same old common practices, which is not evidence-based practice'* (see Figure 7.2).



midwifery knowledge - very important
why because most midwives are used to the
same old common practices which is not
evidence based practice

Figure 7.2. Workshop: importance of midwifery knowledge

In making the decision to become a midwife, students sought to have a balance of nursing and specialist midwifery skills. Marie declared:

I think that midwifery is important coz you can do anything but if you're not a mid, if you don't have knowledge in delivering a baby and if you're a nurse, it will be no more effective than if you're in the bush, because I think it's a field of its own.

Learning more about stillbirth

Students had varying levels of knowledge about stillbirth prior to enrolling in the midwifery programme. Few students recalled learning about stillbirth during their general nursing studies. Eva remembered the nursing curriculum had focused on, *'Normal pregnancy, normal delivery like, what me as a general nurse can manage to do'*. Abby recollected, *'We just study the general—how to give help I mean, to help assist the mother during the delivery and all this and what drugs to give'*. Marie bluntly stated, *'I don't remember learning anything about stillbirth'* as regards her general nursing training.

All students said they understood the WHO definition of stillbirth, yet some students interspersed the term stillbirth with miscarriage¹¹, or were confused about the terms stillbirth and fetal death in utero (FDIU). One student explained, *'I think stillbirth is where the baby is dead inside the uterus before it is being delivered'*. Another student pondered, *'I'm not too sure whether it's a stillbirth, I think it's a FDIU, well I think FDIU is fetal death, yes fetal death in the uterus. I don't know if it's stillbirth or I need to differentiate the meaning'*.

The current PAU midwifery curriculum does not contain specific information about the provision of care to women following stillbirth. Students were learning that stillbirth is an outcome of medical conditions during pregnancy or from complications during labour. Eva

¹¹ The spontaneous loss of a pregnancy before viability (Fraser et al., 2009).

noted, *'In each of the presentations that they used to come and give us regarding complications, stillbirth is made mention as one of the complication to pregnancy'*.

During the course of their midwifery studies, students were developing their knowledge about underlying risk factors for complications, including stillbirth, as well as their clinical management skills. Rebecca provided her perspective on midwifery specialisation: *'Here we are more onto obstetrics and gynaecology, so I think now we are in a better position to handle such cases.'* Reuben believed midwifery training provided students with, *'the bigger knowledge'*. He related practical training components of the programme to possessing the knowledge and capability to operate specialist equipment:

All health facilities have vacuum [equipment for a vacuum-assisted vaginal delivery], but then it depends on the knowledge, who has the knowledge to do this procedure because those community health workers, they are not required to do such procedures or they are not being [trained so], they can at least help someone who have these complicated deliveries.

Gaining confidence

As they progressed through the midwifery programme, students indicated they had gained confidence in their ability to identify and treat women at risk of stillbirth because of complications during pregnancy and at birth. All students responded they felt better prepared to provide physical care for a woman at risk of, or following, a stillbirth. Eva appreciated the more in-depth learning in the midwifery programme, stating she felt better prepared because:

We also learn about abnormals... abnormal comes with all the complications... to me as a midwife... when pregnant mothers come to my care, if I detect problems in them during pregnancy these problems can alert me to anticipate for such outcomes... when she go in for delivery... I can see the condition or the information of the mother, I can anticipate if the mother may go into complications.

Naomi previously lacked specialist skills to help a woman experiencing an obstructed labour, with turtling¹² of the baby's head. The baby was subsequently stillborn. Naomi now felt more confident to manage similar cases:

Since I went through the course and know the techniques of delivering the shoulder dystocia¹³, probably I'll help in the near future... I mean, it was a preventable death, we wouldn't have lost the baby if we knew, we had the knowledge to deal with the condition, we would have saved the baby.

Students were more confident in their ability to provide physical care to women who had experienced stillbirth. Reuben felt better prepared to implement a care plan following stillbirth:

It helps me, the types of treatment to give, the type of care that should be given to the mother if she has experienced stillbirth, assessing the mother's condition and reviewing the mother's care, if the care is given appropriately or not, if not then evaluate and replan and then we give again.

¹² That is, the fetal head retracts after being delivered, like a turtle retracting its head back into the shell.

¹³ This term refers to the failure of the shoulders to traverse the pelvis spontaneously after the head is delivered (Fraser et al., 2009).

Making a difference

Learning midwifery and gaining confidence, students became inspired to educate others about stillbirth and advocate more broadly within their communities to improve women's health during the antenatal, birth and postnatal periods. Abby declared, *'Everything we are doing now, we are the change of agents'*. The students wanted to make a difference in the lives of women and their families. Nathan was passionate about making positive change in his role as a midwife and had big plans for the future:

I've got list of those contributions or my roles as midwife and community service back to my people...we could be a model community and then I can go out and talk about changing other communities and then they want to talk about, they see that my community's already uplifted, it's ok, and then they all will come in together and then we change the whole entire district... and so we can change the provinces.

In the programme, students were learning that effective antenatal care was the primary means of maintaining a healthy pregnancy, with the recommendation that women attend at least four antenatal appointments. Students believed it was important that midwives encouraged women with a history of stillbirth to attend antenatal clinics during their next pregnancy. Leah reasoned, *'If the first birth was a stillbirth then at least there's an ongoing care with her, so for her next pregnancy she knows what are the danger signs of pregnancy, "I have to come for clinic every time."*' Nathan explained how he would share his specialist knowledge during clinics:

Educate her on the importance of how to care for her own body during pregnancy, to help her and the baby as well, to eat the good type of food, good nutritious food and then the importance of exercise during pregnancy, and if the mother has some behavioural addictions like smoking and drinking, these can lead to fetal death as well, so it's good to advise her to come for antenatal clinics so we can advise them, giving them information about these things so in that way she'll learn to change some of her behaviours.

The PNG government recently proposed a ban on home births to reduce maternal and infant mortality. Marie explained, *'What they're emphasising now is that every woman should have a supervised delivery where they deliver in a health care facility'*. Students understood it was important for women to attend a health care facility for a supervised birth under the care of a midwife, especially a woman who had previously had a stillbirth. Abby said that she would advise a woman that, *'The next time she falls pregnant again she has to come to the hospital and give birth because it's a risk to her, it might happen in the next pregnancy again'*.

Students learned that family planning methods would help a woman physically recover following stillbirth. Rebecca maintained, *'Putting them on family planning is very important because it's just the same as other mothers who have delivered'*. Commonly, this was the contraceptive injection Depo-Provera, lasting approximately three months. Nicole said she would advise women who had experienced stillbirth to consider any underlying health issues that might place another pregnancy at risk: *'If the condition is not better and it means the next pregnancy would be the same, then we advise them to avoid [another] pregnancy.'* Students advocated various family planning methods for mothers depending on

the number of children they already had. Students indicated they would encourage women who had experienced a stillbirth with their first pregnancy to use contraception before having another child, advising women with large families to consider a permanent solution. Eva outlined the rationale underlying these actions:

The first born baby... we'll encourage her to use family planning, maybe one year just to recover and then she can have another baby, but for multigravida, they already have lots of children ... so maybe we can tell her to use family planning, or go for completion, complete permanent method like tubal ligation, we must not encourage her to have another baby again because she already had quite a number of babies... so if she wanted to have another baby again, maybe that baby will die again, maybe she'll go into complications during pregnancy or maybe she can lose her life to maternal death.

Improving curriculum

Owing to the condensed nature of the midwifery programme, students took opportunities for self-education (in their limited free time) when they felt they needed further information or explanation about midwifery concepts. Students sought to balance classroom theory with extra reading to investigate topics not covered in the curriculum, including stillbirth. Following our first meeting, Nathan determined to read further about caring for women following stillbirth. Subsequently, Nathan noted there was a need for more balanced care:

The other time we talk, I go back home and I view some of my notes and I see that most women at this stage, they're psychologically affected, so it's more into emotional support and counselling would be better than any other treatments that the woman could receive following stillbirths.

While students felt the curriculum covered high-risk pregnancy and the physical aspects of care to women experiencing complications, most students suggested a module on counselling skills would assist their midwifery practice. Students believed this would provide a balance between clinical management and the psychological and emotional support for women experiencing stillbirth (see Figure 7.3).

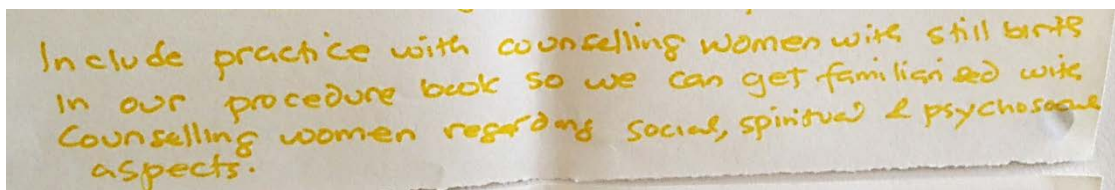


Figure 7.3. Workshop: include practice with counselling

Candace stated, *'How a midwife will counsel and help when [a woman] go through stillbirth, we should learn more about counselling, specific to stillbirth mothers I mean'*.

Abby thought counselling was, *'One of the most important aspect that we should learn, like I've said, counselling is a skill on its own so we need to master this skill'*. Naomi believed women would also benefit from students learning practical counselling techniques:

I really don't know what to do and right now, if one goes through the same thing I wouldn't be prepared to counsel. Generally, I can talk this and that but to counsel

her, it's good to have something to help us, equip us to go and deal with the woman after she's lost the baby, then we can be in a state where we can help her emotionally.

Many students used the term counselling when discussing how they would provide family planning advice for women. Nicole was the one student who noted there was a difference between providing advice and counselling:

I think they should teach midwifery students how to counsel woman and not advise them, where most of the time we're confused with advising and counselling, most of the time we're just advising the woman and we think that's counselling, that's not counselling.

Teaching stillbirth as a discrete topic within the midwifery programme was a popular suggestion by the students. Candace stated, '*For the midwifery students they should have a separate curriculum or at least teach stillbirth in detail*'. Nicole also believed stillbirth was a broad topic that warranted its own place in the curriculum, noting the distinctive care required:

It's different from women who deliver to babies that are alive, the care that we provide for them it's different than the care that we provide for the woman with stillbirth or FDIU baby that are dead in the uterus. I think we should provide different standards of care for them so we can manage appropriately.

What did the students believe the structure of a stillbirth module should be? Ideas on the length and content of a stillbirth module varied among the students. Naomi suggested

stillbirth be covered, *'in a lecture or a few lectures'*. A student in the workshop suggested a standalone topic should emphasise spiritual and social care after stillbirth (see Figure 7.4).

Some students regarded stillbirth as an emergency that should be included as a competency in student logbooks. Reuben declared, *'We learn many things we can forget but what we do on a competency, it's like always when we come across such cases we do it competently so we already know what to do'*.

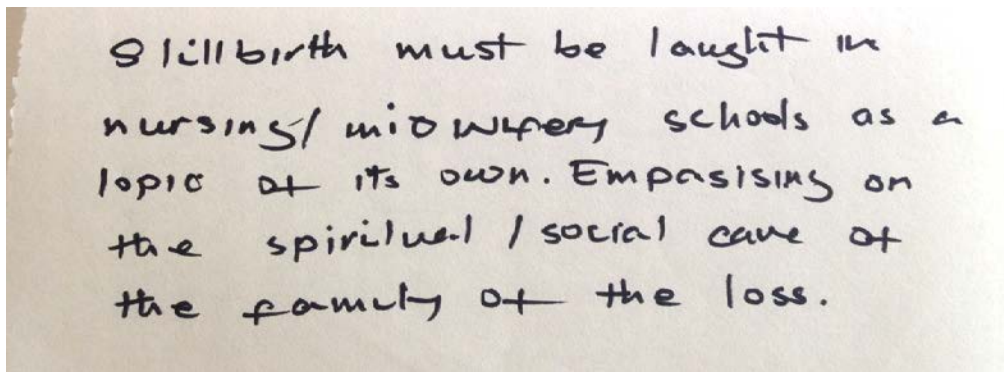


Figure 7.4. Workshop: a topic of its own

7.2.2 Practising care

Throughout the 12-month midwifery course, students extended their classroom learning by undertaking clinical practice modules. While on practice, some students had been involved in a stillbirth event and related the care they had provided. Other students were able to recall aspects of the nursing care they had given following stillbirth, prior to enrolment.

Students referred to the importance of providing holistic care, variously described as physical, medical, spiritual, mental, emotional, psychosocial and social elements of care.

Providing a balance of all four elements—physical, emotional, social, spiritual—during care ensured a woman's overall health and wellbeing, as Abby declared, *'To be a healthy person, healthy human being we have to balance all these side'*. Regarding caring for women

following stillbirth, Reuben explained, *'The woman experiencing a stillbirth are humans like us, so the care that we should give must equalise the four areas of life'*. Abby had a similar perspective: *'If you give nursing care according to that four aspects of health, then I think the mother will be ok. If you concentrate on one only, then it's imbalance.'* Eva considered the provision of holistic care was part of practising as a professional:

Most times ... we normally care for the physical side of life, you know health, to fix, to treat the patient... but we never consider much on the spiritual and social, emotional but as a professional nurse I have to balance you know, at least when caring for any clients who comes my way, it's always good to treat them holistically, not only on the physical side of life but we have to consider the spiritual as well and with regard to culture.

Focusing on the physical

Although students learned about, and understood, the benefits of holistic care, they most often discussed aspects of providing physical care to women following stillbirth. According to them, physical care was the primary focus of the midwifery curriculum. Nicole explained:

Stillbirth, we've learnt mostly the physical side of it, how we should care for them or what the causes of the stillbirth are... we should involve the family yes, we did learn about that... social support for the woman, mental—not really, spiritual—not really, I think we were more focused on the physical.

Students had extensive knowledge about following standards and protocols in assessment, diagnosis, planning implementation and evaluation of physical care. Nathan outlined nursing care standards as, *'Where we do assessment and then we do nursing diagnosis with our planning implementation and then at the end of our shift we come back to evaluate'*. Women who had given birth to a stillborn baby without complications received the same postnatal care as women who had delivered a live baby. Hannah explained this care involved, *'Monitoring the normal blood pressure, we used to say normal obs [observations], vitals [vital signs... we used to assess the PV loss, the bleeding, her vaginal after birth'*. Johanna added, *'But if there's any infection, then we treat her with antibiotics and she can stay at least some days while we give her treatment and when she's okay, they discharge her'*.

Eva explained that in larger health facilities, nurses or midwives often worked in a hierarchical structure, in which they provided ongoing postnatal care for a woman following stillbirth while doctors were responsible for the overall management of the woman's medical care. Nicole noted that with treatment planning, *'It's the doctors that make the decision; we just carry out the decision'*. However, in some settings nurses or midwives working alone or in charge of small teams made all health care decisions. As Hannah stated: *'In places where there is a doctor, the doctors decide for the mother. If there is no doctor, then we nurses do decide depending on the condition of the mother.'* In charge of managing care to women following stillbirth in a remote facility, Reuben said, *'What I do is give treatments accordingly to the miscarriage protocol, give treatments, medical treatments and then assess her condition. If she's well, we discharge her'*. In Nicole's experience, there was little evidence of consultation with the woman about her care:

We don't really talk with them to get their opinions on how they feel and like, to plan a care that will be, what will I say? Like care that they should also decide, like how they feel we should be treating them or things like that.

Rebecca shared details of her multiple experiences of providing care to women following stillbirth in a provincial hospital. Each woman had come to the hospital after noticing the absence of a fetal heart (for a period of up to three weeks). In each case, the doctor on duty was informed and ultrasound scanning confirmed fetal demise. Subsequently, the women were administered the drug misoprostol to induce labour. Rebecca recounted one particular situation that provided insight into the care of a woman following delivery of a macerated stillbirth:

We sedate the mother with pethidine and doctor did manual removal of the fetal parts... clean, D&C [dilation and curettage]... we deliver the placenta and put the mother on triple antibiotic... the fetal parts were still coming out and she was almost going into complications, like puerperal sepsis...we had to put her on a broad spectrum antibiotic, cefiozone with other antibiotics, IV, intravenously... every twelve hourly we did peri-care, peri wash. We used a sponge holder and dipped the gauze into the normal saline, and we do deep cleaning.

Women were administered antibiotics either intravenously or orally following stillbirth to prevent or treat puerperal infection, or to treat existing infections including sexually transmitted diseases. Rebecca described how venereal disease research laboratory blood tests confirmed a woman had syphilis, and the physical care provision included, *'Benzathine penicillin for 3 doses for 3 weeks, weekly doses, we gave her and we gave her*

partner as well'. Women were also administered medication to stop lactation. Reuben recalled an intense situation he experienced when caring for a woman who had begun lactating following a stillbirth:

She had breast milk coming out all this time and she was saying, 'At this time this baby would have breast feed off this milk', she was complaining about that, then we go out and talk about that with the doctors and we say that this woman is like that and she is lactating, and the doctor [says to the woman] 'You can go and feed other babies,' and she say, 'No! I don't want to feed other babies' then they lack communications and they write medications and it work out, it stopped this woman from producing milk.

Looking after many women meant there was often insufficient time to spend with mothers following stillbirth, other than to provide physical care. Nicole spoke of the issues with staff to patient ratios:

[B]ecause I was a nurse before, like most of the things, I've learnt about holistic care but when there's a lot of patients, I don't give holistic care... When you're in the real world when you are working, we don't have time to provide all these care for the woman, maybe if we were one to one patient to staff, then we would have time to do all of this.

In one provincial hospital, women who had experienced stillbirth transferred to the gynaecology ward, together with post-operative patients, cancer patients and other gynaecology cases. Physical care of the women in the ward was on a needs basis, as Nicole

explained, *'For woman with stillbirth we put them as later, or we'll attend to them when we've done with these people or they are ok because they've already delivered ... we prioritise according to the physical aspect'*.

Caring for the stillborn baby

Stillborn babies received basic physical care and little consideration from staff, as described by a student in the workshop, *'Most times we health workers do not pay much attention and care to the dead infant'* (see Figure 7.5). When talking about stillborn babies, students regularly used the term 'it'. Commonly mentioned was wrapping and putting the baby aside in the delivery room. Nathan stated, *'We take it, we roll the baby up and put it away'*.

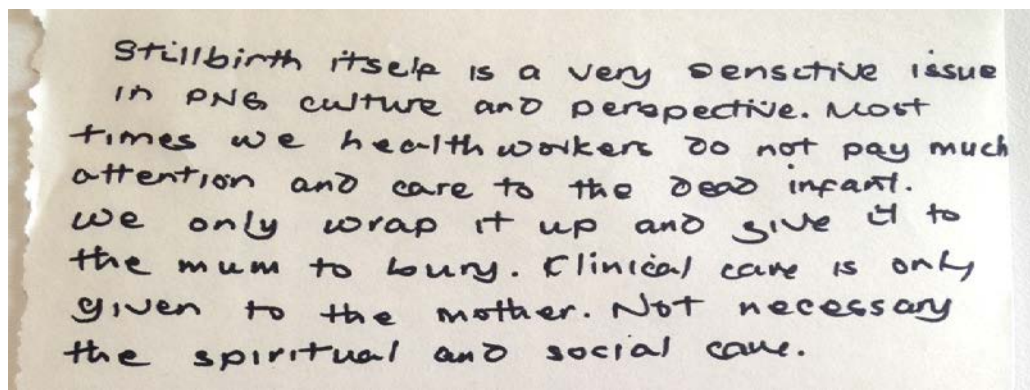


Figure 7.5. Workshop: we only wrap it up

When a woman lived close by to the health care facility, family members often took the baby home for a period of mourning before burial. In Hannah's experience, *'Mothers are given the opportunity to spend time to convey her heartfelt sorry to the baby before taken to burial'*, during which time some women choose to take a photo of their baby.

Students reported larger hospitals provided families the option to keep babies in the morgue until the mother was well enough to leave, when as Eva observed, the family, '*bring it home to bury at the same time after discharging the mother*'. In Abby's opinion, staff attitudes about the status of stillborn babies influenced how babies were cared for, and attitudes needed to improve:

We normally see stillbirth just nothing, it's not a big deal. That's what we see. Not like a human being, I mean a person dies and then we always feel worried - we see that the babies, they're not human being... we have to learn how to care for them because after all, they're human beings as well.

Abby shared how she had been involved in both a professional and a personal capacity when a friend delivered a stillborn baby:

After one week, they came back to our house, they got me because they want me to go and wash the baby and then wrap the baby up ok, so I went with them to the morgue, I wash the baby, wrap the baby up and then put the baby into the casket and then we took the baby to their house and then the baby stayed for a night and then we went to the haus kra¹⁴ with them, we stayed with them and then the next day following that they took the baby to the village for burial.

Hospitals sometimes provided assistance with burial arrangements for stillborn babies, most often for women referred to the hospital from outlying localities prior to the baby's birth. Abby stated that at one faith-based hospital, there were designated areas where

¹⁴ A gathering of family and friends for the deceased.

the babies could be buried, *'beside at the back of the church, the chapel, and then at the back of the ward'*. The families had loan of a spade to dig a grave to bury their baby in one of these areas. Similar provisions existed at the hospital where Rebecca worked. Families could purchase, *'a small piece of land, ground for burial for them to go and dig... we have some cleaners they can get and they will go and bury [the baby] in the hospital ground'*.

Supporting spiritually

Students believed it was important to provide spiritual care to women. Several students recalled how they sought to provide spiritual comfort to mothers after stillbirth. Abby considered praying with a woman, while not essential, was beneficial:

I think what they need is prayer... It's not a must but you can pray so long as we are, what will I say? We give praise to only one God, like we are all Christians and not Muslims and all this... I would ask for Holy Spirit for their guidance and their strength, pray and ask the Lord or Holy Spirit to give the mother the peace that she needs, peace of heart, peace of mind and the strength to carry on, to comfort her... because this is what she needs at the time of her grieving.

Leah provided spiritual comfort to a woman under her care by reading the Bible, and encouraging the woman to have faith in God's judgement:

We gave her some texts and told her ok, in Jeremiah Chapter 1, verse something, we told her, see, God has plans for us and if he wants to take our life, He takes it back.

We don't have a say that because God provides us with the breath of life and if He wants to take it back, He takes it back.

Reuben prayed with mothers about understanding the grace of God and His power to give and take the life of an unborn child: *'Pray with her about what has gone, bear in mind that God gives and God takes it. It's not what we do to get it but it's what God gives.'* Only one student mentioned spiritual care for stillborn babies. Abby stated that at one faith-based hospital, nursing staff had permission to baptise stillborn babies before burial, *'[b]y doing the cross and then we give it the name of a saint'.*

Effecting emotional care

Students recognised that stillbirth was an unexpected outcome of pregnancy. Reuben said, *'It's not what the mother expect, what the father expect or the family as a whole expect. They want a live baby'*. Students tried to show empathy in how they provided care. This included how they communicated with mothers and use of appropriate language to explain medical procedures or when providing comfort. Abby recognised what she said to the woman about her baby and how she spoke could affect the mother's grieving process:

Just say sorry we lost the baby, for me it's not a good word. At least you have to comfort them by saying something good in terms of her grieving, you'll just make the situation go worse by just telling her, sorry we lost the baby as if it's just a doll, it's a human being!

Eva believed compassionate care was important to help the woman with her grieving and recovery: *'We should just, you know comfort them... give them assurance so they can be able to overcome it, they can really overcome the pain and moved on, moved on with life.'* For Marie, emotional care was best provided by spending time and being present for the woman: *'I think the best thing you can give at that time is your time, you don't have to say a word too, you just stand by them, just stand by them.'* Marie was aware of giving false hope to women for future pregnancies, advising the best option was to, *'Just comfort her at that time and tell her what is needed to be told, don't go beyond and say, "Don't worry, you'll fall pregnant again and you might have a nice [baby]" , coz you don't know'*. In contrast, other students encouraged women to look to the future and subsequent pregnancies, particularly first-time mothers. Naomi commented, *'Because she was a first time mother, I advised her that it's ok, you can still have a long time [to] go and will still have a baby'*. Although not common, several students viewed stillbirth was less of an emotional trauma for women with living children, as indicated by Eva's statement, *'For multigravida, they already have lots of children already, for that one that has been lost, I think it's not a big burden to her because she already has many kids'*.

Sharing food is a way to show respect and care in PNG culture. Marie explained, *'You have to bring them food to really assure them that you really care about them'*. Leah provided food as emotional support for a woman who had delivered a stillborn baby boy and was alone in the ward: *'I thought she was gonna be down because of the stillbirth so I went for my lunch and I brought some foods and I said "Ok, let's have something together", just to make her feel happy.'*

Addressing social issues

Students knew a great deal about how social issues contributed to pregnancy complications. Domestic violence, often perpetrated by the woman's intimate partner, was a common issue that students raised with women after they experienced stillbirth. Reuben recalled, *'When I asked the mother about the social issues, she said, "I was kicked by my husband."'* Hannah described how:

[If] they are not happy at home and there are problems in which the husband usually beats the wife most times and so when she ends up in a stillbirth... they'll blame the husband and say 'You are always beating your wife, that's why she's ending in that position.'

Naomi identified men having sex with other women as a contributing factor for stillbirth, *'When he goes out and comes back to the woman there's infection, like STIs [sexually transmitted infections], syphilis which can cause death to the baby'*. In larger health care facilities, women were referred to social workers or counselling services for treatment. Abby sought assistance for women from the support services in the hospital where she worked: *'These people, they're counsellors so we consult them, they can come and then they counsel the woman and then the husband as well.'* However, in many settings, social services were under resourced or non-existent, as Candace reported, *'We suppose to refer her to social workers but this was not [done], maybe there's no social workers around during that time'*. In these instances, nurses or midwives provided advice in lieu of professional counselling. Naomi recounted the advice she provided to one woman following stillbirth:

There was social issues within the family; something was not right with the family... I said to her if such thing was happening then you should have sort yourselves out before you go into labour, if there was a problem, probably you reconcile to it.

Students understood women's own social behaviours contributed to stillbirth risk, including the chewing of betel nut and consumption of alcohol, tobacco or other drugs. For students in this study, social care was educating the woman to effect lifestyle change. Reuben commented, *'If we find that there's some issues like alcohol, she's an alcoholic or smoker, betel nut chewer, we have to educate on behavioural change. Change in behaviours so that next time you won't come with this problem'*.

7.2.3 Being a male midwifery student

Nathan and Reuben, the male midwifery students participating in this study, faced unique challenges as men working in a female-dominated profession, providing care to women in communities that maintained strict cultural standards about the role of men during pregnancy, birth and the postnatal period.

Becoming like a woman

The male students were defying cultural norms as they pursued a career in midwifery. Reuben acknowledged the widespread belief about loss of male virility from contact with blood or vaginal discharge related to birth:

It is very stricted that we don't exposed to woman's environment during childbirth, during pregnancy and after delivery, postpartum period, we don't come in contact with their blood and all this...it's a very strong culture that when we touch womans, in contact with pregnant woman blood and all this, we are low classed and to do strong work in the community or very hard job we are not able, that's what we believe.

Nathan and Reuben experienced veiled criticism within their community and teasing from their male friends and female peers. Reuben faced the loss of social status in his community because of his decision to practise as a midwife:

I've been already said something that I'm like a woman now because most of the time to be in the labour ward and all this...and they are making like, words that are funny too, saying that you are of no use to this society or this community....they just really get me off track!

Vagina voyeurs

Nathan and Reuben accepted that others perceived an element of voyeurism in their choice of midwifery as a profession. Nathan described the teasing from the female midwifery students in his cohort, who jokingly told him, '*You just want to see vaginas*'. Nathan laughed as he recounted how he maintained his professionalism, avoiding answering questions from his friends about how many women he cared for in a day:

We would come back and we would say none, and most of the time they would say 'Ssst, you are telling lies and you're hiding that' ... we say, 'We have our rules that guide our practices... we won't even tell you anything that we do during the day or during our cares', they don't think what they are expecting, they don't think the results.

Managing masculinity

Nathan and Reuben agreed that cultural beliefs about gender roles were the major barriers to providing care to women. Reuben stated, *'As a male looking after woman is a challenging job to do'*. Nathan described a situation where one woman was reluctant for male provided care, following a stillbirth after emergency caesarean section:

I think that that woman, she hesitated for me to help her because I'm man, I'm a male and she's a female, that's the main barrier that we have there in that care, when all the other staff work it's ok but for us boys it's more like, embarrassing to them.

Nathan also spoke about the challenges he faced as a younger male midwifery student providing care to women:

For me personally, they see my size and they think that he's too young to see us, that's what most of them they tell to me...if I went into a cubicle room to help a woman, she should say, 'I don't like that boy, he's too young', that's most of the time or most of the challenges that I face when working with woman, they say we are males so, we are young to take this role as midwife.

Reuben believed midwifery training should consider gender issues in care provision and the implications for male students, *'We are trained to be midwives, then it looks at gender—who is taking care of this woman—because it's like, we are looking into the private areas of people so they will go for woman than man'*. Reuben considered his maleness made completing his midwifery competencies during hospital practicum more difficult:

When I ask how many speculum have you done, they said, 'I've done three', 'I've done two', 'I've done four', and me? I'm one, so why are woman coming to you more than me? So it's like, even I'm distressed and like, do they trust me? Do they see me as a health worker or because of I'm male, that's why they have to go for woman.

Acutely aware of their masculinity, the male students sought to manage the issue of their gender by working alongside female colleagues or health workers during practicums. I observed Reuben working at Port Moresby General Hospital (POMGen) with a Marie Stopes¹⁵ nurse in the postnatal ward, giving a woman Depo-Provera, the contraceptive injection. Similarly, Nathan perceived working together with his female peers would help overcome women's aversion to male midwifery care:

It mostly comes back to our explanation and the proper procedures that we will be doing to them and the benefits... the main barrier is explanation and the main barrier is shame, they're more shameful, one, the two is explanation and three, that one is our culture and customs that mostly prohibits sexual and reproductive health is more into female/female than male/female, that's a main challenge for PAU midwifery is for

¹⁵ Marie Stopes International is the largest provider of sexual and reproductive health care in PNG. For more information, see <https://mariestopes.org/where-we-work/papua-new-guinea/>

both of us boys it's more challenging, and most of the time we use our classmates who are working with us to go and we work together and then those barriers are removed.

However, the male students contemplated the barriers they would face as men practising midwifery in their home provinces. Opposition came not only from the women in their care but also from men. Nathan stated, *'Husbands don't like male health care workers looking after their wives. You need to explain that's a job, I see her as my mother, my sister, doesn't make any difference'*. Reuben voiced his concerns: *'It's a challenge that if I go as a male in my home... to do my job as a male midwife, from this experience during my practical I am seeing that, will the woman come to me?'* Nathan admitted gender was the primary barrier to care for male midwifery students, *'But when women in severe pain they forget, other times they are more shameful'*. Nathan had critically observed that, while averse to male midwifery students, women were willing to see a male doctor as they were *'seen as a higher level'*. However, some women preferred care by male midwifery students because of the latter's respectful attitude and quality of care. Nathan described what women told him:

They will say, 'Ah, you boys should take care of us, you talk nicely and what you say is more polite and how you take care of us is more good than females that they come and they talk to us there' ... they say, 'You come and you talk nicely and you talk softly and we want to work with you but those ones, they come and they scold on us and they swear at us' ... I'm not like what other nurses they provide... even though we have this same knowledge and only our experiences varies because of different length or different times that we come to school... mostly depends on our attitude towards our clients or our behaviours goes towards our clients.

Reuben planned to use the *Healthy Islands*¹⁶ holistic approach to help him build relationships and influence attitudes about males in midwifery:

There's an approach which is now going on with Healthy Island concept, that's a good way of going into the community. Healthy Island, which is, ah, the concept is developed by the National Department of Health but that's the way I see the way to tackle this issue out, change... I'm thinking of doing regular visits in the community.

Changing perspective

Studying midwifery had changed how Nathan and Reuben perceived gender roles and customs surrounding pregnancy and birth. Reuben spoke of his changing beliefs about women's blood:

It is the biggest challenge to me that I have made it this far and it's like a change of mindset to me, a change of mindset that I see that this is not true. It's like we are just proposing that going in contact with woman's blood, is like it's reducing men's strength or growing very old too quickly, that's how they believe but to me, I see that there's nothing, it's like I'm cutting myself and bleeding and touching the blood [mimes cutting arm] so there's no difference in there.

Nathan described how studying midwifery had changed his views on the roles of women and men during pregnancy and birth and more broadly within society:

¹⁶ A Pacific-wide health programme that aims to promote the health of people and communities (World Health Organization. Regional Office for the Western Pacific, 2002).

It saves me or it changed my whole perspective into looking at a pregnant woman, or looking at my mother or looking at my sister that she's pregnant...my ideas are broaden about looking at someone who's pregnant and my social contribution or my brother's or [her] husband's contribution to her pregnancy and our church's responsibility to the women ...previously, I don't consider woman as equal to man or something but now currently even you are who small or you are young we are all equal, that's what I see.

Nathan revealed that male nursing students viewed male midwifery students as role models: *'They say that those boys or those men you are taking midwifery, "You a hero for us boys here, for us males, especially in the field of nursing... it's more challenging than us working in other areas", that's what they say.'* Despite the challenges faced in providing care to women, Nathan and Reuben had no regrets about their decision to become midwives. Nathan stated, *'As I provide what's best for my clients during the day and I come back with job satisfaction, that's all my goal for the day'*. Reuben exclaimed: *'Oh, I just say that's my profession, I just say this, that's my profession, I love it!'*

7.3 Traversing different belief systems

In PNG, the question of blame for life's misfortunes often exists, including for illness and death. Nicole stated that people expected the outcome of birth should be a live baby: *'So when we say in our terms the baby is dead, "baby die lo bel" or "mama carry na baby die", that means the baby has died in the uterus or the mother has already delivered and the baby's dead.'* Reuben acknowledged during pregnancy and birth, *'If it turns out to be bad for that woman, we blame the situations around'*.

Students endeavoured to respect the diverse cultural and spiritual beliefs of women and their families, yet some students experienced a tension in their provision of care between traditional and non-traditional beliefs about the causes of stillbirth. Beliefs influence how the students create knowledge and their subsequent decision-making and conduct. The unique worldview that students construct from learning and interacting within different settings influenced their behaviours and actions when providing care to women following stillbirth. Students sought to make sense of each stillbirth event, either rejecting or drawing on their own beliefs.

‘Traversing different belief systems’ is a central dimension that explores how students seek to balance competing belief systems and incorporates the attributes of ‘traditional truths’, ‘religious rationalising’ and ‘blaming the midwife’. ‘Traditional truths’ introduces the inherited beliefs and knowledge about stillbirth, shared by people living in a particular place at a particular time. These beliefs became obstacles for the midwifery students when they attempted to convey the cause of a stillbirth from a medical perspective. ‘Religious rationalising’ refers to the knowledge introduced in church doctrine and accepted by the faithful as the principles for living a Christian life. Students experienced a tension between traditional and religious beliefs, and individual and collective understandings of the role of God in stillbirth. ‘Blaming the midwife’ discusses the contemporary belief that stillbirth is the result of professional negligence by nurses or midwives and outlines threats made against students as they provided care to women following stillbirth. Figure 7.6 shows the dimension of ‘Traversing different belief systems’ and its attributes.

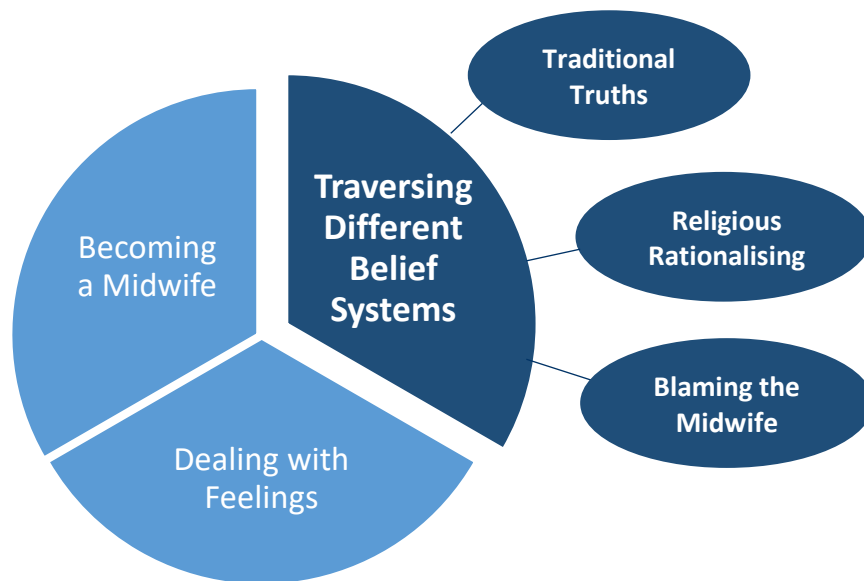


Figure 7.6. The dimension of ‘Traversing different belief systems’ and attributes

7.3.1 Traditional truths

In many parts of PNG, people gain traditional cultural knowledge through ceremony, instruction from older, more experienced members of the community and observation during everyday activities. Johanna stated, *‘The cultural beliefs, these are inherited sort of practices’*. Eva’s responses during discussions indicated she learned a great deal about village beliefs and customs from her father, saying, *‘When we were small, my father used to tell us...’* and, *‘We don’t know about all this stuffs but my father used to tell us...’*. Hannah recounted how in her place, knowledge is passed down from male elders to the younger men, *‘During time for moka, it’s time for sort of gathering... wise men will go and give the wise talks to the young’*.

Traditional knowledge extends to matters of family planning. Eva said, *‘They use their own traditional understanding of spacing... and it worked... we learn about all this artificial methods but people in the past used their own wisdom and understanding’*. This

could include knowledge about plants that are effective for inducing abortion. Rebecca told how in her place, *'They have special leaves in the bush... when mother takes it the baby... can get the effect of her taking the leaves and the bark of the tree... it will cause the baby to die in the uterus'*.

Many communities continue to attribute stillbirth to ingrained cultural beliefs and practices. Rebecca explained, *'Cultural and spiritual things, it's just a belief that they have practiced for a long time from generation to generation'*.

Looking for masalais

Students described inherited cultural beliefs about the power of spiritual beings to induce stillbirth. Masalai are spirits of the dead known to inhabit natural environments. The areas where masalai dwell are restricted, 'taboo' places. One belief is that stillbirth results from masalai exchanging babies when a pregnant woman enters a restricted place. Reuben recalled what his father had told him about the birth of Reuben's sibling: *'"[Your] first born brother who was exchanged by the spirits... those spirits took theirs, put inside your mother's belly and then took out the one inside, your brother out"'. So that's how they believe and it's still there.'* Following stillbirth, Reuben said that a woman and her partner would reflect on their actions during pregnancy to identify when and where an exchange may have occurred:

They will have to look for masalais, where they have gone, their hunting or fishing place. If they have hunted in the bush, they go under a big tree or near a big stone which is highly respected, then they blame that one. And if they've gone for fishing,

then they have to look for where they have gone, place where masalais are there, then they blame them. In the water and on the mountain.

Night was seen as the most dangerous time for pregnant women to be outdoors.

Nathan explained the beliefs about malevolent spirits in his community:

They said pregnant women shouldn't go out in the dark, when it's dark they should be already at home, maybe they went out walking at night and evil spirits might disturb the baby from growing and the baby might die... they believe the spirits possess the woman and then they kill the baby during childbirth.

Suspecting sanguma

Students reported people commonly attributed stillbirth to acts of sorcery, described by the students as *sanguma*, *poisen* or *kastomary* work. Disharmony in social relationships was the major factor for the use of sorcery. Abby explained about engaging the services of a sorcerer:

'Sanguma' we call them, they're the sorcerers, they are human beings just like you and me but they practice some sort of cult and then they go out killing people... if I have any problem with you or I am angry with you, I'll go and hire those sangumas who are the sorcerers, I give some amount of money.

Reuben said the cost of a sorcerer varied, from '500 kina, 600 kina, 150 kina for a day. They are still hiring them to go in and look for ways and with things are going wrong'.

Eva stated sorcery was widespread across PNG and recounted what her father had told her about the practice in his village:

They normally say poisen, that form of sorcery and the poisen man... they used to speak words, you know, spell... if the mother is pregnant and she went to the garden and work and that poisen man came along and say something bad, maybe the baby can die or the woman can die during birth or during delivery, or the baby might die in the uterus, I mean that's the reality.

Rebecca discussed the use of sorcery against a pregnant woman during tribal fights, when the woman's enemies seek to, 'kill the baby in the uterus'. Rebecca explained how the sorcery was performed:

They have magic powers or potion they can create... so maybe they can drop the poisen in the drinking water source or laundry or something like that, they drop it and when this pregnant [woman] go and have a bath she can be in contact with the poisen that they have thrown into that, or in the drinking water source as well. That's one way and cultural cause of stillbirth.

Marie recounted how in her province, no preparations are made in advance for a baby owing to the risk of a sorcery act being performed:

Sometimes, if you hang those things, you just want to rinse, wash them and prepare them, if we hang them on the line that means someone picks it up or like witchcraft, they might do something to the baby's clothes then that's why the baby might die.

Students also knew about food being used for sorcery. Naomi explained, *'For us it's like giving a piece, a plate of food or can be a betel nut or can be something like that to cause the death of the baby'*. Acts of sorcery as retribution in unresolved relationship issues could target the unborn child. Leah explained,

They'll say because you have a problem with that person, you haven't solved it, so he's gonna do some kind of magic or something to kill the baby, so you have to know that ok, I was supposed to tell sorry to that person but no, so they've killed my child. So, these are some of the customs that we Papua New Guineans have.

Nicole related that stillbirth could also be viewed as consequential to an act of sorcery against the mother: *'If they are not successful, then they can kill the baby because the baby's small and can't defend himself... that's what they think, yeah, some people think that way.'*

Blaming the woman

Students reported that because people saw pregnancy and birth as women's business, women mostly bore the blame for stillbirth if they transgressed against cultural norms. As Abby noted:

Childbirth is part of woman's job so if the woman disobeys... she eat food that's she's not supposed to eat and then she go to places where she's not supposed to and then she ended up having a baby died and she got the blame.

Hannah spoke how women entering restricted male-only domains risked harm to their baby:

Sometimes the woman end up in that places where they are not supposed to go, it is forbidden but they're going...when you go there, your baby will deform...if the woman delivers a stillbirth then they will blame the belief, they will say 'Oh, she goes there, that's why she's having the stillbirth'.

Marie related a belief about babies' reluctance to be born, with responsibility laid upon the woman's state of mind and social status:

If it wasn't a planned pregnancy, if she is a teenage pregnancy or if she's a single parent or if her husband has left her, then they'll say that she wasn't psychologically prepared for the baby so the baby must have sensed it, that's why during that time of delivery, it not wants to be, it's what they believe.

Restrictions on sexual intimacy between couples applied as the woman approached her due date. Rebecca explained how defiance could result in stillbirth:

Taboos in our community or in our society, if a mother is pregnant and she's reaching the term, meaning she's ready to deliver, the man are not allowed to sleep with their wives, they believe that a child cannot be delivered within the normal time of delivery, the child will think the mothers don't allow it to come out of the womb so I can stay inside...so the woman are not allowed to sleep with their husband, body contact with their husband...if they sleep with their husband when the baby's ready to

deliver, the baby cannot deliver, it can stay in the uterus and for long time then later they can come out and they can face some problems.

Certain foods, in addition to being considered tools of the sorcerer, were restricted for women during pregnancy. Eva explained beliefs regarding stillbirth occurring because women had not followed cultural prescriptions about totem foods,

This particular animal or that particular plant is where our clan originates from, so you are not allowed to eat it, or you are not allowed to spoil it... when a woman is pregnant and she happened to touch that thing or kill that particular bird or chop that down, cook it and ate it, then maybe it can affect the baby inside and maybe during her pregnancy she might have a stillbirth.

Students reported most restricted foods were protein based, with variation according to different cultural groups or provinces. Rebecca explained pregnant women in her place were, *'not allowed to eat a forbidden thing, like some meats, fresh meats or fish and when she takes that it can cause the baby to die in the uterus'*. Nathan said that in his province pregnant women were not allowed to eat a fish known as *murum* since this was reported to cause congenital deformities, explaining, *'Then, on delivery the baby might die or the baby might die before being born'*. However, students knew that poor nutrition increased the risk of stillbirth in pregnancy. Abby stated, *'In my village, we say when a woman is pregnant she's not allowed to eat eel and bird, flying fox... this is some of our beliefs in terms of food and protein, these are some contributing factors to stillbirth'*.

Being 'midwife in the middle'

Every student agreed that cultural beliefs had the greatest impact on how they provided health care for communities. Reuben learned during midwifery studies, *'that culture interferes with the medical practice... relating medical practice into the culture it's like there's a collision, there's a bit of collision'*, adding:

Treatment and medical knowledge are just nothing to them...what they think and believe is like faith, is a substance to them, their culture and beliefs is a substance. Then medical is like is an option to them, they just believe that medical is just a kind of belief to them that they don't really put trust on.

Students described how inherited cultural beliefs caused tension as they tried to provide respectful care to women following stillbirth. Johanna said:

If we say the cause is a problem with the placenta, so the baby is not getting enough oxygen from the mother and stillbirth, they will say 'No, mother went to that place last time and that's why the baby has died'. So, sometimes it's really hard for us to explain to them the medical side because they have their own beliefs too in the village... when we explain the cause of death of the baby, we have to be sensitive because they have their own beliefs too and they will not accept in terms of medical.

Changing longstanding beliefs and opinions presented challenges for students, made more difficult by the high rates of illiteracy within communities. Abby laughed as she described her frustration, *'Sometimes when I have an explanation to give, sometimes I will*

say nothing. Okay anyway, I cannot talk to you people because you people cannot understand'. A student from the workshop warned about the risk of traditional beliefs for progressive midwifery practice: 'Because inherited is most valued in the society, sometimes nurses/midwives falls into the customs/beliefs and don't become agent of change' (see Figure 7.7).

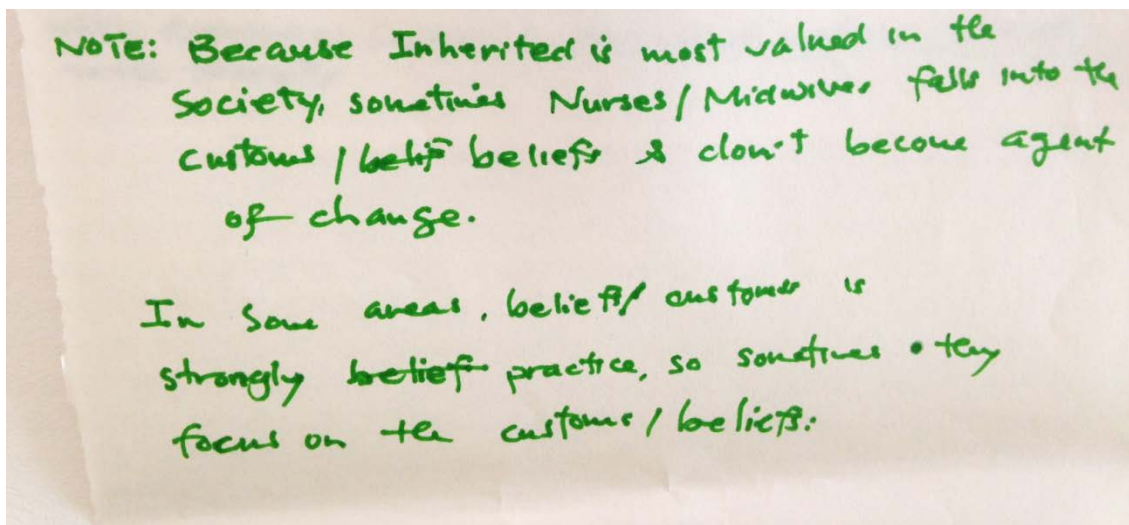


Figure 7.7. Workshop: falling into customs and beliefs

Rebecca considered it was part of her role as a midwife to discourage cultural beliefs:

It's just information, they are lack of information so I have to carry awareness in the communities that effect of this cultural practices and I can tell them to stop it, as this can affect health, affect their childbirth and the pregnancy. So, I can discourage them to believe their culture, that's the only way we can help them, nothing else.

Candace however, observed the resistance to new ideas and cultural change:

It's not easy to convince the people out there back in the village...it's a challenge...some are stubborn, they don't want to believe in new things, so they will say, 'Who are you to come and change our culture?' Like, it's a long time ago to believe this so it's a barrier...we can say they illiterate...they are not educated, so if we tell them they will not understand but they will not go and read up and find out about the informations, they are hard for them to accept.

Students saw formal education as the key factor in how people in their community understood stillbirth, and considered that educated people were more likely to accept a medical explanation for the stillbirth. Nicole stated, *'I try to advise them to see it in other perspectives like health perspective but then it depends on their education level and how they see things'*. Students perceived uneducated people were naïvely trusting in traditional beliefs and customs. Hannah declared:

Most people, they don't really know what is going on and with the stillbirth and the reason and causes of stillbirth and they are sort of just assuming and building their faith or belief on the traditional things rather than seeing the real thing. Like, now we are educated and we can see that something is like that and we are following, mainly due to education and most, they're depending on the cultural side.

Students brought their own individual beliefs and attitudes to their midwifery practice. The students' increased specialist knowledge about pregnancy, birth and stillbirth frequently

challenged their own knowledge and beliefs of what was real and true: two terms students commonly used throughout the discussions. Hannah saw the midwifery programme as *'true education'*. Eva pronounced on behalf of her fellow students:

We'll depend on our knowledge that it's true, that's what we've learnt and that's how things are happening, that's how the physiology happens and during pregnancy and all this, so we will tend to stick and depend on our knowledge that we learned.

Students trusted their newfound midwifery knowledge. Naomi explained, *'I think I come from the midwifery point of view, I'd say that stillbirth happens because there are factors that may contribute... there are medical condition that may contribute'*. Candace had similar thoughts, saying:

From what I learned it, think I would say the medical view is right, those people back in the village are not educated so they don't know, so, as a midwife I have a big responsibility to play to go back and educate them, tell them about their beliefs it's wrong, because of some complication during pregnancy, some infection of some cases during pregnancy, malformation of the placenta, something like that cause the stillbirth.

For Abby, midwifery education was a transcending experience and she now rejected traditional ways, *'Culturally now, as I have gone a step higher than them I say that no, this customs are no longer useful... I would rather disregard my customs, my customs are not good'*. Marie also disagreed with the cultural beliefs in her community, giving this advice for her midwifery colleagues in conveying the cause of stillbirth to women:

Because of our culture, most of us would want to give our advices and tell them that it's because of the culture this and that has happened but I think we should do away with that and be honest with the woman, coz sometimes they ask the woman 'Where do you come from? Oh, so that's what they practice in your place', and then they'll agree with them... we should tell them the truth... teach the woman what we learnt, what causes stillbirth, not what they know and we just agree with them, coz if you tell them the truth they might tell their friends and relatives and then they'll know, so some of them [stillbirths] could be prevented.

Other students however, found it more difficult to reconcile contradictory biomedical and cultural beliefs about stillbirth causes. Johanna stated, *'Sometimes we believe them too because it's our culture, so it's not kind of balance, I mean, hard to explain because we believe the culture as well when explaining the medical views, we believe the culture, their culture as well'*. This tension was evident especially in situations where the cause of a stillbirth was undetermined. Rebecca recounted a case where a woman delivered after confirmation of FDIU:

We did everything to the mother but we have to find the cause of that stillbirth... we collected blood for blood works... but the blood results were ok. This might be due to some cultural beliefs, coz later we found out this mother is a second wife, so maybe his first wife might have did something to spoil the baby... did sorcery or poisen as I have said, so the baby died in the uterus.

Reuben recounted a disturbing incident where late one night he discovered friends were members of a sorcery group. One of the friends described practising sorcery against

women to remove unborn babies from the womb, to use the decaying body fluids of the baby during initiation of new members. Reuben had been unaware of his friends' secretive role in the community: *'They are real people who you eat, drink, everything you are doing with them but you don't know who he is or who she is—it's a belief but how it happens to be, I'm still confused.'* Eva summed up the issue of practising midwifery at the cultural interface:

We are Papua New Guineans and this is our culture... we come out from that culture and then we are being educated, we want to become a nurse and a midwife and learning all about these medical things... our nursing ethics states yes, we have to at least balance it or something... we will trust the knowledge that we learn that's true, that's how our body works and how the pregnancy happen... but when complications occur, they will still relate back to that culture thing, the belief thing, so sometimes we'll still believe them.

Nathan saw the provision of midwifery care as an act of balance between juxtaposed belief systems, declaring:

How I view cultural perspective and health perspective, or benefits of health compared to benefits of the cultures when they come together in us as nurses or midwife in the middle, this is our role as midwife and this is our culture where our born is and we have to balance both of them to manage our mother or the welfare of our mother and the welfare of her baby and for me personally, I see that I should remove those cultures which are not good.

7.3.2 Religious rationalising

Students described the tension between traditional beliefs surrounding stillbirth in PNG society and the beliefs of people in their communities with a strong Christian faith who drew on their religious beliefs to make sense of a stillbirth event. Naomi considered the introduction of Western Christian religions had affected great change within communities:

Because of the church, missionaries coming into the village, that has changed too many things about the cultural beliefs and all that, it's not really that effective because of the introduction of churches, religions that coming into the villages that they've changed the societies.

Degrees of spirituality

Eva believed that Christian spirituality had diminished the confidence people had in traditional practices:

If they are spiritual people and they don't really believe all these things like sorcery and all this, they believe in God and they don't trust all these things, then I don't think they'll put much of their thoughts or much of their trust in those things like sorcery.

Conversely, Reuben maintained that people reverted to traditional practices in times of trouble, even when they were regular churchgoers or religious leaders:

Spiritually, they are not really communicating... even though they are in the church, and one day there is a bit of problem in the family, that person preaching out there already communicates with the sorcery person to come and do sorceries and all this to help solve this problem but even he doesn't think of praying to God and get help... he always preach good words, sermons prepared but he went back to heed the old habits that he left.

To combat reversion to traditional ways of thinking, Hannah believed midwifery students should encourage community members to attend church, to be part of the wider congregation and commune with God to overcome their reliance on sorcery practices:

Some of them, they don't attend churches and they just stay at home... we can advise and encourage people to attend at least a church, so that they a member of any church that they might be attending, yeah it will benefit them... they are having or suspecting and having the blame too much on those sorceries and all those, so when their true spiritual side they can at least believe in the Lord and then they will forget or subtract all those other things... and in any cases they can connect with the Lord and pray.

Leah understood Christians had no particular beliefs about stillbirth, stating, '*Out there, it's only Christianity there, you have Seventh-day Adventists, Catholics, not much Lutheran out there, but they think pregnancy, it's a normal process, they accept whatever that comes after delivery*'. Marie had doubts about the religious beliefs surrounding stillbirth in her church: '*[I'm] not really sure about spiritual belief... I don't agree with my cultural and some spiritual beliefs, there are other medical causes that can cause stillbirth.*' Nathan

expressed a similar view: *'I'm mostly into midwifery than into my culture and into my religious belief, I'm more into my career, into midwifery and my nursing'*.

Accepting God's will

Several students stated that Christian women understood stillbirth was the will of God. Candace said, *'When a women has experienced stillbirth and she's a Christian, she believes that maybe it's God's plan, so God gives or God takes... they just accept'*. Many of the students participating in the study also viewed stillbirth through a religious lens. As a Christian woman, Nicole saw stillbirth was part of God's bigger picture, saying, *'I was taught that only God gives life and if God has taken away the life, then maybe He has a plan for something better or something else to happen'*. Nicole described the support her church provided to women following stillbirth: *'For woman who maybe lose their child, the churches that they worship with... for my church... they do visit the woman and the family, let them tell their story and support them with Bible verses and songs and things like that, pray with them.'*

Facing spiritual consequences

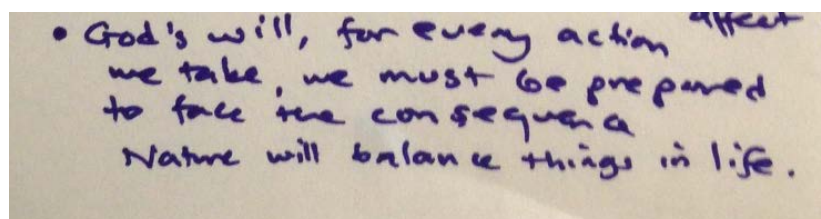
Students described children as being a gift from God, which He could take back at will, as Candace explained, *'God gives the child as a gift, so maybe God has His reason to take the child back'*. Some students suggested stillbirth was a punishment from God, for sins committed by one or both of the parents. Naomi said, *'a punishment for not doing something right or doing something bad'*. Rebecca explained one scenario regarding a woman's transgression:

If the mother doesn't want the child, or she had a deliberate miscarriage or abortion for the previous one and she's pregnant again... God will think this lady doesn't want a child, so God cannot give the child to the mother because she doesn't want it and she deliberately killed the baby, that's one cause according to the Christian.

Abby rationalised how Christians in her community ascribed stillbirth to a father's conduct:

If he's a very bad man or he's one that fools around with other ladies... the woman is pregnant and then she delivers and the baby dies, they'll blame the father, he's not a good man. If he's good, faithful to his wife then the baby won't die. Baby dies, it's because of his disobedience to God, this is spiritually what we believe.

Abby also believed that stillbirth could be a life-defining moment, encouraging behavioural change by the woman or her partner: *'Because of our disobedience to God, these are some of the punishment that the Lord God wants to show us and then it will be a kind of turning point to us'*. During the workshop, one student perceived that stillbirth would compensate for previous transgression against Church canon, noting, *'For every action we take, we must be prepared to face consequences whether it is good or bad. Nature will balance things in life'* (see Figure 7.8).



• God's will, for every action we take, we must be prepared to face the consequences. Nature will balance things in life.

Figure 7.8. Workshop: face the consequences

Students with a strong Christian faith spoke of their belief in God and the truth of religious principles they had learned, some since early childhood. Reuben's father had been instrumental in bringing religion to his area: *'The word of God went in about 1962, that's when the church established in the place... my father was the founder of the church.'* It was apparent that students held strong convictions about prayerfulness. During student conversations and in the workshop, students identified connection with God occurred through prayer and church attendance (see Figure 7.9). Students also noted the importance of biblical teachings, with several students referring to the Bible as a source of wisdom in troubled times. Candace advocated reading the Bible, since *'God has the answer for everything that happens in life'*.

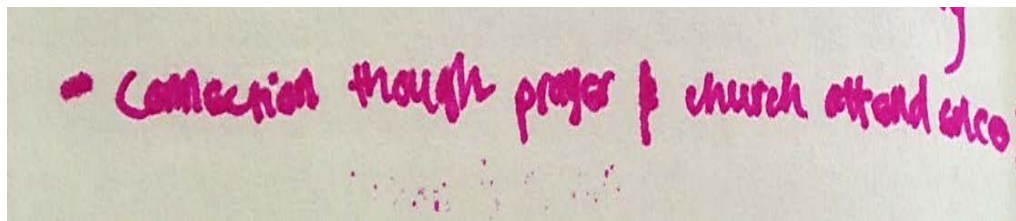


Figure 7.9. Workshop: connection through prayer

Some students were able to reconcile religious beliefs surrounding stillbirth with their medical knowledge by viewing stillbirth as God's will and His larger plan for living a spiritual and obedient life. Nicole stated, *'God has created the baby and I think God has a plan, God has plan for everything so if the baby is dead then maybe He has a plan for that too, we don't know but that's about it'*. Abby provided a rating for her beliefs: *'I would give a rate, that's rate of ten, then cultural belief I'll give it zero, spiritual belief I think I'll give five and then medical perspective on midwifery, I'll say five. It's like balance.'*

7.3.3 Blaming the midwife

The midwifery students believed community beliefs and attitudes were changing. Hannah stated, *'Now the world is changing and then everything is changing'*. Nathan observed that in his place, *'Recently, as development and all this taking place and then we began to lose some of our cultural belief'*. Students reported that while some people rejected traditional beliefs about the causes of stillbirth, women and their families still sought to lay blame for their baby's death. As frontline providers of care, families now accused nurses and midwives of being negligent in the management of care. Naomi said, *'Some blame the health worker or the system that they've not acted promptly or do what they supposed to do, maybe it was they did not tell it quickly, that's why that results in the baby died, the stillbirth'*. Marie stated, *'If they know they had the fetus kicking and then when you tell them the baby has died, they will blame you, they will say that you must have done something wrong along the way'*. Students experienced conflict and tension as they sought to manage accusations that they were to blame for a stillbirth.

Taking precautions

Abby and Marie told how relatives threatened midwives and nurses with sorcery as retribution following stillbirth. Although both students said they disregarded cultural beliefs, they still took precautions to avoid harm. Their conversation described how this could occur:

Marie: *'They'll threaten us, so what we do is be careful. How it works is sometimes they'll get something that belongs to you, especially clothes and then after some time you will get sick, so when we are threatened we don't hang our clothes outside.'*

Abby: *'And when you're working in the night it is.'*

Marie: *'... so in the night we don't hang clothes... once they go missing...'*

Abby: *'This is part of our culture, this is what we live [laughing]...we take extra precautions.'*

Marie: *'We can pay someone who can rid us of... but most times we pray about it and it doesn't happen... when they threaten us like that, we know what to do, make sure we put our things carefully away.'*

Facing down violence

Students described how following their involvement in a stillbirth delivery, they were at risk of physical violence from angry relatives. Nathan provided an account of how one particular group responded with violence following a stillbirth during a terrifying situation he and Reuben experienced as student nurses:

One mother she had cord prolapse... we delivered the baby and the baby was already dead, fresh stillbirth and we managed that mother with PPH, postpartum haemorrhage management, we get the mother surviving but we lost the baby. In coastal regions, it is so easy to negotiate with people, and up in the highlands regions, it's a little bit harder to get along with people, their mindset, it's really hard to get along with those guys, they're mostly against health workers, and even though you can see that this is the real causes, this one we try to manage all our best, and they even put bush knife on my neck... I was thinking 'Jesus Christ this is my last time to survive again'... we fear our life and all of us we just don't believe what to do at that time. The HEO [health extension officer] came in... then the villagers go ahead,

they all had a talk with the community centre and peacefully solve the problem but they already blaming all of us students who were there... we were so like, confused. We lost the baby and at the same time, they blame us and they even try and kill us!

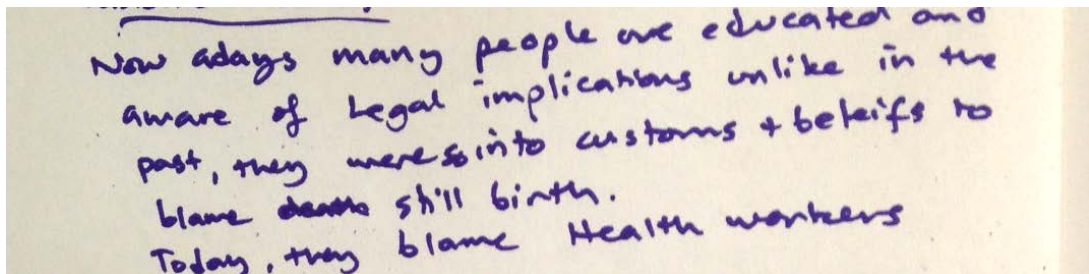
Marie believed community education about pregnancy and birth was the key factor to facilitate understanding and minimise the tension between health care staff and families following stillbirth:

Angry relatives. Nobody want to get bad news so the only people they find are us. If anything happens, whether they are the cause or not, they still get the blame, they are still threatened. So, it's important that people get educated so they know, they'll understand what we are saying to them about causes...some cultures are good, some cultures are very aggressive, they won't even let you explain and the knife goes first.

Receiving legal threats

However, students in the study observed that as education levels increased, so too did accusations of malpractice against medical staff as people gained awareness of their legal rights. One student in the workshop wrote, *'Nowadays many people are educated and aware of legal implications, unlike in the past, they were into customs and beliefs to blame stillbirth. Today, they blame the health workers'* (see Figure 7.10). Abby recounted her experience of dealing with an angry relative threatening legal action in the regional hospital where she worked:

Some they accept it, others no, they blame us... a first time mother she delivered and then she had a prolapsed cord... the cord had stopped pulsating so the baby has died already... a week later the grandfather of that baby came, he was very mad at us... he said that he would sue the hospital for mismanagement... it's rare in the rural hospital but I think POM Gen [Port Moresby General Hospital] they have many cases of this, like patients react and they threaten to sue the hospital for mismanagement and then it causes fear to us the staff as well.



Nowadays many people are educated and aware of legal implications unlike in the past, they were into customs + beliefs to blame death still birth. Today, they blame Health workers

Figure 7.10. Workshop: awareness of legal implications

Hannah understood that hospitals did not conduct reviews or autopsies for stillborn babies, 'unless it is required by parents or court or any purposes'. While Abby thought the instigation of legal proceedings for stillbirth was rare outside of larger urban areas, Reuben's experience in the aftermath of a stillbirth event demonstrated that legal action could arise in rural areas of PNG. Reuben recalled:

... [t]heir family were not accepting this death of the baby, so they had to go through the legal process, counsellors reporting to them... so they've come to me, saying how was the death of the baby and then they demanded I should not respond properly you will seek legal process so, because it was the elder brother of the husband of that woman, I told him one, that child was born dead, confirmed dead, no life existing,

none, not at all, so I have witnesses... I had to make report directly to the police to see that the situation going on... it was a difficult time for me.

Students belong to, and identify with, multiple communities: their family, their village, their clan, their religion and denomination. They are members of church congregations, health care teams and professional groups. Students denoted connection to place and collective identity through their use of phrases such as:

In my place	Back in my village	For my community
Us health workers	We nurses	Our role as midwives
Our customs	This is our culture	We have this clan
I am a Catholic	My church	We are all Christians

However, students exhibited both connection and othering when they voiced disagreement with diverse beliefs held by the people within their communities. This switching was common in the student responses. Nathan's comment provides an example, and I have used bold text for emphasis: *'In **my** place, **they** say that if woman is pregnant she shouldn't eat a certain type of fish in the sea, **we're** from coastal, so **they** say you don't eat this fish.'*

7.4 Dealing with feelings

Being involved in a stillbirth event had been an unforgettable and sometimes traumatic experience for students. 'Dealing with feelings' is a central dimension that explores the emotional responses of students and ways in which they regained emotional balance and

moved forward, to provide their best care to woman following stillbirth. ‘Dealing with feelings’ incorporates the attributes of ‘consequences of caring’ and ‘capacity for coping’.

‘Consequences of caring’ describes their range of feelings related to the woman, her family and themselves as students engaged in providing care before, during or after a stillbirth event. Students demonstrated a ‘capacity for coping’ by enacting a variety of strategies to help manage the emotions and feelings that had a negative impact on their professional practice, health and wellbeing. The dimension of ‘Dealing with feelings’ and its attributes is shown in Figure 7.11.

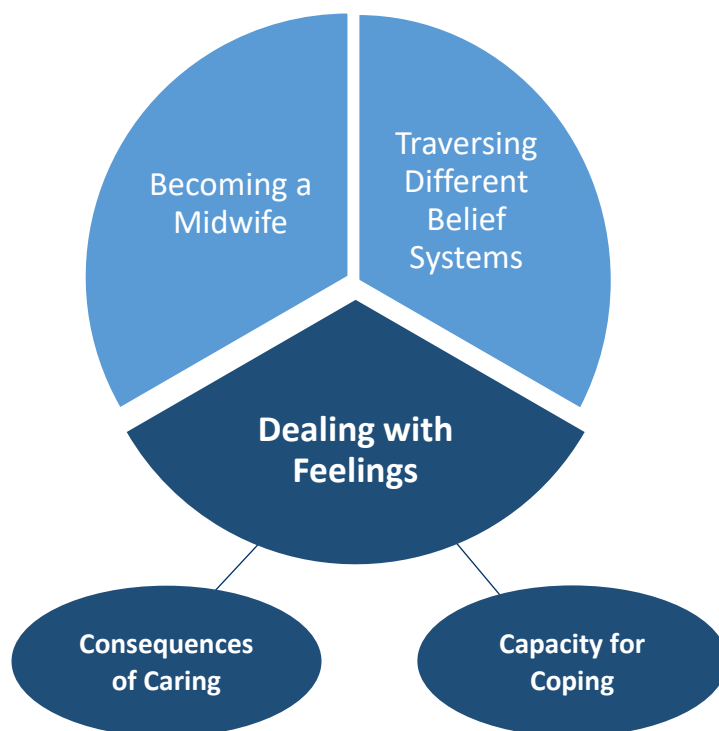


Figure 7.11. The dimension of ‘Dealing with feelings’ and attributes

7.4.1 Consequences of caring

Stillbirth is often an unexpected event, which thrusts a nurse, midwife or midwifery student into a critical situation. Whether or not their experience had occurred recently, students in the study were able to recall clearly the emotional impact and their feelings following their involvement in a stillbirth delivery, or when providing care to a woman following stillbirth. Some students continued to struggle with painful memories.

Being fearful

Students had strong memories of their first stillbirth event. Eva recalled, *'I was thinking ok, so this is how a dead baby looks like, I mean if I happen to deliver some more dead babies in the near future'*. Eva described feeling afraid while delivering the baby:

When I pull the baby out all the skin on the abdomen, the hands and the legs they just peeled off and I was afraid, and then the sister said, 'No, the baby's dead already, you just take it out, it's dead inside the mother's womb so just deliver the baby, just do normal delivery'.

Other students felt scared and anxious for the outcome of their own pregnancy. Candace explained, *'I'm scared, like if I'm pregnant, then I will have my child like this... malform, so it's very scary. That time I was a [nursing] student but now it's ok'*. After witnessing stillbirth, Marie also feared giving birth to a stillborn child, her anxiety prompting her to take preventative care during her own pregnancy:

I also had fear in me that I might have a stillbirth, coz when I fell pregnant I would say 'No, I hope my baby's ok' ... it affected me coz I witness with my eyes, every time I always go for check up to make sure that my baby's fetal heart was ok, so I had this fear, anxious from what I saw.

Meeting the challenge

Students felt that attending to a women following stillbirth was a challenge, not only wanting to provide a clinical explanation but also psychological and emotional support under difficult circumstances. As Leah commented, *'Giving feedbacks to [the] mother or talking to the mother after their baby have died, it's a very hard thing to do, I mean very hard thing to approach them'*. Finding the right words was not always easy, as Eva recounted, *'I don't know what I'm going to say'*. Candace spoke about the challenge of being available to the woman to provide reassurance and comfort as well as providing reasons for why the stillbirth occurred: *'You have to be there to explain to the mother, try to convince them and reassure and comfort them. It's a very big thing to do, attend.'*

Students felt satisfied with the care they provided to women, when a stillbirth resulted from complications in pregnancy, fetal abnormalities or when the baby had died in utero some time prior to birth. Abby stated:

If I think that I did the things that I supposed to do and then the baby died, then I'm satisfied, or because of other causes, let's say the mother might pre-eclampsia¹⁷ ... I see that I'm not at fault then I am happy.

Hannah was satisfied with the care she gave to a woman, whose first child was stillborn after death in utero:

I was not affected in that way because I didn't cause it, it was already detected and informed earlier that you were expecting maybe a stillbirth because I can't hear the fetal heart sound... I was quite ok because the baby was dead already inside, it was not my problem or not to do with the interventions that I offered to the mother.

Candace believed the health care team had performed competently during the stillbirth of a baby diagnosed with hydrocephaly¹⁸,

We did everything well, I mean the prognosis, the outcome will still be poor because the head was not fully formed, we thought that the baby's alive but after we deliver and during the examination we found out that the baby has no head, we did everything we can.

Rebecca felt excitement when she was involved in the care of a young woman delivering a macerated stillborn fetus: *'We were very excited because we cared for the mother*

¹⁷ A disorder of pregnancy characterised by hypertension and involvement of one or more other organ systems and/or the fetus (Fraser et al., 2009).

¹⁸ A condition that arises from blockage in the circulation and absorption of cerebrospinal fluid in the ventricles of the brain (Fraser et al., 2009).

and the mother had complications but we managed it and the outcome was very good so we were very excited. Because the outcome was very good.' Nathan recalled a feeling of satisfaction regarding the care he provided to a woman with non-pregnancy related convulsions. Even with an emergency caesarean section, it was not possible to save the baby: *'I look after her post-caesarean section, so I think that what I did was good and it satisfied me during the day when I go back home, I had job satisfaction.'*

Feeling frustrated with self and others

While satisfied with their own performance, some students felt frustrated with the situation or with other health care staff. Marie was frustrated, *'because you feel like everything should go right in the delivery room and everybody looks, they look upon you'*.

Naomi voiced her frustration at the behaviour of the doctor who was on call at the time of the stillbirth, saying angrily:

I sat back and I was just thinking, why didn't the doctor do something, if only he done something then we won't lost this baby and we should have acted already than that time we acted was a late time we did something for her, because the baby was already dead, they could have done something earlier on.

Some students also expressed feelings of frustration with the behaviour of the woman in their care. In Leah's experience of providing care following stillbirth for a grand multiparous woman:

The other feeling that came in was if the mother felt that her baby was not moving, she should have come quickly to the hospital so I could've helped her. Why did she come late?... why did she have to have another baby and give birth to a stillbirth baby, she should have just accepted that she had six children already and now the seventh one, you know the seventh one has died.

Rebecca felt frustrated with the behaviour of a nursing officer colleague whose baby was stillborn owing to undiagnosed syphilis. Rebecca explained:

She should have come earlier but she came late when the fetal, when she had reduced or no fetal movement two weeks ago... she must have aware [of having syphilis], I don't know, she was ashamed of going for blood check and treated because she's a nursing officer, so she did not go.

Relating to the woman, her partner and the family

While frustrated and angry, the students felt empathy for women following stillbirths, envisaging themselves in the same situation. Naomi said, *'I was imagining if it was me, then I would feel the same as her'*. Marie explained further:

If you really put yourself in the person's shoe, when you're with them when they're grieving, especially the women's age, you feel empathy... especially if you're a mother it won't go, it will stay with you for some time... how would you feel if you had a dead fetus in you?

Nathan was sensitive to the husband's thoughts and experience of losing a much-anticipated child:

I was thinking if it was my wife, after all this long periods or months taking her across to clinics, and just to be ready to welcome someone new into the family and then you just wasn't quick enough, even if it is within some few hours.

Sadness and sympathy for the woman and her family were common feelings among the students. The loss of a male child in regions where men enjoy a higher status than women engendered sympathy for the woman and her family. Abby stated, *'Most of the men they want baby boy, according to our PNG culture, giving birth to baby boy, it's a big thing'*. In Abby's experience, when a woman delivers a baby boy, *'The husband, well he comes to see and he's like a drunkard person, he's happy... he rejoices'*. Marie recalled that a woman, whose only male child was stillborn, *'kept on saying that she wish that she had a baby boy, so it's sad, especially in that kind of situation'*. Nathan not only felt sympathy for the father losing a child but also sadness that the loss was felt more keenly because the baby was male:

The husband when he cried, he says, 'I lost a baby boy', that's what most of the time he comes back and he talks... he valued that baby [more] than losing a female baby, that's what I see, so I feel sad about that too.

Witnessing distress, being distressed

Sadness also came from professional experience and realising the risks associated with pregnancy. Candace stated:

I was sad because I found out from that time that every pregnancy that a woman has comes with complication or every pregnancy is at risk, not every mother that are pregnant will keep it, normally some will stillbirth, some will go through complication... it's very complicated thing to go through pregnancy and childbirth.

Nicole felt sad realising her care was not enough to prevent a stillbirth resulting from pre-eclampsia and oligohydramnios¹⁹: *'I was sad I couldn't help her... because my help wouldn't even be enough.'* Abby's sadness was exacerbated by her close relationship with the woman and family for whom she was caring: *'I was very sad too, they were our friends too, family friends, when that sister or that mother she cried, me too, I was emotional too.'*

Students were frequently distressed following their involvement in a stillbirth event. For Naomi, the memory was still painful and she wept when recalling, *'And here the baby is dead and it was very difficult for her and for me too'*. The most common emotional response was crying. Reuben tried to remain stoic but admitted, *'Seeing mothers crying also, having tears in their eyes—you will also have tears in your eyes, I even don't like seeing mothers crying in front of me when they experience stillbirths'*.

Abby spoke of needing to remain in control of her emotions so that she could continue to provide support and care:

I was thinking that you couldn't be that emotion 'coz it's your patient, you have to be strong like, you have to be strong so that you can comfort the patient. I cannot like put

¹⁹ A deficiency in the amount of amniotic fluid (Fraser et al., 2009).

myself into the patient shoe and then I have to cry in front of her, this is not good, this is not my code of ethics.

Marie described an emotional experience shared with a grieving mother, recalling her supervisor requested she leave the room:

I delivered a big baby and it was all green coz meconium²⁰ stained but it was dead and I had to hold up that baby and show it to the mother and she hugged the baby and cried, and I cried with her and I was told by my supervisor that I'm not supposed to cry, 'You're not supposed to cry in front of her, you should go somewhere else', I say 'Well I can't help it, there's nowhere to go', so it was really emotional.

Some students said their emotional reactions depended on the mother's emotional response to the stillbirth at that time. Abby observed, *'They don't take it that seriously, they don't feel so emotional about having a miscarriage or stillbirth,'* and in those situations, *'Sometimes we feel sorry for them as well but, if only they're so emotional at that time, and if not then we just take it as normal'.* However, on certain occasions, it was difficult for Abby to control her emotions while providing care and she too felt the need to hide away:

Sometimes we are so emotional too and then we try to talk and comfort them but then, sometimes we shed tears as well with the mothers, when you see them crying you cannot stop it, you will definitely cry. It's a sad thing, they're expecting their baby to be born alive and then somehow the mother had a stillbirth and it's very sad... If you

²⁰ Dissolved solid matter present in amniotic fluid including food substances and waste products (Fraser et al., 2009).

feel like crying and then you have to run and hide somewhere... sometimes I grieve and weep.

Naomi spoke of feeling something akin to grief for the loss of the stillborn baby: *'It's a feeling you've lost something, a death or something happened in your family and you're feeling that sort of feeling.'*

Most students felt depressed following a stillbirth. Naomi recalled, *'I was really down that time... for a day or two I will feel this kind of feeling that I feel down or something'.*

Nathan spoke about how stillbirth affected the mood of the labour ward staff in the hospital:

All of us in the wards too were silent... previously we'll go and we'll work with enjoyment and that thing just happened right within our care and all of us were just, what would I say? It weakens our work for two days... our morale of working it was so good and then two days like, if that thing happened outside of the hospital and wasn't brought in yes, [but] it was right in our care that it happened.

Marie was the only student who reported sleep disturbances related to the stress of caring for women experiencing stillbirth:

At the first place, I didn't sleep well, I was a bit disturbed but then over time when I heard from my other colleagues and I actually spoke with one of my lecturers she said it's life... you will come across a lot of woman who will go through that but you must learn how to manage them.

Living with guilt

Most students had feelings of incompetence dealing with a stillbirth event. This was particularly true for Eva, who first experienced stillbirth when a student nurse:

I saw myself as a junior nurse among the seniors there and I kind of feel a bit, you know, incompetent or something and I was expecting them to supervise me, like when I need help I call for them so that time, maybe I'm not that well prepared to care for that mother because I just deliver the baby.

Naomi too, had doubted about her capabilities: *'I feel like I miss something, like I did not do my job well... I was really feeling discouraged, thinking I should have done something better.'* The thought of overlooking an aspect of care or not intervening in a timely manner elicited guilty feelings among many students, as Leah explained, *'I'll say a feeling of guilt or something, that I should have done something before'*. Abby shared the same guilty feeling: *'For me personally, sometimes I feel guilty, if I was supposed to do that and then prevent the baby from dying and then the baby died, that's a guilty feeling.'* Rebecca also noted, *'If the baby dies in the hospital during our care, I think I would be guilty, I would be guilty and uneasy'*. When working as a general nursing officer on the labour ward, Johanna blamed herself for improperly caring for the woman until the midwife in charge provided an explanation for the stillbirth,

At first I was blaming myself, maybe I didn't handle the mother properly... then the midwife came and we talk about it and she said she was a post-term²¹ and she never

²¹ Pregnancy equal to or more than 42 completed weeks (Fraser et al., 2009).

attended the clinic, that's the reason why the baby must have died and she was in labour and she came to do a normal delivery.

Feelings of self-doubt and guilt were not limited to the immediate time of stillbirth event but were ongoing, with lasting effects on students' emotional wellbeing. Several students had taken photos of the stillborn babies they had delivered. Reuben disclosed his anguish upon reviewing the images he had kept:

It really hurts when you see people like this. Sometimes last month when I was sorting the photos of those babies and I told them that I never tell this until I go back, even to the class I won't present it, because it really hurts me a lot. It's like, maybe I'm killing people, I'm not helping people.

Naomi projected the guilt she felt over the stillbirth of a baby to other deaths, and hoped the passage of time would help her to overcome feelings of self-blame:

For me I was very guilty... I was just blaming myself for the death, not only for the baby but every other death, it's like I'm blaming me, myself for not doing what I suppose to do to save that life, so as times goes on I forget, but as times goes on I can overcome the fact that I was the one who was the one to blame for the life of that baby.

In contrast, Marie doubted that time would minimise guilty feelings, commenting:

Well, if you're innocent you won't feel anything you know, but if you are guilty you'll feel like it, yeah. If you're innocent, you'll just accept it and you'll say no, I didn't do that, you know that you didn't do anything it will be ok, but if you did something wrong then you'll feel guilty, maybe for the rest of your life.

7.4.2 Capacity for coping

Students employed a number of coping strategies to improve their emotional wellbeing following their involvement in a stillbirth event. They mitigated their emotional stress through their personal relationships with family and friends, their colleagues and with their God through prayer.

Keeping busy

Being active with family, friends or in solo activities was the most common coping mechanism reported by the students. Marie sought to maintain an optimistic viewpoint, saying, *'Things that trigger my stress, I don't want to think of them too much, I see on the bright side'*; and that she tried to keep busy in the kitchen, *'baking, cooking... all sorts of cakes and a shepherd's pie. I get together with my friends, that's what we do'*. Socialising with friends was a coping mechanism also employed by other students. Nathan explained, *'When I have stress or overloaded with work I left, I just nip out and went out with my friends'*. Nicole said she would, *'just try to socialise with my friends and forget about that'*.

Some students found comfort and joy in music: *'It's always my happy sound'*, said Marie, *'I love singing, it helps me, and dancing.'* Reuben used music as a tool to improve his mood, *'Playing guitars and singing songs are the ways to which I reduce depression'*, while Nathan managed his emotions by working on his guitar-playing technique:

I like playing... I like the country music, the old ones because I try to play guitar following how they play... it's more they play with instruments than our current music that they use computers and it's more complicated to follow.

Several students improved their mood by keeping physically active. Marie exclaimed, *'I love gardening'*; Nathan said, *'I like playing soccer'*; Naomi disclosed, *'I have children as well, so being with the children, talk with them and play with them, I get over this'*. Other students attempted distraction from their inner emotional turmoil by watching television and movies. Abby remarked, *'I watch TV so I work through why or tell stories just to try to forget and then make me feel better'*. However, for Nathan this was not a successful strategy: *'When I watch movies, the bad thing is that I slept, I won't complete the movie and I will sleep, that's why when I'm stressed I don't watch.'* Reuben sought distraction by logging on to the Internet and social media, saying, *'They make me feel like I'm not concentrating on these things what I'm trying to get off, ways to read some journals or go through social media and chatting with people so that I lose track'*.

[Sharing stillbirth experiences](#)

Sharing experiences with others was an important coping technique. Married students often shared with their partners. Abby explained:

If I feel that I'm hurt or I'm guilty about anything regarding the patient, I go and I tell him, 'Oh I did this and the baby died or the mother died and I feel very sorry about this', and then what he normally says is that 'We are not God, we are just human beings, you only do our part, if you cannot manage it, that's it'.

Hannah reported that students sometimes undertook reflective practice and discussion following a stillbirth but not in a structured way. Some students sought advice from their nursing and midwifery lecturers. Candace recalled, *'I ask my lecturers, then they explain why this happens, I tell my friends too, sometimes things like this happens beyond our controls'.* Others chose to share with colleagues, as Leah articulated:

I think sharing the story with my other colleagues so I can gain comfort and strength from them, so I can share my experience and they can share their experience, I think my experience may be not worse than their experience so at least it balance off my feelings so I can feel well after sharing experience to them.

However, one student stated she would not share her experience with people outside of the clinical setting because of professional ethics. Eva declared, *'It's unprofessional yeah because this is what I experience in my workplace and I'm not allowed to share what I experience in the workplace, patient's privacy and confidentiality'.* For Abby, sharing with colleagues was not always a safe option and could have personal consequences, as she explained:

Sometimes I feel that it's risky telling them, they might go and tell others or I might get the blame... our culture, people might come back and get on us so it's not good

you go ahead and you tell others. If you trust them, you tell them but you don't trust them, you go and you tell it to the Lord.

Finding comfort through God

Students gained solace and strength from their belief in the wisdom of God and the healing power of prayer. Naomi sought forgiveness through prayer: *'Sometimes I pray and ask the Lord if I've done wrong then forgive me.'* Leah recounted how a prayer had helped her cope:

I told God, 'God, we have delivered this unborn, I mean stillbirth child and you are the main reason why, you know why that baby has died, and you give me a peace of mind so that I can have peace within me so that I must not think of what has happened. I must accept it that you give life to us and you take it, you take our lives back'. So, after praying that was it, I felt good.

Candace had metaphysical questions that needing answering before she could find peace:

I was questioning why do these things have to happen, like every child is a gift from God. Then by reading through my Bible, everything happens for a reason... everything that happens, happens for our own good, so sometimes, many times we question God but after all, God has the answer for everything that happens in life, so I found comfort.

Helping others

Students reflected on their experiences of providing care to women following stillbirth, and the action they would take in the future should the same situation arise. They spoke of the importance of experiential learning, as Hannah stated, *'Because if we know that we contributed to the stillbirth then we improve the next time'*. Candace had this suggestion for other midwifery students reflecting on their provision of care to women following stillbirth:

If they think that they should have done something and they not doing it well, well everybody makes mistakes, so it's nothing for them to worry about, they can learn from their mistakes and when another mother come they will be in better position to help them.

Using knowledge and experience to enable others to avoid stillbirth was a strategy Nicole employed to improve her feelings: *'People that I think I can help them earlier to avoid such conditions, I will try to help them to make myself feel better.'* Candace managed her feelings by improving her knowledge: *'I go back and do my own reading about stillbirth and then, that's way that we can try to prevent, educate the mothers, go to early check-ups.'* Hannah was able to alleviate her sadness by giving health care advice to women and their relatives for any subsequent pregnancy: *'How they must always attend antenatal clinic to check how the baby is inside and on the type of foods she will be eating and how she will be staying... at least I feel ok.'*

Enrolling to study midwifery enabled some students to move forward from their involvement in a stillbirth delivery. After a traumatic experience of delivering a stillborn baby following shoulder dystocia, Naomi revealed, *'If only I had this knowledge it be ok, I would have saved that baby. That made me to come here, pick up midwifery'*.

7.5 Summary

In this chapter, I have:

- described midwifery students' understanding and experiences of providing of care to women following stillbirth in PNG
- explored these experiences through the three central dimensions of 'Becoming a midwife', 'Traversing different belief systems' and 'Dealing with feelings'
- described the attributes of each dimension with supporting data
- presented a theoretical understanding of how midwifery students provide the best possible care to women following stillbirth through the experiential process of 'Balancing It Out'.

In the chapter that follows, I will:

- position the findings in the existing literature
- compile the findings under broader theoretical constructs to show how ideas that emerge from this study are consistent with global definitions of health
- discuss the use of philosophical assumptions to conceptualise the findings through global frameworks.

Chapter 8: Discussion

8.1 Chapter outline

In this chapter, I provide a summary of the findings and position the findings in relation to the extant literature. I show how this addresses the study aims and how the grounded theory emerges from the research methodology and practical application of the research methods. I compile the findings under broader theoretical constructs to show how ideas that emerge from this study are consistent with global definitions of health and the practical application of these through the Alma-Ata Declaration (WHO, 1978) and the Ottawa Charter (WHO, 2009). I discuss the explicit use of philosophical assumptions to conceptualise the findings through global frameworks and qualitative research approaches. I explain how I ensured the quality of the research and list the limitations of the study.

8.2 Locating the findings within the literature

‘Balancing It Out’ is the core category of the grounded theory and the social process by which midwifery students actualised their core concern of how to provide the best possible care to women following stillbirth. ‘Balancing It Out’ can be best understood by using the conceptual model as the framework to position the grounded theory within the literature. In the study, I identified the contextual environment and three dimensions, each with a number of attributes. These offer a grounded theory of how PNG midwifery students experience caring for women following stillbirth. The three dimensions that emerged from the data were (i) ‘Becoming a midwife’; (ii) ‘Traversing different belief systems’; and (iii) ‘Dealing with feelings’. These dimensions describe different aspects of the experiences of the students in

their provision of care following stillbirth. The dimensions and attributes associated with the provision of care that emerged from this study complement and extend the literature examining the experiences of midwifery staff in PNG and international contexts.

8.3 Acknowledgement of the Papua New Guinea context

The theory is grounded in the experiences of the midwifery students situated within the PNG environment. This environment incorporates the broader social, structural and cultural elements that affect health care for childbearing women in PNG. Students related how concepts of gender diminished the autonomy of women, including the right to decide on matters related to their own sexual and reproductive health. Gender refers to the socially defined characteristics of men and women within a culture. Men and women are assigned gender roles and learn accepted social behaviours according to gender norms (WHO, 2018). The PNG Constitution decrees ‘equal participation by women citizens in all political, economic, social and religious activities’ (Government of Papua New Guinea, 2017, p. 3). However, the students acknowledged that the authority to make decisions is a privilege usually accorded to men. This finding is consistent with those of the existing literature. Each day, PNG women face challenges because of their gender and the culturally sanctioned model of PNG womanhood. PNG women are under-represented in leadership, political and governance roles (Baker, 2018). Despite a record number of female candidates standing for election in 2017, men continue to dominate the PNG political sphere. In 2018, there are no female members in the PNG parliament, making it much more difficult for women to contribute, at a national level, to the gender discourse and decision-making processes regarding women’s health and wellbeing. Gender inequality results in unequal opportunities for PNG women to access education, economic resources and property, increasing the risk of

early marriage, disruption to family ties and frequent childbearing (Hinton & Earnest, 2009). While literacy rates for PNG women have steadily increased in recent years—64% of women are able to read and write at least one PNG language—fewer girls than boys complete their secondary schooling (National Statistics Office Papua New Guinea, 2015).

Attaining higher levels of education reduces a woman's risk of stillbirth at all gestational intervals, in both high-income countries and LMICs (Auger, Delézire, Harper, & Platt, 2012; Chomba et al., 2017). Women in LMICs with higher levels of education more regularly attend antenatal care, deliver in a health facility and use contraceptives for family planning (Afulani, Altman, Musana, & Sudhinaraset, 2017; Ahmed, Creanga, Gillespie, & Tsui, 2010; Chomba et al., 2017; Langer et al., 2015; Liese & Maeder, 2018; Weitzman, 2017). The first two increase the chances for timely detection and treatment of complications leading to stillbirth, while the last improves birth spacing and reduces the number of women seeking abortions for unwanted pregnancies (Liese & Maeder, 2018; Weitzman, 2017). Education and maternal health are connected. Extended schooling for girls brings opportunities for greater cognitive skills, social and economic improvement and autonomy. These factors improve women's ability to seek and understand information about their health, and enable them to contribute to household finances through employment, affording them greater decision-making power—including choices about childbearing and health care (Afulani et al., 2017; Ahmed et al., 2010; Langer et al., 2015; Weitzman, 2017). The midwifery students noted that illiteracy and a lack of education was a major barrier to communicating with women about maternal health behaviours and the cause of their baby's stillbirth.

The midwifery students in this study reported low utilisation of maternal health care services in PNG, reflecting the reality of PNG antenatal coverage of 54%, supervised deliveries of 40% and family planning (couple years of protection)²² at 81 per 1000 women (National Department of Health Papua New Guinea, 2017). However, the reasons for poor service utilisation described by the students are not all related to PNG women's power of choice. The intersection of sociocultural and structural factors in maternal health care-seeking behaviours needs to be understood. Barriers to PNG women's access and use of maternal health care facilities include community beliefs and attitudes about pregnancy and birth; decision-making; health care system resourcing; difficult and hazardous travel; as well as domestic and childcare responsibilities (Andrew et al., 2014; Browne, 2017; Ipi, Vince, & Mola, 2016; Larsen et al., 2004; Mola, 2018, May 22; L. M. Vallely et al., 2015; L. M. Vallely et al., 2013). Studies on other LMICs report similar findings (e.g., see Fauk, Cahaya, Merry, Damayani, & Liana, 2017; Finlayson & Downe, 2013; Ganle et al., 2015; Gitobu, Gichangi, & Mwanda, 2018; Mahato, van Teijlingen, Simkhada, Sheppard, & Silwal, 2017; Obermeyer, 2000; Simkhada, Porter, & van Teijlingen, 2010; Sychareun et al., 2012; Weitzman, 2017; Yang et al., 2016; Zakar, Zakar, Mustafa, Jalil, & Fischer, 2018). As reported by the students, these adverse conditions reduce a woman's autonomy and ability to seek health care, even when services are available (Langer et al., 2015).

The absence of support from a pregnant woman's male partner is a major barrier to her utilisation of health care services throughout her pregnancy and at delivery (Davis et al., 2018; Kura, Vince, & Crouch-Chivers, 2013). In two PNG studies—one in Southern Highlands Province and the other in East New Britain Province—women believed lack of

²² A measure estimating the protection from pregnancy provided by contraceptive methods during a one-year period—see <https://mariestopes.org/media/2188/msi-cyp-infographic.pdf>

partner support to attend health facilities should be a legislative issue (Holmes et al., 2012; Ipis et al., 2016). In accordance with the findings from the current study, authors associate men's lack of public support for their partners with social and cultural factors and health service provision (Davis et al., 2018; Holmes et al., 2012; Kura et al., 2013). Although some men are willing to be more involved in maternal health care, notions about masculinity and the social role of men influence behaviour because pregnancy, childbirth and newborn care are widely regarded as women's business (Davis et al., 2018; Holmes et al., 2012; Kura et al., 2013). In PNG, it is uncommon for a man to accompany his partner to an antenatal clinic, let alone participate in the consultation (Holmes et al., 2012). Men performing this public act of care experience community ridicule and shame (Davis et al., 2018). Customary practices also influence male involvement at the time of delivery. Men observing traditional ways typically provide no support to their partner during labour. The common belief is that contact with the birth liquor, blood and placenta will contaminate a man: He will become less virile and suffer poor health, illness or premature death (Fiti-Sinclair, 2002; Ipis et al., 2016; L. M. Vallely et al., 2015; Winkvist, 1996).

Health service-related barriers to male involvement in maternal health described by the students are located within the extant literature. The PNG National Sexual & Reproductive Health Policy (National Department of Health Papua New Guinea, 2014) encourages men to be actively involved in antenatal care and during childbirth in the labour ward. However, woman-centred facilities, poor staff attitudes and behaviour and lack of privacy and space for couples are aspects of service provision that deter men from greater involvement (Davis et al., 2018; Holmes et al., 2012). PNG men are criticised for being unsupportive of their pregnant partners yet receive little guidance on the best way to provide

support, being ‘actively excluded from the reproductive functions of the health system’ (Browne, 2017, p. 214).

While reporting many challenges in the PNG contextual environment, students recognised their specialist role as midwife would offer opportunities to promote male involvement in maternal health care and family planning. Men’s knowledge about sexual, reproductive and maternal health is gained from a variety of sources—older family members, friends, church or community leaders and health workers—who may not always be well informed (Holmes et al., 2012). A study based in the Mendi district of PNG supports the student observation that educated husbands are more likely to help their wives seek health care. Literate men are more likely to discuss reproductive health matters with their partners and provide better support, thus increasing women’s use of antenatal care, supervised birth and family planning services (Kura et al., 2013). The benefits of involving expectant fathers in antenatal care include improved knowledge of pregnant women’s health needs, recognition of obstetric danger signs in pregnancy and increased support for service access (Davis et al., 2018). Students believed the provision of more inclusive antenatal care was an important starting point to engage men in maternal health and educate them about childbirth. They felt this would help the men better care for their partners from pregnancy to the postnatal period, thereby reducing the risk of stillbirth. Students actively sought men’s involvement by requesting a pregnant woman to invite her partner to her next antenatal appointment.

Reviews of male involvement in maternal and newborn health in LMICs show that interventions to engage men are associated with improved use of health services for antenatal and postnatal care, facility birth with a skilled birth attendant, birth preparedness and complication recognition, improved maternal nutrition and more equitable communication

and decision-making (Tokhi et al., 2018; Yargawa & Leonardi-Bee, 2015). Male engagement in maternal health has positive effects; yet, it is important to consider that interventions need to be context-specific to understand dynamic social and cultural norms (Holmes et al., 2012). In settings with defined gender roles and power imbalances, the design and implementation of maternal health programmes for increased male involvement need to account for women's autonomy (Tokhi et al., 2018). Maternal health is one of the limited areas within a patriarchal society where women have a degree of empowerment (Dumbaugh et al., 2014). Increasing men's capacity to influence maternal health risks replicating existing elements of gender inequality, leading to negative outcomes for childbearing women, including men's ability to coerce or use force against their partner, further decreasing women's decision-making power (Dumbaugh et al., 2014; Tokhi et al., 2018). This aspect is particularly challenging in countries such as PNG where a predominantly patriarchal society exists and needs careful thought.

8.4 Becoming a midwife

For the students in this study, the transition from nurse to midwife began with the decision to undertake midwifery education. The students balanced the disadvantages of leaving family and/or employment separation with the advantages of furthering their knowledge and skills. A major motivating factor to study midwifery was altruism. Students revealed a strong desire to be an 'agent of change' to improve maternal and neonatal outcomes in their communities. Students recognised their general nursing skills and training had not sufficiently prepared them for the life-and-death situations they faced caring for women and their newborns. There is a dearth of literature examining reasons nurses decide to undertake midwifery study in PNG. Supporting this study's findings is research by Moores et

al (2015), who report PNG nurses chose to study midwifery because of altruistic motives: Being aware of high maternal mortality rates, or having been involved in a maternal death, provided the motivation to learn midwifery skills to help better serve women and improve maternal and child health. The students in this study felt that serving pregnant women was important and as health professionals with specialist skills, they could provide the best possible care.

Altruism is the most often cited reason for pursuing a career in health care (Miers, Rickaby, & Pollard, 2007), and notions of altruism are evident throughout the international midwifery literature. In LMICs with a shortage of skilled personnel, students perceive midwifery as a service vocation (Huicho et al., 2015). Midwifery students often enter the profession because they want to learn skills to help reduce high maternal and neonatal mortality rates, particularly in rural areas (e.g., see Bennett, 2014; Huicho et al., 2015). In contrast, studies from high-income countries report altruism related to the empowerment of childbearing women (Carolan & Kruger, 2011; Seibold, 2005; Ulrich, 2009; Williams, 2006). The focus on advocacy is driven by the students' desire to facilitate positive birth experiences for women (Carolan & Kruger, 2011; Ulrich, 2009). Individual, situational and environmental variables influence career choice (Rousseau & Venter, 2009). Evident in the wider literature, but not in this study, were other motivating factors, including: financial gain and job security (Abushaikha, 2006; Al Hadid, Al-Rajabi, AlBarmawi, Yousef Sayyah, & Toqan, 2018); media representations of midwifery (Carolan & Kruger, 2011; Cullen, Sidebotham, Gamble, & Fenwick, 2016); fascination with pregnancy, birth and babies (Carolan & Kruger, 2011; Charrier, 2011; Cullen et al., 2016; Seibold, 2005); and not wanting to be a nurse (Cullen et al., 2016; Seibold, 2005; Williams, 2006). These motivators

reflect contextual differences between and within countries, in settings vastly different to PNG.

As a primary health care strategy, midwifery is defined by the relationship between the midwife and the woman (Australian College of Midwives, 2018; ICM, 2017). The concept of woman-centred care is fundamental to the profession's philosophy, practice and relationships, as expressed in the statements of many midwifery colleges and associations worldwide (Leap, 2009). Although the conceptual framework of the PAU midwifery programme articulates the relationship between midwife and woman, students did not use the term woman-centred care, instead expressing a holistic approach to care. The provision of holistic care, 'grounded in an understanding of the social, emotional, cultural, spiritual, psychological and physical experiences of women' (ICM, 2014) is one element of woman-centred midwifery care. Students utilised the concept of balance in holistic care to provide the best possible care to women following stillbirth, asserting that a balance of physical, spiritual, emotional and social aspects of care would help a woman regain health and wellbeing following the loss of her baby.

There are several indicators as to why the midwifery students took a holistic approach to health. First, the study found students brought to their midwifery studies a strong nursing identity. As registered nurses, the students provided nursing care based on PNG nursing philosophy, where 'nursing addresses the complexity and uniqueness of the whole person in the environmental context...nurses provide care, simultaneously attending to the biological, psychological, social and spiritual needs of the person, and by being aware of the interrelationships between these needs' (Papua New Guinea Nursing Council, 2002–2014). Second, the *Strengthening Midwifery Toolkit* (WHO, 2006) provides the foundation for the

PAU midwifery programme. The toolkit enables countries to establish a curriculum balancing international midwifery competencies with national health priorities and needs (WHO, 2011a). The toolkit offers education providers flexibility to develop a curriculum according to institutional ideals while ensuring graduates meet professional accreditation requirements (WHO, 2011b). The students' focus on providing holistic care to women following stillbirth reflects the educational philosophy of the PAU midwifery programme, which states:

Women require care in pregnancy and childbirth which is not only safe, but which also meets their individual psychological, emotional, physical and social, including spiritual needs. The education of the midwife therefore needs to focus on meeting the holistic needs of the woman in a sensitive and competent manner. (Pacific Adventist University, 2014, p. 10)

Third, PAU views 'true education' as personal holistic development—intellectual, emotional, physical, social and spiritual growth—founded upon a Christian worldview (Pacific Adventist University, 2014, p. 13). Figure 8.1, an image of the door to the SOHS student welfare centre, illustrates how the four aspects of holistic care underpin the notion of health and wellbeing at PAU. The strong religious philosophy of PAU translates into the midwifery programme by the embedding of Christian principles, values and attitudes across the curriculum and the inclusion of a subject where ethical practice is explored from a Christian viewpoint.



Figure 8.1. Holistic approach to welfare for School of Health Science students

The midwifery students in this study were motivated, confident learners. Self-confidence is an indicator of clinical competence and ability in midwifery students (Ertekin Pinar, Yildirim, & Sayin, 2018). Students reported their growing knowledge base and clinical skills helped them feel confident in their ability to recognise and manage complications. Similarly, midwifery students in the UK believe there exists a distinct body of knowledge and a skill set in midwifery, that, once attained, would enable them to perform an activity correctly and practice effectively in an emergency (McIntosh, Fraser, Stephen, & Avis, 2013). The UK students, similar to their PNG peers, perceive that increased knowledge provides a ‘defence against uncertainty’ in practice (McIntosh et al., 2013, p. 1181).

The high confidence level of the PAU midwifery students to manage obstetric complications contrasts with findings from other research. An earlier PNG study found graduate midwives lacked confidence in emergency obstetric care and neonatal skills, including vacuum extraction and managing breech birth or shoulder dystocia (Moores et al., 2016). Similarly, midwifery students in Sweden lacked the confidence to manage unexpected

and emergency complications, such as shoulder dystocia (Bäck, 2018), while Indian midwifery students had low levels of confidence in recognising and managing complications during pregnancy, birth and in the postpartum period (Sharma et al., 2015). Explanation for the variations in confidence levels of midwifery students are beyond the scope of this research; however, the literature posits a number of contributing factors, such as time spent in clinical practice, quality and duration of education, the learning environment, student age and personal attitude (Fenwick, Cullen, Gamble, & Sidebotham, 2016; Sharma et al., 2015).

The midwifery students noted the focus of the theoretical and clinical components of the midwifery programme was the provision of physical care for a woman. Students typically afforded limited care and consideration for a stillborn baby and did not view the baby as a person. Research in other settings has examined this social identity of stillborn babies. A survey of health professionals from 135 countries reports that in LMICs, most stillborn babies are disposed of without being held by the mother, without being named and without recognition or ritual (Frøen et al., 2011). In some countries with high infant mortality rates, babies are often not acknowledged ‘as fully “human”’ or as ‘true members of society’, and thus, it is likely an unborn child would share a similar social status (Cecil, 1996, p. 7). Consequently, the birth of a stillborn baby may be considered insignificant. Studies undertaken in Cameroon (Savage, 1996), Ethiopia (Sisay, Yirgu, Gobezaeyehu, & Sibley, 2014), India (Jeffrey & Jeffrey, 1996), Tanzania (Haws et al., 2010) and Uganda (Kiguli, Namusoko, Kerber, Peterson, & Waiswa, 2015) report stillborn infants are devalued: They are seen as inhuman, and neither named nor mourned because they are not recognised as members of the society. In this study, the dehumanisation of the stillborn baby by the midwifery students was incongruent with their view that the baby was someone to be mourned by the woman and her family.

The students reported that unlike miscarriage, stillbirth was not included as an obstetric emergency in the PAU midwifery curriculum. Students knew about stillbirth from their lived experiences and the teaching of stillbirth as a complication of pregnancy. Students recognised women experiencing stillbirth needed supportive care. They suggested expanding the curriculum to teach more about stillbirth and the particular bereavement care these women required. Experiencing stillbirth can have lasting cognitive, emotional, physiological, psychological, social and spiritual consequences for women and their families; this can be intergenerational (Cacciatore, 2013; Lewis, 1979). Professional support for bereaved families is a determinant in how effectively they will recover from their grief (Cartwright & Read, 2005; Homer et al., 2016). The comments and actions of midwifery staff become part of the memories parents will forever retain of their baby (R. Smith, Homer, Homer, & Homer, 2011). However, the attitudes and skills of health professionals caring for women following stillbirth are inconsistent and often dependent on the understanding and compassion of the individual carer (Modiba, 2008). The students in this study relied on their own skills when providing support following stillbirth.

Students lacked confidence in their ability to provide bereavement care in a sensitive and competent manner and suggested learning practical bereavement care skills would help prepare them to provide better care. The study highlights how a student's care for a woman experiencing stillbirth depended on their personal skills and feelings. This finding is consistent with earlier research reporting that midwifery students involved in the death of a baby are anxious and uncertain about ways to provide supportive care (Begley, 2003; Doherty, Coughlan, et al., 2018; Mitchell, 2005; Morake, 2013; Rolls & McKenna, 2010). Development of communication and bereavement counselling skills is addressed in a study of the experiences of student nurse-midwives caring for women following stillbirth in South

Africa (Morake, 2013). The nurse-midwifery students perceive being able to communicate effectively with the woman improves the quality of care and the woman's ability to cope with the loss of her child (Morake, 2013). Many authors agree that midwifery students need knowledge and skills to provide appropriate and sensitive support following stillbirth (Begley, 2003; Doherty, Coughlan, et al., 2018; Homer et al., 2016; L. McKenna & Rolls, 2011; Mitchell, 2005; Modiba & Nolte, 2007; Nallen, 2007; Ravaldi et al., 2018; R. Smith et al., 2011; Warland & Glover, 2018). The *Essential Competencies for Basic Midwifery Practice* (ICM, 2013) include the provision of support for women and families experiencing bereavement following stillbirth. However, a recent study of the inclusion of stillbirth in midwifery programmes in Australian universities illustrates the diversity in curriculum design, content and delivery and the relatively little time spent on the topic, and calls for the development of a national, standardised curriculum (Warland & Glover, 2018). This finding was also identified in a study in Ireland, where quality and scope of instruction on the topic varied between midwifery schools (Begley, 2003). While there are risks for staff and students in teaching and learning about the sensitive topic of stillbirth, education and training will better prepare students for this aspect of practice (Warland & Glover, 2018). For the midwifery students in this study, having competency in bereavement care would enable them to achieve balance in the provision of holistic care to women following stillbirth that incorporated mind, body and spiritual aspects.

The midwifery students believed that spiritual care for a woman with stillbirth was a significant part of holistic care provision. Health organisations consider the spiritual element of holistic care as fundamental to health and wellbeing (Attard, Baldacchino, & Camilleri, 2014). Spirituality is embedded in midwifery philosophy and midwives are expected to provide spiritual care competently (ICM, 2014). Spirituality in midwifery is described as the

search for meaning and purpose in life related to strength, hope, relationships, nature and faith (Mitchell & Hall, 2007; Ross et al., 2014). Spirituality can be non-religious, yet within monotheistic religions, such as Christianity, spirituality centres on a person's relationship with God (Pembroke & Pembroke, 2008). It was evident in this study that students connected spiritual care with their strong religious beliefs. Prayer and reading Bible verses with the woman were common elements of care used by the midwifery students after stillbirth. Prayer can be a tool for healing and a motivating force for social change (Coyle, 2002). Prayer may also foster spiritual connection between a midwife, woman and God (Tanyi, 2002). Although no studies of midwifery students' use of prayer in care provision were located, one Hawaiian study reported that midwives recited from the Bible during births and used prayer as a spiritual tool when caring for women during difficult or challenging deliveries (Linhares, 2012). A study of American obstetric nurses present for a perinatal death described nurses praying while caring for mothers during labour and delivery (Puia, Lewis, & Beck, 2013). Being spiritual, having spiritual experiences and attending religious services frequently are contributing factors for a positive attitude towards spiritual care provision (Attard et al., 2014). As practising Christians, the midwifery students in this study perceived spiritual care would help the bereaved woman make sense of her loss and ease her grief. Spirituality is discussed in detail in Section 8.5.

The study findings illustrate that concepts of gender created personal and professional challenges for the male midwifery students as they transitioned from nursing to midwifery. Gender-typical occupations act as a type of gender identity measure in society (Wood & Eagly, 2015). Midwifery, similar to nursing, is a female-dominated profession and even though male obstetricians are socially accepted, the idea of men in midwifery is contentious (Pilkenton & Shorn, 2008; Scully, 2018, July 12). A recent study found that during labour,

PNG women preferred to be cared for by a female health worker (Ipis et al., 2016). The male midwifery students reported stigmatisation by others who believed the students' midwifery practice made them more feminine; subsequently, the male students did not measure up to their community's standard of masculinity. Conversely, the students' motivations to become a midwife were under suspicion when their masculinity was brought to the fore. Male students needed to minimise their masculinity to function successfully in professional contexts and, at the same time, uphold their masculinity to conform to social standards. One male midwifery student reported the male nursing students at PAU considered that he and his male peer were heroic for undertaking such challenging work.

The themes identified in the study are evident throughout the limited literature on the experiences of male midwifery students and midwives. Male midwives are often seen as effeminate, or presumed to be homosexual by other health professionals and by the community (Buscatto & Fusulier, 2013; Charrier, 2011; Scully, 2018, July 12). The notion of the feminine is juxtaposed with that of the masculine when the intimate care provided by male midwifery staff is sexualised (Kantrowitz-Gordon, Ellis, & McFarlane, 2014). Male midwifery staff achieve a balance between the feminine and masculine by adjusting their gender identity to their professional circumstance (Charrier, 2011). Hard work is involved in breaking down gender barriers. One Australian male midwifery student was told by his female mentor, 'You're a guy, you're going to stand out. You're going to need to bring your A-game every day you walk on this ward' (Scully, 2018, July 12). With a minority of males in the midwifery profession, it is hard for male students to find role models to help them negotiate the social and clinical challenges during training (Pendleton, 2015; Pilkenton & Shorn, 2008). Currently there are few male midwives in PNG. Midwifery programmes could assist the transition of male students into the profession by having former students act in

recruiting and mentoring roles to attract more males into midwifery (Pendleton, 2015; Pilkenton & Shorn, 2008).

8.5 Traversing different belief systems

The study documents the diverse social and cultural beliefs and practices surrounding pregnancy and birth in PNG. The midwifery students traversed multiple knowledge systems to make meaning about stillbirth in local and broader contexts. The study findings show three knowledge frameworks—culture, biomedicine and religion—helped shape the students’ understandings and influenced their attitudes and actions. In cross-cultural research of understandings of birth, Jordan formulated the concept of authoritative knowledge, observing:

[T]hat for any particular domain several knowledge systems exist, some of which, by consensus, come to carry more weight than others, either because they explain the state of the world better for the purposes at hand (efficacy) or because they are associated with a stronger power base (structural superiority), and usually both. In many situations, equally legitimate parallel knowledge systems exist and people move easily between them, using them sequentially or in parallel fashion for particular purposes. But frequently, one kind of knowledge gains ascendance and legitimacy. A consequence of the legitimization of one kind of knowing as authoritative is the devaluation, often the dismissal, of all other kinds of knowing... The constitution of authoritative knowledge is an ongoing social process that both builds and reflects power relationships within a community of practice. (1997, p. 56)

Midwifery students faced the challenge of negotiating multiple ways of knowing about stillbirth to deliver holistic care to women in various clinical settings. Jordan's observations provide a useful frame for situating the study theory of traversing different beliefs about stillbirth in the extant literature. Multiple ways of knowing is a part of everyday life for people in PNG.

The Melanesian worldview is holistic, where everything is related to the natural environment, the seen and the unseen, and creatures and persons both living and dead (Pauka, Treagust, & Waldrip, 2005; Vallance, 2007). Relationships and the social interactions between people underpin Melanesian society, where 'one must make meaning of everything in terms of culture, religion and one's social status' (Tommbe et al., 2013, p. 2). People have connection to *ples*—their ancestral village or community—and to their ancestral clan or tribe. Every community has standards and rules that prescribe how members should interact with each other to maintain social harmony (Tommbe et al., 2013). The *wantok*²³ system has been a fundamental part of Melanesian life for centuries (Arua & Eka, 2002). Under the system, people who share the same culture, language and values are obliged to support each other in all aspects of life (Marme, 2018). Important values and meanings within the system unite and strengthen Melanesian people and their cultural traditions (Arua & Eka, 2002). In PNG, reciprocity is a collective effort, with *wantoks* showing how much they care for others by working together to strengthen relationships or achieve goals, with personal contributions discharging, or creating new, obligations among group members (Kula-Semos, 2014; Narokobi, 1983). However, this practice can cause tension when community conventions impinge on relationships in the workplace and there is little separation between the public and private space (Kula-Semos, 2014). Community support plays a vital role in the motivation

²³ 'One talk' in English. A kinsman or close friend; one who speaks the same language.

and performance of PNG health workers (Razee, Whittaker, Jayasuriya, Yap, & Brentnall, 2012). Managing social relationships with *wantoks*, thereby maintaining a sense of belonging and identity, was an often-difficult task for the midwifery students when there was differing discourse about the cause of a stillbirth.

Across PNG, communities have their own explanation for illness, yet similarities exist (Frankel & Lewis, 1989). Taboos for pregnant women identified in the study as inducing stillbirth include sexual intercourse as pregnancy nears term, trespassing upon restricted grounds and eating certain types of food. Abstaining from sexual intercourse during pregnancy protects the unborn child, who may be killed by contact with semen (Kyakas & Wiessner, 1992; Scaletta, 1986). The concepts of taboos and restrictions are not unique to PNG. In Laos and Uganda, the health of the fetus was considered at risk from sexual intercourse (Kiguli et al., 2015; Sychareun, Phengsavanh, Hansana, Somphet, & Menorah, 2009). Failure to observe custom by venturing into sacred clan places or consuming the clan's totem animal also risk complications during birth (Macfarlane, 2009). Consistent with the study findings, earlier research undertaken across nine PNG provinces identified a list of foods, which if consumed, resulted in stillbirth (Whittaker, Piliwas, Agale, & Yaipupu, 2009). Protein-based foods, including various types of seafood, and meats, such as cuscus, flying fox, cassowary, pork and snake, were prohibited (Whittaker et al., 2009). Although students maintained SDA food taboos, they stated that food customs of others were wrong, stating decreased protein intake was a risk factor for stillbirth.

In PNG, health and illness are often understood to originate in the hidden world of spiritual beings and sorcerers (Sharp, 1982). Spirits are believed to cause illness as punishment for one's defiance of social norms or taboo violations, while sorcery is the work

of a living individual harbouring resentment towards another because of disorder in social relationships (Macfarlane, 2005). Spiritual beings, referred to by students in this study as *masalai*, are believed to inhabit waterways, trees, rocks, caves and other parts of the natural environment (Pulsford & Cawte, 1972; Sloane, 2001). *Masalai* affect an individual's health by injuring or stealing part of their soul, spirit or shadow (Pulsford & Cawte, 1972). Women and children are said to be susceptible to attack because they are too weak to defend themselves (Barker, 1989). During pregnancy, when the developing baby is especially vulnerable and malleable, pregnant women avoid going out alone and after dark when spirits are thought to be most active (Tietjen, 1984). Pregnant women from PNG's Enga province recite a magic spell to ensure birth does not occur in the middle of the night:

In my womb there is a baby.

Is it a boy or girl?

Well, we'll meet tomorrow at daybreak,

Lest spirits eyes might see you at night,

People's eyes might look at you,

We'll meet at midday when the sun is bright.

(Kyakas & Wiessner, 1992, p. 94)

Supporting the study findings are other PNG studies reporting stillbirth as retribution by *masalai* for a transgressive act, from trespass to singing loudly by a stream or stepping on sacred *masalai* stones (Mead, 1933; Winkvist, 1996). Theories of spiritual interference causing stillbirth are common. Pregnancy loss may be caused by ancestral spirits in Tanzania; ancestral ghosts called *duppies* in Jamaica; and evil spirits known as *asar*, *bhut*, *hawā* and *satāo* in India; *wukabi* in Ethiopia; and *sap dak*, *klu*, *tsan*, and *yul lha* in Tibet (Jeffrey &

Jeffrey, 1996; Raman, Nicholls, Ritchie, Razee, & Shafiee, 2016; Sisay et al., 2014; Sobo, 1996; Wembah-Rashid, 1996). Where nomenclature may differ between PNG and the literature from other settings, there are conceptual similarities. These cultural constructions of stillbirth rest upon the belief that a successful pregnancy requires a state of balance, where the physical health of the woman, the natural environment and various spiritual beings all work harmoniously together (Wembah-Rashid, 1996).

Sorcery as a cause for illness and death is a common belief across PNG among both formally educated and informally educated citizens and is a part of the social fabric (Onagi, 2015). Some midwifery students attributed stillbirth to acts of sorcery—referred to as *sanguma* or *poisen*—following a breakdown in social relationships. When sorcery is a suspected cause of stillbirth, women and their partners examine their relationships with family and neighbours for signs to explain why the attack occurred. Negative emotions of anger or jealousy are the predominant factors leading to sorcery in PNG (Hamnett & Connell, 1981; Winkvist, 1996). Similarly, in Cameroon, feelings of anger, jealousy, hatred and envy are the underlying reasons for pregnancy loss related to sorcery (Savage, 1996). Bewitchment by jealous co-wives in polygamous relationships features as a cause of stillbirth in research from Uganda (Kiguli et al., 2015). Sorcery is a growing industry in some areas of PNG with practitioners gaining respect and power among the community (Onagi, 2015). In accordance with the study findings, authors liken contemporary sorcerers to hired assassins who ply their trade for cash at local markets (Forsyth & Eves, 2015; Onagi, 2015). Students experience and need to contend with different specificities of beliefs in different regions.

Colonisation and the subsequent arrival of Christian missionaries to PNG brought new biomedical concepts to people with local understandings of health and illness (Kelly-

Hanku, Aggleton, & Shih, 2018). The anthology by Frankel and Lewis (1989) on medical pluralism in PNG examines the relationship between traditional interpretations and treatment of illness and Western biomedical concepts and practice. Multiple belief systems surrounding health and illness continue to exist in PNG (e.g., see Herbst, 2017). Papua New Guineans reject, adopt or adapt biomedicine depending on contextual practicality (Frankel & Lewis, 1989). Where traditional practice asks *who* caused the stillbirth, biomedicine asks *what* caused the stillbirth (Gibbs, 2015). For some midwifery students, their biomedical knowledge gained legitimacy when they identified stillbirth as the outcome of a medical condition or a complication of pregnancy or birth: that is, *what* caused the stillbirth. However, these students subsequently experienced tension in their relationship with a woman when competing interpretations of the event existed, that is, when traditional practices asked *who* caused the stillbirth. Other students viewed those who claimed stillbirth resulted from the work of spirits, sorcery or the breaking of taboos as uneducated and devalued these other ways of knowing.

The disdain expressed by midwifery students for alternative meanings and practices surrounding health and illness corresponds with the findings of other studies in PNG. Kelly-Hanku et al. suggest that, '[w]hen local understandings run contrary to global biomedical beliefs, there may be a tendency to posit such understandings as irrational and resistant to scientific authority rather than as people's attempts to make sense of... biomedicine in local, contextually specific ways' (2018, p. 1458). The students self-identified as a distinct group of health professionals with biomedical knowledge that differentiated them on some, but not all levels, from those who believe in traditional causes of stillbirth. This perceived distinction is reflected in a study conducted at PNG's Madang Hospital, where doctors spoke of experiencing a transformation during their time in medical school and of becoming different

from villagers as they rejected traditional beliefs about illness and disease: Biomedicine is equated with modernity and culture with tradition (Street, 2014). French philosopher Michel Foucault posits that critical thinking experience is a transformative force, arguing, ‘As soon as people begin to have trouble thinking things the way they have been thought, transformation becomes at the same time very urgent, very difficult, and entirely possible’ (1997, p. 457). Similar to their medical colleagues in Madang, the midwifery students live in a system embracing modernity and for many, acquiring biomedical knowledge was a transformative experience that changed their foundational beliefs.

Nevertheless, the study also found some midwifery students were uncertain when confronted with competing interpretations of stillbirth, particularly when the cause of a stillbirth was undetermined. Established belief systems are not easily changed, and many Papua New Guineans continue to rely on local knowledge systems to account for health and illness (Koczberski & Curry, 1999; Onagi, 2015). The study finding that the students’ learned biomedical knowledge overlays their inherited local knowledge is comparable with studies reporting how health workers in PNG and Uganda traverse diverse knowledge systems to diagnose illness and manage treatment (Davy & Patrickson, 2012; Hewlett & Amola, 2003). However, rather than seamlessly transitioning between belief systems, reconciling multiple ways of knowing was often challenging for the midwifery students in this study, who saw themselves as ‘midwife in the middle,’ needing to balance traditional and biomedical belief systems. Foucault’s notion of transformation can apply to biomedical education systems. Educators need to think differently about the social determinants of health and transform the curriculum to situate multiple ways of knowing, being and doing in educational content.

The importance of religion, in particular Christianity, in the everyday life of the midwifery students featured prominently in this study. Across Pacific nations, ‘Christianity, which of all things first foreign has been the most thoroughly indigenised... [is] usually seen as inherently local, fundamental to the Pacific way and as foundational to the imagination of most Pacific nations’ (Jolly, 2005, pp. 139–140). Christianity, deeply embedded in PNG as unequivocal truth, is a lens through which people view the world (Eves, 2012). Christian institutions extend their influence with extensive networks across the country, including regional and remote areas (Anderson, 2015). Most people worship at village churches—some villages have a single church established by the denomination that introduced Christianity to the area (Eves, 2008).

Christianity is an important feature of individual and collective PNG identity, with prayer and the seeking of salvation both personal and relational activities (Robbins, 2004). It is common for PAU staff to hold impromptu prayer meetings in offices and corridors, as an adjunct to the university’s structured devotional programme. This is seen as an essential element of life at PAU, not merely an option (see Figure 8.2). SDA churches in the area between Bisiatabu and Sogeri, near the PAU campus, have tithe huts where it is expected people of the faith will leave a percentage of their crop, or the equivalent earnings, for the church leaders. Members of the SDA church perceive this action as a mechanism to gain God’s blessing for the giver and the receiver. People of SDA faith living in the district attend daily services, regular Bible study and weekly Sabbath school and other services on a Saturday at their local church. Historically, pastoral power aimed to lead people to salvation in the afterlife; now, pastoral power seeks to ensure salvation in earthly life (Foucault, 1997). All local SDA churches in the area have satellite dishes installed to receive live broadcasts from pastors from the United States visiting PNG. Satellite also enables the congregation to

receive the Hope Channel, the television network owned by the SDA church broadcasting guidance for SDA living.

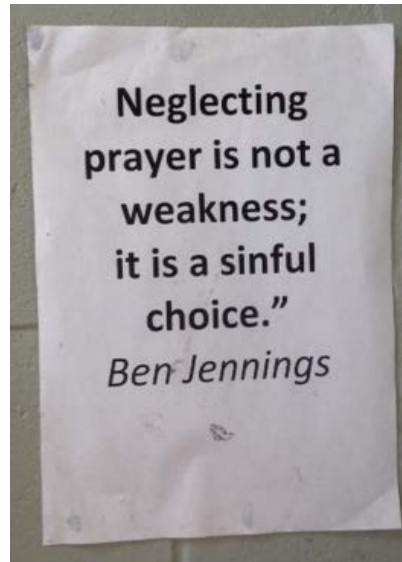


Figure 8.2. School of Health Science office: reminder to pray

As a central reference point in life, religion can influence sense-making of illness and disease (Kelly-Hanku et al., 2018). Midwifery students with strong Christian beliefs drew on religious narratives to make sense of the stillbirth. The belief that God is in control of life, consistent with the students' beliefs, includes misfortune and death as God's warning against sin or the consequence for transgression (Eves, 2010; Gibbs, 2015; Kelly-Hanku et al., 2018). Christian churches consider sorcery a heathen custom representative of the 'old way' (Frankin, 2010, p. 3), yet more than a century of Christianity has failed to eradicate sorcery beliefs and practices (Onagi, 2015). As reported by the midwifery students, many Papua New Guineans continue to believe in sorcery, yet profess their Christian faith. Traditional life is often carried out in the village while religious life is carried out in the church, 'each moral system applies in the space appropriate to it' (Robbins, 2004, p. 325). A former PAU academic related his understanding of the relationship between Christian and traditional

beliefs using the metaphor of a toolbox: Traditional beliefs are under a false floor, Christianity is the hammer on top. When misfortune occurs that cannot be fixed by a hammer, then people discard the hammer and take out the tools of the old beliefs that can fix the problem.

During this study, midwifery students reported instances where they were threatened by relatives of a woman dissatisfied with treatment outcomes following a stillbirth. Workplace violence towards midwifery students or midwives has been documented in high-income countries (L. McKenna & Boyle, 2016; Yoshida & Sandall, 2013) with fewer studies exploring the issue in LMIC settings. One study in South Africa reported midwives experienced verbal abuse, threats and physical assault by women in labour and their relatives (Khalil, 2009). A study across three PNG provinces documented the extreme and often life-threatening situations health workers faced providing care, describing how a nursing sister was shot at by a group of men acting on behalf of a well-known local person whose baby was ‘born “abnormal” and had died’ (Razee et al., 2012, p. 832). Across the diverse knowledge systems of PNG, a culture of blame exists with the steadfast belief that angry or malicious agents, including spirits, sorcerers or even God, have the power to cause misfortune, illness and death (Haslam, 2015). This is consistent with the notion that people want to know *who* caused the stillbirth rather than *what* caused it. Student narratives illustrate that people now also believe nursing and midwifery staff are responsible for stillbirth through their professional negligence. In some high-income nations, midwives fear litigation for adverse birth outcomes, whereas midwives in LMICs fear community exposure, denial of the right to practice and the continuous development of preventative measures (McCool, Guidera, Stenson, & Dauphinee, 2009). In contrast, findings from this study show students are more concerned with their personal safety from physical violence or acts of sorcery than with the

legal ramifications of a stillbirth, taking social and cultural precautions and praying for a positive outcome. Students were using all the ‘tools’ in the toolbox.

Despite the diverse beliefs about the causes of stillbirth, the study found hospitals rarely conduct an autopsy of the stillborn baby. Perinatal autopsy, including examination of the placenta, summarises the pathological findings and is the most accurate biomedical means to determine the cause of a stillbirth (Ernst, 2015). Autopsy can assist in identifying the underlying cause of stillbirth in up to 86% of cases (Downe et al., 2012). In addition to presenting parents with knowledge of how and why their baby was stillborn, autopsy can inform future practice (Downe et al., 2012). Autopsies are also valuable for reporting negative findings, or what is *not* present (Ernst, 2015). This is important in the PNG setting where death is often attributed to sociocultural causes: Autopsy provides an alternative, biomedical explanation for death; however, access to pathology services for autopsy remains unreliable in the current PNG health system (Haslam, 2015). Being able to provide families with biomedical evidence of the cause of the stillbirth would offer midwifery students a degree of defence against accusations of clinical mismanagement while easing concerns about their personal safety and ongoing social and cultural implications.

Beliefs about the causes of stillbirth need to be considered in the PNG context. This is because ‘the power of authoritative knowledge is not that it is correct but that it counts’ (Jordan, 1997, p. 58). In this study, midwifery students faced difficulties and challenges providing care to women experiencing stillbirth when the knowledge system used by women and their families to explain the cause of a stillbirth was as equally legitimate as the knowledge system espoused by the students. When this occurred, students sought to find a balance, traversing parallel systems to settle on knowledge that counted in the specific

situation and was appropriate for accomplishing their task of providing holistic care for a woman within the community where they lived as *wantoks* and maternal health care providers.

8.6 Dealing with feelings

Childbirth is usually a celebrated event, but sadly, some pregnancies result in the loss of a baby. Thomas writes that stillbirth is ‘against the natural order of things. It is unique, incomprehensible and unlike any other death’ (2011, p. 953). Midwifery students experience a range of emotions and feelings when a baby is stillborn to a woman in their care and seek to manage negative emotions to achieve personal wellbeing in various ways.

Several midwifery students in this study talked about having positive feelings following their experiences of a stillbirth delivery. These students felt satisfied with their clinical management of the stillbirth and the care they provided for a woman when the cause of the stillbirth was beyond their control. This echoes findings from studies in Ghana (Petrites, Mullan, Spangenberg, & Gold, 2016) and South Africa (Modiba, 2008), where midwives cited a lack of resources or the late arrival of the woman to the health facility—often with a complication, such as an obstructed delivery—had contributed to a perinatal death. Under these circumstances, midwives believed they could not have done anything to save the baby. Similar to the midwifery students in the study, they felt job satisfaction since they had performed to the best of their ability in challenging situations.

The findings reaffirm that being with a woman experiencing a stillbirth negatively affects the physical and psychological wellbeing of health care professionals (McNamara et

al., 2017; Shorey, André, & Lopez, 2017). Feelings of grief are ubiquitous yet remain deeply personal and subjective (Sadak & Weiser, 2017). Many students in the study described a need to cry when the baby was stillborn. Studies from Australia (L. McKenna & Rolls, 2011) and Ireland (Begley, 2003) reported crying as an initial physiological response among midwifery students, with some students continuing to cry several days after the stillbirth (L. McKenna & Rolls, 2011). Similarly, experienced midwives in Israel (Halperin et al., 2011), Namibia (Ndikwetepo & Strumpher, 2017) and New Zealand (Jones & Smythe, 2015) described being overwhelmed with a feeling of sadness and crying together with the woman. Midwives perceived crying as an appropriate response to the event, reflective of their close relationship with the woman and her family (Roehrs, Masterson, Alles, Witt, & Rutt, 2008). In her study of clinical health care staff responses to childbearing loss, Mander (2009) found there was a continuum of crying, from shedding a few tears to total emotional breakdown. Staff describe the need to control their crying and keep their feelings inside to avoid adversely affecting provision of care or further upsetting bereaved parents (Mander, 2009; McCreight, 2005; Roehrs et al., 2008; Sheen, Spiby, & Slade, 2016).

American sociologist Arlie Hochschild, a leader in the field of emotion in the workplace, proposed the theory of emotional work/emotional labour (1979, 1983). Hochschild described how service workers perform emotional labour to 'create and maintain a relationship, a mood, a feeling' in their interactions with people (1989, p. 440). Emotions are managed according to conventions or 'feeling rules' that delineate which emotions are appropriate to feel and display in a particular context, thus reflecting 'patterns of social membership' (Hochschild, 1979, p. 566). When people are uncertain about feeling rules, they turn to authority figures for guidance (Hochschild, 1983). For midwifery students, the majority of learning occurs in a clinical setting; they learn feeling rules for interpersonal

contact with women under the guidance of their supervisors, from more experienced colleagues and through trial and error (Hunter, 2009; McCreight, 2005). Students report supervisors did not often acknowledge the students' grief; some midwifery students learned from their supervisors that becoming emotionally overwhelmed following a stillbirth risked compromising midwifery care, so they worked to control their emotions in accordance with the established feeling rules to maintain a professional approach to care.

Students also experienced feelings of guilt, blame and self-doubt. Nurse-midwifery students in South Africa expressed guilt, blaming themselves for not preventing the stillbirth even though their clinical knowledge and skills were in the early stages of development (Morake, 2013). The emotional responses of midwifery students to stillbirth are not unlike those of qualified midwives (Doherty, Cullen, et al., 2018). In Ireland, midwives had feelings of guilt and questioned their clinical skills and ability to cope with the emotional demands of their work following their involvement with an intrapartum death (McNamara et al., 2017). The midwives reported a prevailing 'culture of silence' where staff sought to protect themselves from blame for the loss (McNamara et al., 2017, p. 848). Midwives in Australia (H. Rice & Warland, 2013), Denmark (Schrøder, Jørgensen, Lamont, & Hvidt, 2016) and Namibia (Ndikwetepo & Strumpher, 2017) blamed themselves and felt guilty following the loss of a baby, reflecting on how their own actions may have contributed to the death. The guilty feelings experienced by midwives can remain raw and unpredictable long after the stillbirth event (Kenworthy & Kirkham, 2011). This was true for several PAU students, who sustained intense emotions from feelings of self-blame and guilt and continued to live with remorse and grief following their involvement in a stillbirth event.

The various coping strategies that the midwifery students employed to balance their wellbeing after the stillbirth of a baby are consistent with research exploring the experiences of nurses and midwives dealing with perinatal loss in hospital settings. Students sought to offset negative feelings through socialising, being active (McNamara et al., 2017; Shorey et al., 2017) and spending time with their children (Roehrs et al., 2008). Unsurprisingly, the midwifery students in this study described Christian faith and the use of prayer as a coping mechanism. When religious faith forms the basis of an individual's beliefs and goals, religious meaning may be fundamental to their coping process (Park, 2005). In stressful circumstances, such as loss of life, faith practices become more significant. They promote a positive outlook on life and an acceptance of suffering, reaffirm the belief that a benevolent God is in control of events and increase inclusiveness by providing 'a community of support, both human and divine... available to anyone at any time' (Koenig, 2009, p. 285; Park, 2005). Religious faith and prayer have been shown to help staff come to terms with perinatal death in different countries, including England (Gardner, 1999), Ghana (Petrites et al., 2016) and the United States (Roehrs et al., 2008). The PAU midwifery students' application of religious practices of reading sacred text and praying to God reflects a need to make meaning of a stillbirth event and obtain a sense of forgiveness for clinical wrongdoing, acting as a mechanism to restore peace of mind.

Midwifery students in this study also described how sharing their experiences of care following stillbirth with close family members (usually husbands), colleagues and lecturers helped them feel better. This finding adds to those of L. McKenna and Rolls (2011) and Morake (2013) in their studies of nursing and midwifery students' experiences of stillbirth and neonatal death. The authors comment that to deal with feelings after their immediate physical and emotional responses to the event, students drew support from various sources,

including family, friends and mentors outside of the work environment, clinical educators and student peers. Sharing with colleagues is a common and effective coping mechanism following perinatal loss for nurses and midwives (Roehrs et al., 2008; Wallbank & Robertson, 2008). Yet, self-disclosure with unsupportive colleagues risks blame or ridicule, leading midwives to feel rejected or excluded in the workplace, affecting midwives' professional and personal identities (Halperin et al., 2011; Wallbank & Robertson, 2008). However, it was clear that for students in this study, issues of trust and personal safety determined whether, and with whom, they shared their experiences of care.

Caring is a holistic practice facilitated through the carer's physical and mental presence (Leinweber & Rowe, 2010). In midwifery, the relationship between the woman and midwife is characterised by empathy and compassion, which increases the midwife's risk of emotional stress when witnessing or caring for traumatised women (Leinweber & Rowe, 2010; H. Rice & Warland, 2013). The emotional consequences of caring remain largely unrecognised and undervalued (Hunter, 2010). Caring for a woman experiencing a stillbirth involves significant emotional labour (Kenworthy & Kirkham, 2011). There is a high risk of midwifery students and experienced midwives developing secondary traumatic stress as they engage with the trauma of stillbirth experienced by women in their care (Leinweber & Rowe, 2010; Pezaro et al., 2016). Such stress is 'the natural consequent behaviours and emotions resulting from knowing about a traumatizing event experienced by a significant other – the stress resulting from helping or wanting to help a traumatized or suffering person' (Figley, 1995, p. 7). The terms compassion fatigue, vicarious trauma and post-traumatic stress disorder also describe the psychological impact on health professionals of working with traumatised people (Leinweber & Rowe, 2010; Pezaro et al., 2016). Traumatic stress can result from a single event or repeated exposure to work-related traumatic events (Leinweber

& Rowe, 2010). For midwifery staff, particularly those working in LMICs, stillbirth may be a frequent experience (Pezaro et al., 2016; Wallbank & Robertson, 2008).

The ability to clearly recall the stillbirth and the feelings of distress, guilt, frustration and anger experienced by the midwifery students are symptomatic of traumatic stress (Leinweber, Creedy, Rowe, & Gamble, 2017; Sheen et al., 2016). There was limited formal support for students, and therefore, personal relationships, individual attitudes and religious faith affected the students' capacity for coping as they sought to balance their emotional and psychological wellbeing. There is a growing call for acknowledgement of the costs of caring in midwifery, as well as increased professional support for midwives experiencing workplace trauma and education to prepare midwifery staff for exposure to traumatic events and to build resilience (Pezaro et al., 2016; Power & Mullan, 2017; Sheen et al., 2016). As Leinweber and Rowe argue:

Midwifery defines the relationship with the woman as its core. If midwives' capacity to engage with childbearing woman is compromised because of unacknowledged secondary traumatic stress, midwifery's claim to be the most adequate profession to provide care for childbearing women may be threatened (2010, p. 85).

These are important considerations for the midwifery profession as it works to develop and maintain a healthy and resilient workforce, to achieve national and global maternal and newborn health goals (Homer et al., 2017; Pezaro et al., 2016).

8.7 Global health frameworks

Key themes from the research involve interconnected social, cultural, psychological, spiritual and professional concepts in the provision of maternal care for PNG women. These concepts relate to the meaning of health as holistic and are consistent with the constitution of the WHO, which incorporates the definition of health as ‘a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity’ (WHO, 2014a, p. 1). The study helps our understanding of WHO operational frameworks that underpin health promotion internationally and emphasise that to attain good health, we need to address the social determinants.

Affirming the WHO definition, the Alma-Ata Declaration on Primary Health Care in 1978 added that health is ‘a fundamental human right and that the attainment of the highest possible level of health is a most important world-wide social goal whose realization requires the action of many other social and economic sectors in addition to the health sector’ (WHO, 1978, p. 1). The Alma-Ata Declaration noted that primary health care relies on health workers, including midwives, appropriately trained both socially and clinically, to work as members of health care teams to respond to the health needs of people in their communities (WHO, 1978). Representatives from the WHO member countries at this first International Conference on Primary Health Care in Alma-Ata, Kazakhstan resolved to achieve health for all by the year 2000 (Hall & Taylor, 2003). The vision of health care conceived at Alma-Ata was a significant move away from top-down service delivery by medical authorities to solve health problems (Baum, 2007). The novel approach was based on ‘a holistic understanding of local primary health-care needs, across the social determinants, and of people-centred action’ (Marmot, 2007, p. 1161).

The notion that the conditions under which people live and work affect their health and wellbeing was not new in the 1970s: During the mid-1800s, activists such as Edwin Chadwick, Rudolf Virchow and Friedrich Engels studied the social, economic and political factors that contributed to poor health (Manning, 2017; Raphael, 2006). The Alma-Ata Declaration was informed by the work of social activists, as well as lessons learned from grassroots health initiatives in China, Mexico, India and Latin America that stressed the social origins of illness and a primary health care approach (Baum, 2007). The Alma-Ata goal to provide comprehensive health care for all by 2000 was not realised; however, the Alma-Ata ideal continues to inspire health professionals worldwide who want to deliver effective and efficient health care that is responsive, equitable and people-centred (Baum, 2007; Marmot, 2007).

Building upon the progress made through the Alma-Ata Declaration, the Ottawa Charter for Health Promotion was endorsed at the first International Conference on Health Promotion in Ottawa, Canada in 1986 (WHO, 2009). The Charter asserted that ‘health is a resource for everyday life, not the objective of living’ (WHO, 2009, p. 1). The Ottawa Charter identified the prerequisites for health as peace, food, shelter, education, income, a stable ecosystem, sustainable resources, social justice and equity (WHO, 2009). The Ottawa Charter helped move the discourse on health promotion, described as ‘the process of enabling people to increase control over, and to improve their health’ (WHO, 2009, p. 1), away from individual behaviours, accentuating the role of communities, systems and organisations in achieving and promoting good health (Catford, 2011; Thompson, Watson, & Tilford, 2018).

The Ottawa Charter stated that ‘health is created and lived by people within the settings of their everyday life; where they learn, work, play and love’ (WHO, 2009, p. 4).

Five action areas for an interconnected, whole of society approach to effective health promotion were identified: build healthy public policy; create supportive environments; strengthen community action; develop personal skills; and reorient health services, along with the three overarching strategies of advocacy, enabling and mediating (Thompson et al., 2018). The settings approach advocated in the Ottawa Charter became the basis for leading WHO health promotion programmes (Kickbusch, 1996). Three decades on, the Ottawa Charter continues to shape health promotion policies and practice. Subsequent WHO conferences and global health declarations have focused on one or more of the five action areas, and the Ottawa Charter's principles of health promotion have been developed to meet current health challenges (Catford, 2011; Thompson et al., 2018). In October 2018, representatives attending the Global Conference on Primary Health Care in Astana, Kazakhstan, marking the 40th anniversary of the Alma-Ata Declaration, endorsed the new Astana Declaration, emphasising the crucial role of primary health care internationally. The Astana Declaration reaffirms the commitments of the Alma-Ata Declaration and the United Nation's Sustainable Development Goals addressing social and economic development issues. The Astana Declaration aims to refocus efforts on the provision of primary health care to achieve health and wellbeing for all (WHO & UNICEF, 2018).

Midwifery students in this study spoke of using the three Ottawa Charter health promotion strategies in their practice. Students actively advocated pregnant women's health, recommending women attend antenatal clinics to maintain a healthy pregnancy, learn about danger signs in pregnancy and avoid complications leading to stillbirth. Students promoted a supervised delivery for women with a history of stillbirth to help reduce complications during labour. They also advocated family planning, especially for women at risk of, or recovering from, a stillbirth. By providing access to information about maternal health, students enabled

women and their partners to lead healthier lives and the opportunity to act to make healthy choices in pregnancy. Students also sought to mediate between the different interests of women and men in the community to promote maternal health, working to change beliefs about men's involvement in pregnancy and birth, to benefit the women in their care. Yet advocating, enabling and mediating for change was not easy when longstanding beliefs and customs existed within and between communities.

Characteristic of the settings approach is that strategies and programmes for health promotion should be adapted to local contexts taking into account differing social, cultural and economic factors (WHO, 2009). The Healthy Islands initiative is the Pacific realisation of a settings approach that aims to promote the health of Pacific Island people and communities (WHO Regional Office for the Western Pacific, 2002). A concept emerging from a 1995 meeting of health ministers from Pacific Island countries and included in the Yanuca Island Declaration on Health in the Pacific in the 21st Century, the Healthy Islands vision blends health, environment and Pacific cultural concepts in health promotion programmes (WHO Regional Office for the Western Pacific, 2015). Achieving the goal of Healthy Islands requires not only robust systems and programmes but also respect for the distinctive cultures and traditions of Pacific peoples (WHO, 2013a).

Healthy Islands adopts a salutogenic perspective to health promotion: a view that focuses on wellness and considers health as holistic and determined by interacting factors within the dynamic contexts of people's lives (Dooris, 2009; WHO, 2013a). The theory of salutogenesis was introduced in the late 1970s by medical sociologist Aaron Antonovsky. He posited that health is a state of balance between complete health and the total absence of health that oscillates along this continuum throughout the lifespan (Perez-Botella, Downe,

Magistretti, Lindstrom, & Berg, 2015). The Healthy Island strategy is incorporated into the PNG National Health Plan 2011–2020, which envisages a healthy island as ‘one that is committed to and involved in a process of achieving better health and quality of life for its people, and healthier physical and social environments in the context of sustainable development’ (Government of Papua New Guinea, 2010, p. 66). In turn, the PNG National Health Plan informs the competency standards for registered nurses and midwives in PNG and the PAU midwifery curriculum (Pacific Adventist University, 2014; Papua New Guinea Nursing Council, 2002–2014, 2003–2014). Students spoke of caring for women with different cultural understandings about stillbirth. This reflects the underlying concepts of the Healthy Islands approach, founded upon the settings approach of the Ottawa Charter that considers social and cultural factors. However, the reality was that students often experienced tension when working between competing biomedical, cultural and religious knowledge systems to provide holistic care to women following stillbirth according to professional standards and practice.

Context plays a crucial role in health care by shaping the links between knowledge and behavioural change (Airhihenbuwa, Makoni, Iwelunmor, & Munodawafa, 2014). As Airhihenbuwa et al. stated:

Theories about health and behavior typically focus on the objectives of interventions designed to improve individual behaviors that are usually measured as individuals’ inability or refusal to heed preventive messages, recommended behavioral changes, or treatment actions... many interventions fail to account for the complex interplay of historical, social, economic, and political contexts that are shaped by social structures and cultures. (2014, p. 3)

This study illustrates the realities of holistic care provision for women experiencing stillbirth in PNG. In accordance with the tenets of the Ottawa Charter, the findings demonstrate the need to advocate, enable and mediate for health protection and promotion across health, social and economic sectors to achieve the best outcomes for the women and the midwifery staff who provide them with care. The study findings show the reality of midwifery practice within these broad international frameworks and the importance of this unrecognised issue of care. The experiences of the PAU midwifery students documented in the study demonstrate the reality for health professionals, not only in PNG but also in other LMICs.

8.8 Philosophical concepts in research

Qualitative approaches provide researchers with the ability to use philosophical concepts to assist their understanding of the contexts of health and health care. Qualitative research is increasingly being used to determine the meanings underpinning sociocultural beliefs and practices so that they can be employed, not confronted, in the pursuit of better health (Jan Ritchie, 2001). This study was able to engage with the philosophical concepts of axiology, ontology and epistemology by applying the qualitative approaches of constructivist grounded theory and decolonising methodologies to gain a rich understanding of the experiences of midwifery students' provision of care to women following stillbirth in PNG. Within each Pacific society there exists 'a framework of knowledge that is systematically gathered and formulated within a paradigm of general truths and principles' (Health Research Council of New Zealand, 2004, p. 10). For cross-cultural health research, as well as midwifery education and health professionals in PNG, this requires taking into account diverse and dynamic philosophies. People in PNG and across the world continue to struggle

with the complexities of different, yet often intersecting, values and ways of knowing, being and doing.

Reflecting on multiple truths, Nigerian teacher and writer Chinua Achebe said, ‘Where one thing stands, another thing must stand beside it... This saying “there is only one way” is something which is new to my people’ (as cited in Airhihenbuwa, 1995, p. ix). Achebe’s philosophy about the human construction of reality normalises the coexistence of otherwise disparate ways of knowing in African sociocultural settings (Airhihenbuwa et al., 2014). However, the idea of multiple truths does not always transfer from theory to practice: Identity and agency have many facets yet these complexities have been given scant attention in understanding how people make decisions about their health (Airhihenbuwa et al., 2014).

Looking through the lens of diversity, qualitative inquiry enables researchers to discover the crucial cultural characteristics that need to be integrated into health programmes and practice, allowing insight into diversity through the presentation of contextual cultural interpretations (Dutta, 2016, p. 7). Kagawa-Singer et al. define culture as:

an internalized and shared schema or framework that is used by group (or subgroup) members as a refracted lens to ‘see’ reality, and in which both the individual and the collective experience the world. This framework is created by, exists in, and adapts to the cognitive, emotional and material resources and constraints of the group’s ecologic system to ensure the survival and well-being of its members, and to provide individual and communal meaning for and in life. The framework also shapes and is shaped by the forms and institutions developed by its members to structure their world. (2016, p. 242)

This definition reminds us that individuals are members of multiple cultures and possess multiple social identities: Similar to the students in this study, individuals may ‘code-switch’ values and behaviours according to the contextual environment (Kagawa-Singer et al., 2016). Many scholars have explored the complexities and tensions of negotiating across cultural spaces—a challenge experienced by the students as they provide health care. Anthropologist Mary Louise Pratt introduced the concept of the ‘contact zone’ as the ‘social spaces where cultures meet, clash and grapple with each other, often in contexts of highly asymmetrical relations of power, such as colonialism, slavery, or their aftermaths as they are lived out in many parts of the world today’ (Pratt, 1991, p. 34). Postcolonial scholar Homi Bhabha sought to challenge thinking about cultural differences in the academy:

What is theoretically innovative and politically crucial is the need to think beyond narratives of unitary cultures and initial points of reference and to focus on those moments or processes that are produced in the articulation of cultural differences.

These ‘in-between’ spaces provide the terrain for elaborating strategies of selfhood—singular or communal—that initiate new sights of identity, and innovative sites of collaboration, and contestation, in the act of defining the idea of society itself.

(1994, pp. 1-2).

Ontology and epistemology are fundamental concepts in this study. Torres Strait Islander academic Martin Nakata coined the term ‘the cultural interface’ to describe the place where Indigenous and Western knowledge systems intersect (2002, p. 285). Nakata described how discourse about culture often references Indigenous and Western ontologies and epistemologies as two separate domains, leading to simplifications that obscure the complex cultural practices in each domain and promotes the process of othering (2002). Nakata stated:

In complex or contested terrains of overlapping knowledge systems different understandings often conflict, contradict, produce incoherence and make it difficult to 'make sense' of these contradictions. To make sense and bring order to it we organise our thinking according to a position that we believe is useful in explaining or making sense of all these elements. (2007, p. 197)

Nakata recognised the need for researchers and professionals working in the intercultural space to consider the nature of competing knowledge systems not as binary but as 'a layered and very complex entanglement of concepts, theories and sets of meaning' (Nakata, 2006, p. 272). In this study, students' sense-making of stillbirth was contextual, dependent on the knowledge system that made the best sense in a particular time and place. For Nakata, the intercultural space is a place of tension and negotiation but also provides scholars with the opportunity for 'open, exploratory, and creative inquiry' to produce richer forms of analysis and other possibilities for action (Nakata, Nakata, Keech, & Bolt, 2012, pp. 121, 133).

Conscious decision-making about ways of knowing, being and doing are also apparent in the writing of Papua New Guinean lawyer, philosopher and politician Bernard Narokobi, who posits that in acknowledging both the good and bad of the past and present, Melanesians are free to choose 'our philosophy, our life-styles and our whole-beings' (Narokobi, 1983, p. 5).

8.9 Ensuring research quality

Researchers across all disciplines attempt to account for the quality of their research, but what constitutes quality in research practice is not well defined (Mårtensson, Fors, Wallin, Zander, & Nilsson, 2016). In quantitative research, outcomes are judged valid and reliable when produced through the implementation of rigorously controlled methods and processes (Birks & Mills, 2015). Qualitative researchers do not use predetermined and quantifiable methods and processes because they seek to answer different types of questions in depth, through an interpretive lens (Creswell, 2013). This has given rise to the suggestion that qualitative research lacks the rigor of quantitative research. The issue of quality in qualitative research was the catalyst for the development of grounded theory methods by Glaser and Strauss (Birks & Mills, 2015).

Many schema for assessing quality in qualitative research are built on the concept of trustworthiness proposed by Lincoln and Guba, who asked, 'How can an inquirer persuade his or her audiences (including self) that the findings of an inquiry are worth paying attention to, worth taking account of?' (1985, p. 290). Mentioned in Chapter 3, the CASP Qualitative Research Checklist²⁴ is a widely used tool for evaluating published qualitative studies across the three broad criteria of validity, results and value. Guidance in the form of prompts, or anchors, for each of ten questions assists researchers, especially those new to research or working in teams, to reduce ambiguity surrounding a question, thus facilitating critical appraisal (Newton, Rothlingova, Gutteridge, LeMarchand, & Raphael, 2012).

²⁴ For more information about CASP, see <https://casp-uk.net>

Criteria for evaluating qualitative grounded theory studies vary among grounded theory approaches. Charmaz (2014) posits that evaluation of research is dependent on the individual developing the criteria, the context in which it is developed and the purpose of developing it. As discussed in Chapter 4, Glaser and Strauss (1967) first proposed that a grounded theory study should be measured in terms of fit within its field of intended use, be understandable by those working in the area and be general enough to be flexible in application while allowing the researcher to control its use. In the ensuing years, further criteria for evaluating grounded theory studies have been described by Glaser, Strauss, second-generation grounded theorists and by authors within specific disciplines (Charmaz, 2014). Addressing both the disciplinary and creative aspects of qualitative grounded theory studies, Charmaz promotes four criteria for assessment: credibility, originality, resonance and usefulness, including prompts for consideration (Charmaz, 2014; Corbin & Strauss, 2015). As I employed Charmaz's constructivist grounded theory methodology in this study, I evaluated the research according to these four criteria (2014, p. 337); see Table 8.1.

Table 8.1. Criteria for grounded theory studies

Criteria for evaluation	Prompts to consider	Application in the study
Credibility	<p><i>Has your research achieved intimate familiarity with the setting or topic?</i></p> <p><i>Are the data sufficient to merit your claims? Consider the range, number, and depth of observations contained in the data</i></p> <p><i>Have you made systematic comparisons between observations and between categories?</i></p> <p><i>Do the categories cover a wide range of empirical observations?</i></p> <p><i>Are there strong logical links between the gathered data and your argument and analysis?</i></p> <p><i>Has your research provided enough evidence for your claims to allow the reader to form an independent assessment – and agree with your claims?</i></p>	<p>Anchoring the inquiry in the PNG setting using decolonising methodologies, including an awareness of local values, beliefs and history. A range of data sources including group and individual interviews with midwifery students from various geographical locations in PNG provided a range of empirical settings.</p> <p>Purposive and theoretical sampling of midwifery students with experience of the phenomenon of stillbirth. Mechanisms in place throughout the research process for the CRG mentors and midwifery students to provide input and feedback.</p> <p>Intimate involvement in the topic of study through personal experience, an interdisciplinary review of literature and a discussion of the research findings situated within the extant literature.</p> <p>Theory is generated from data obtained from those living the experience of stillbirth. The words of the midwifery students illustrate categories and are embedded in the theory.</p> <p>The interdependency of dimensions, attributes and the core category resulting from comparative analysis of rich, extensive data describing empirical events.</p>
Originality	<p><i>Are your categories fresh? Do they offer new insights?</i></p>	<p>The data presented within the study provide a new conceptual framework of the social, cultural, spiritual and professional factors</p>

	<p><i>Does your analysis provide a new conceptual rendering of the data?</i></p> <p><i>What is the social and theoretical significance of this work?</i></p> <p><i>How does your grounded theory challenge, extend, or refine current ideas, concepts and practices?</i></p>	<p>that inform the provision of care to women following stillbirth in PNG. The findings provide evidence of how midwifery students balance these factors to provide the best possible care to women following stillbirth.</p> <p>The grounded theory presented in the study contributes to the limited knowledge of midwifery students' experiences of stillbirth. The process of 'balancing it out' used by the midwifery students operationalises the broader health frameworks that underpin midwifery education and practice in PNG.</p>
Resonance	<p><i>Do the categories portray the fullness of the studied experience?</i></p> <p><i>Have you revealed both liminal and unstable taken for granted meanings?</i></p> <p><i>Have you drawn links between larger collectivities or institutions and individual lives, when the data so indicate?</i></p> <p><i>Does your grounded theory make sense to your participants or people who share their circumstances? Does your analysis offer them deeper insights about their lives and worlds?</i></p>	<p>A workshop with midwifery students confirmed emerging concepts were true to experiences and made sense. Students expanded upon concepts, contributing to construction of the grounded theory.</p> <p>Findings present insights into the students' worlds through linking individual and collective factors where indicated by the data. Balance is connected to midwifery education and practice within the scope of health care provision as well as within students' personal lives.</p> <p>At two professional forums, PNG health workers and midwives, as well as academic staff from across Melanesia, authenticated the key findings and theoretical concepts of the study. The midwifery students' experiences of providing care as presented through quotations resonated with audience members.</p>
Usefulness	<p><i>Does your analysis offer interpretations that people can use in the everyday worlds?</i></p>	<p>The study findings are being used to inform midwifery practice and curriculum. The study outcomes have the potential to make a positive</p>

Do your analytic categories suggest any generic processes? If so, have you examined these generic processes for tacit implications? Can the analysis spark further research in other substantive areas?

How does your work contribute to knowledge? How does it contribute to making a better world?

difference in the lives of midwifery students and midwives and those within their care.

The final theory may be transferable to other settings where practitioners are working across multiple knowledge systems.

Data analysis revealed scope for future research in other substantive areas. Findings indicate the need for research exploring the competencies required for managing cross-cultural knowledge and practice.

The study provides novel insight into the unexplored topic of stillbirth in PNG, extending our current knowledge of this phenomenon in the Pacific region.

In addition to the aforementioned criteria, numerous other conditions related to the personal and professional characteristics of the researcher foster research quality (Corbin & Strauss, 2015). These include a strong desire to undertake research, a willingness to work hard, training in the conduct of qualitative research, clarity of purpose and self-awareness (Corbin & Strauss, 2015). Birks and Mills (2015) have added the condition of researcher expertise, which includes evidence of scholarly writing skills. My interest in the social determinants of health and my personal interests and experience of stillbirth led me to undertake this study. From the outset, I used my skills as a librarian to locate and access a wide and extensive body of literature, which I read to gain an understanding of philosophical assumptions, methodologies and methods and of the discourse surrounding the topic of stillbirth. There were times when I struggled with so many new concepts, but I worked hard to overcome feelings of self-doubt and manage my imposter syndrome. Senior researchers and cultural mentors *in situ* have overseen this doctoral study, and my work has been subject

to peer review through university entry and exit seminars, competitive research grant funding, two international conference presentations and publications in peer-reviewed journals. Each of these activities provides evidence of my expertise as an emerging researcher and mark significant moments in the conduct and development of this study.

My first publication, a metasynthesis of seven papers from six studies related to women's experiences of stillbirth in the Asia-Pacific region (Cheer, 2016). I argued that social and cultural contexts and women's engagement with the health care system influenced their experiences of stillbirth. This paper was published just prior to commencement of this study. The second publication, co-authored with two of my advisors, was a systematic literature search related to the use of grounded theory methodology in 15 grounded theory studies of the coping processes of nurses and midwives (Cheer et al., 2016). In this paper, we concluded that authors should clearly state the theoretical foundations of the study and use of grounded theory methodology and characteristics in research reports to improve grounded theory research studies in the field of nursing and midwifery. With a focus on this doctoral research project, the role of collaborative partnerships in decolonising research was the topic of my presentation at the Pacific Society for Reproductive Health Conference in Port Vila, Vanuatu in July 2017. I presented the study findings and the grounded theory at the 3rd Symposium of the PNG Midwifery Society in Port Moresby, PNG in May 2018. Additionally, I presented a poster of grounded theory at the WHO Collaborating Centres for Nursing and Midwifery Conference in Cairns, Australia in July 2018. I plan to submit further papers for publication. One article will provide an overview of the study and present the grounded theory. A second article will present analysis of the coping strategies of Papua New Guinean midwifery students following stillbirth. A third article will present analysis of the male midwifery students becoming midwives in PNG.

This constructivist grounded theory is a product with credibility, originality, resonance and usefulness. Adherence to grounded theory methods, consistent with my stated philosophical and methodological stance, as well as my demonstrated attributes as an emerging researcher establish the quality of this grounded theory research project.

8.10 Limitations of the study

This study has several limitations. It was a qualitative study with the aim of exploring and describing the experiences of just one group of midwifery students providing care to women following stillbirth. The study was conducted with a small number of midwifery students from one, faith-based university and included only two male students. The selected research methods ensured I collected detailed information about the student experiences that generated a substantial amount of rich data for analysis at this site, with this group of students, in this specific location at this point of time (Creswell, 2013). Although there was variation of regional locations and settings where the students had previously lived, worked or undertaken their clinical placement, the voices of the students in this study may not be representative of the experiences of other midwifery students in PNG and hence are not generalisable. Yet, the study provides insight into the broader context of care provision and the themes emerging from the student narratives may resonate with other midwifery students and midwives regardless of their workplace setting.

There was also a delimitation to the study. To compensate for the unlikely possibility that students may not have experienced provision of care to women following stillbirth during their midwifery course, I expanded the timeframe to include students' previous care

experiences as nurses to gain a better understanding of the complex nature of the topic under investigation.

There was a risk that my personal experience of stillbirth may influence my interpretation of the data. This risk was mitigated by the strategies that were in place to ensure trustworthiness, including critical review of the analytic process by my advisory team. Further, I am not a trained nurse or midwife; hence, the strategy of having an experienced registered midwife and nurse on my advisory panel with local PNG cultural mentors who were registered nurses. A benefit of not being a clinician is that I came to the project without preconceived notions of midwifery theory, nursing practice or professional agendas.

As a white Australian undertaking research in a postcolonial space, I was conscious of how my cultural identity might affect the research. Owing to the costs of travel, accommodation and family commitments, I undertook my fieldwork at PAU in stays of approximately three weeks at a time, which were not conducive to nurturing relationships. The support of the members of my cultural reference group and the midwifery lecturers were pivotal in addressing this limitation and helping me maintain relationship links. Each time I returned to the field, I found the students were genuinely interested in my ongoing research and willing to share their personal experiences with me, freely discussing issues of concern under conditions of anonymity. Further, the feasibility of the project was advantaged by the existing link between JCU and PAU and the success of previous and existing research projects between the two universities, most notably those of my supervisor Dr David MacLaren. I also learned lessons from Dr Michelle Redman-MacLaren, who conducted her PhD research in PNG, including at PAU.

Finally, as an emerging researcher, I also acknowledge possible shortcomings in my application of grounded theory methods. The grounded theory presented in this thesis is my interpretation of the data collected and analysed: Other researchers may have different interpretations.

8.11 Summary

In this chapter, I have:

- reviewed and positioned the study findings in the existing literature
- outlined how ideas that emerge from this study are consistent with global definitions of health
- discussed the use of philosophical assumptions to conceptualise the findings through global frameworks and the broader context of qualitative research
- outlined methods to ensure research quality
- discussed the study limitations.

In the final chapter that follows, I will:

- summarise the thesis
- outline recommendations for action
- discuss action that is underway
- make recommendations for future research
- reflect on my journey in undertaking the research.

Chapter 9: Recommendations and Conclusion

9.1 Chapter outline

In this chapter, I conclude the thesis by reviewing my doctoral research journey: where I began the study, what I did along the way and what I found at the end. I then outline recommendations for action informed by the study findings, as well as action already commenced. Finally, I make recommendations for future research.

9.2 Where I began the study

My research journey was motivated by my own experience of stillbirth and by my deep and abiding interest in the Pacific and its peoples. The burden of stillbirth on families and nations is profound, yet stillbirth receives little public recognition or consideration in global or national health agendas. Stillbirth also affects the health professionals who provide maternal health care, notably the midwifery staff who are the frontline providers of care for childbearing women. While the experiences of stillbirth for midwifery staff in high-income countries are evident within the literature, few studies have examined stillbirth from the perspective of midwifery students and midwives in LMICs. There are no known studies based in PNG, and thus, this study was born. I set out to explore the experiences of midwifery students who provide care to women following stillbirth in PNG.

In the early stages of this research, I identified my own worldview upon which the research design was founded. I chose to conduct a qualitative study with constructivist grounded theory and decolonising methodologies. I wanted to account for social and

historical contexts, including my identity as researcher from a previously colonising country. I also wanted to explain the processes used by the students to manage care in the context of their practice.

The contexts in which everyday lives are lived are an important determinant of the health and wellbeing of individuals and communities. Qualitative research offers researchers scope to explore the social determinants of health. Qualitative inquiry enables researchers to construct findings that explicate the social influences on health including practitioners' decision-making processes and patient experiences of care (Greenhalgh et al., 2016). Of the various qualitative approaches, constructivist grounded theory allows researchers to better comprehend the underlying processes related to an event such as stillbirth through rigorous analysis and generation of theory grounded in the data. In this study, constructivist grounded theory and decolonising methodologies combined to capture the complex social and situational contexts surrounding stillbirth and helped preserve the participants' voices in theory construction.

9.3 What I did along the way

Congruent with decolonising methodologies, my relationships with PAU staff and students were vital to the success of this doctoral research project. At the outset of the study, I was unsure about my position as an Australian researcher undertaking research into the lives of Papua New Guineans. I did not want to repeat the mistakes of the past by accident. Thus, throughout each stage of the study, I worked closely with cultural mentors and reflected on my own practice to ensure the conduct of the research was culturally appropriate. Before undertaking data collection, I made a concerted effort to build professional relationships with

SOHS staff, midwifery lecturers and tutors and with the cohort of midwifery students likely to participate in the research. Showing reciprocity and respect and maintaining a reflexive stance helped to reduce hierarchical relationship between the participants and me as researcher. These relationships developed and deepened throughout the research process. I continue to maintain many of these relationships through ongoing research and professional activities.

The study proceeded through three stages: focus groups, interviews and a workshop. Midwifery students participating in focus groups discussed beliefs and attitudes about pregnancy, birth and stillbirth in their communities and the maternal health care services available to women. Students brought different stories to a collective space. Personal narratives about care provision were shared. Data generated from the focus groups, as well as data generated from individual interviews where students expanded upon concepts raised in the focus groups and other issues of concern, were analysed using grounded theory methods of coding and categorisation, enhanced by memo and journal writing and diagramming. Consistent with the selected methodologies, I returned to the study site and in a participatory workshop with midwifery students, discussed the emerging theory from my analysis—elements that fit and elements that needed to change.

The selected methodologies enabled me to construct a grounded theory that provided understanding of the phenomenon of stillbirth from the student perspectives. A theoretical model that identified the core category of ‘Balancing it Out’ was developed. Once again returning to the study site, I presented the findings and grounded theory to an audience of students, academics and health workers. I received only positive comments on how my

research reflected real-life experiences of health care provision for communities across PNG by those living and working in the study environment.

9.4 What I found at the end of the study

In this doctoral research, I set out to explore, describe and theorise how midwifery students at a university in PNG experienced the provision of care to women following stillbirth. The study reveals three dimensions that reflect how midwifery students achieve their goal of providing the best care to women following stillbirth: (i) 'Becoming a midwife'; (ii) 'Traversing different belief systems'; and (iii) 'Dealing with feelings'. Midwifery students experienced tension in providing optimal care because of the constraints of working in an unevenly resourced health system operating under the biomedical model of care and limited knowledge about stillbirth and bereavement care. They practice across liminal spaces with diverse and dynamic knowledge systems, experiencing dissonance as they try to understand stillbirth and relate to the woman in their care. Owing to the close and intimate relationship they share with the woman, the midwifery students need to manage the conflicting feelings and emotions they experience when a baby is stillborn, to not only meet the needs of the woman but also the organisational culture of the workplace. 'Balancing it Out' is an individual process consisting of caring experiences, meaning making and coping strategies, situated in a complex sociocultural context.

In positioning the study findings in relation to the literature addressing the experiences of stillbirth for midwifery students and experienced midwives, it was evident there were similarities but that our understanding of the provision of care to women following stillbirth should be extended to account for the PNG context. Many attributes corresponded

with the literature, yet the students' strong religious beliefs and holistic worldview contrasted with much of the international literature.

9.5 Recommendations for action

Grounded theory is valued for informing action for change (Charmaz, 2014). Consistent with this methodology and the theory constructed from the research, I have identified the recommendations for action as presented below. These recommendations will assist midwifery students to achieve their core concern of providing the best possible care to women following stillbirth.

Changes should be implemented in the PAU midwifery curriculum to assist students in their practice. Midwifery students expressed that they lacked sufficient knowledge about stillbirth and confidence regarding how best to provide psychological care to women experiencing stillbirth. Students requested that the midwifery curriculum include specific education about stillbirth as well as training in bereavement counselling for women in their care. The students determined that counselling skills would assist their practice and provide a balance between clinical management and the provision of emotional support for women experiencing stillbirth. Midwifery professionals need skills to be able to have a layered discussion to reach desired outcomes and improve health behaviours. Students use basic communication skills in care provision, and counselling skills modules could be built upon this foundation. Counselling skills need to be appropriate for the Pacific setting, and modules should be cognisant of cultural and spiritual aspects and take into account different beliefs. As regards the health and wellbeing of the midwifery students, the study found that their reflective practice and discussion following a stillbirth was informal and irregular. Midwifery

students should be provided formal support and opportunities for debriefing to support best practice in care.

Recommendations for the provision of care to women

- (i) Review the current literature about evidence-based education and training for bereavement care in midwifery.
- (ii) Develop and introduce specific modules in the PAU midwifery curriculum for the provision of care to women experiencing stillbirth that incorporate not only the clinical management but also social, cultural and spiritual aspects of care.

Recommendations for the provision of care to midwifery students

- (i) Review the current literature about resilience programmes for midwifery staff.
- (ii) Develop and introduce self-care practice modules for midwifery students to build effective coping mechanisms that help them deal with the trauma they experience as they provide care to women. The modules need to account for the spiritual and social frameworks in which the students live and work.
- (iii) Introduce supervision and support after a critical incident as part of student welfare policy and procedure to avoid the effects of accruing trauma for midwifery students.

Action to date

I have engaged in the following action:

- (i) recommended that the PAU SOHS curriculum developers include stillbirth in the revised midwifery curriculum
- (ii) delivered a policy brief summarising research and recommended actions
- (iii) recommended that the PAU SOHS lecturers incorporate appropriate emotional care to women following stillbirth.

9.6 Recommendations for future research

Midwives worldwide provide care to women experiencing stillbirth every day, yet existing literature tends to focus on the experiences of stillbirth for midwives in high-income nations. This study has contributed to our understanding of midwifery students' experiences of stillbirth: It is the first to document the social, cultural, spiritual and professional factors that inform provision of care from the perspective of midwifery students at a PNG university. This study also demonstrates a methodology for cross-cultural research in the PNG context. Thus, this study provides a platform for future research.

This study investigated the experiences of midwifery students at one faith-based university in PNG. Future research could explore the experiences of midwifery students from other PNG institutions to investigate similarities and differences in midwifery students' experiences of care provision and the ways in which they manage their wellbeing. Similarly, the experiences of the two male midwifery students participating in this study may not be

representative of the experiences of other male midwifery students in PNG. Future studies should:

- explore the experiences of male midwifery students in learning and practice environments across PNG
- investigate the transferability of this grounded theory to other Pacific Island contexts to inform local action
- evaluate a new curriculum that includes stillbirth and bereavement care to document the outcomes for PNG midwifery education and practice.

Epilogue

It was hot and blindingly sunny on the morning of 24 February 2017. Several hundred people sheltered under the broad shade of the raintrees, waiting for the graduation ceremony to begin. Among the crowd were one Australian researcher, and 13 excited Bachelor of Midwifery graduands dressed in their heavy black academic gowns, hoods edged in white and bright purple, the colour of midwifery worldwide. The sound of the slit drum reverberating through the air announced the ceremony was soon to commence, only a little later than scheduled. Family and friends shuffled into the open-sided chapel, filling the hard timber pews. There was a soft whooshing sound as people waved their programmes as fans. Assembling in two lines to enter the chapel, the students laughed as they adjusted the swinging tassels on each other's mortarboards. The processional music began. The assembled crowd rose from their seats as the academic procession entered and slowly made their way to the stage. More solemn now, the graduating students were ushered into their seats. The ceremony commenced (Figure Epilogue 1).

I felt privileged to be invited to the midwifery graduation ceremony for the Class of 2016 and share in the celebration of the students' achievement with their families and friends. The students participating in this study showed a passion for their chosen career and wanted to make a difference to the health of women and babies in their communities. I wished the students well as they embarked on a new career as qualified midwives. I know first-hand how important competent, compassionate midwifery care is for mothers experiencing stillbirth.



Figure Epilogue 1. PAU 2017 Graduation Ceremony

Conducting this research project was an extraordinary experience. My time spent at PAU with the midwifery students and staff was without doubt the most enjoyable part of the project. People readily accepted me into their lives and the affection and support shown to me was humbling. Of course, there were times during the past four years that were challenging but I got through with the support of a team of advisors, mentors, friends and family. My sheer stubbornness and determination also helped! I feel I have grown both personally and professionally from my PhD experience. While I have learned a great deal, I also realise how much more there is to learn.

I conclude this thesis with a poem by Papua New Guinean writer and poet, Chris Baria, which I first read in an Air Niugini²⁵ inflight magazine during one of my field trips and later located online²⁶. The poem seemed particularly relevant to my research findings and

²⁵ Air Niugini is the national airline of Papua New Guinea.

²⁶ Chris Baria has a website at <http://protozoat.weebly.com/poetry.html>

highlights the importance of understanding, accommodating and reconciling diverse ways of knowing, being and doing in contemporary society, not only in PNG, but across the world.

I Brandish Hope

I brandish hope

That one day soon

We shall climb the wall

Of ignorance and arrogance

And on common ground we shall meet

To plant a seed

Of understanding, love and respect

That had eluded us for so long

We shall cast aside our pride, our differences

Relinquish those delusions that hold us captive

To unravel what's in store for us

We shall embark on a journey

Of self-realization and discovery

To believe and achieve

Our dreams and goals for tomorrow

References

- Abushaikha, L. (2006). Midwifery students' enrolment reasons and evaluations of the first Bachelor of Midwifery programme in Jordan. *Midwifery*, 22(4), 323–329.
doi:10.1016/j.midw.2005.11.001
- Afulani, P. A., Altman, M., Musana, J., & Sudhinaraset, M. (2017). Conceptualizing pathways linking women's empowerment and prematurity in developing countries. *BMC Pregnancy Childbirth*, 17(Suppl 2). doi:10.1186/s12884-017-1502-6
- Ahmed, S., Creanga, A. A., Gillespie, D. G., & Tsui, A. O. (2010). Economic status, education and empowerment: Implications for maternal health service utilization in developing countries. *PLoS One*, 5(6), e11190. doi:10.1371/journal.pone.0011190
- Airhihenbuwa, C. O. (1995). *Health and culture: Beyond the western paradigm*. Thousand Oaks, CA: Sage.
- Airhihenbuwa, C. O., Makoni, S., Iwelunmor, J., & Munodawafa, D. (2014). Sociocultural infrastructure: Communicating identity and health in Africa. *Journal of Health Communication*, 19(1), 1–5. doi:10.1080/10810730.2013.868767
- Al Hadid, L. A., Al-Rajabi, O., AlBarmawi, M., Yousef Sayyah, N. S., & Toqan, L. M. (2018). Exploring factors that influence students' attitudes toward midwifery in Jordan: Measuring psychometric properties of a newly developed tool. *Nurse Education in Practice*, 29, 219–224. doi:10.1016/j.nepr.2018.02.005
- Ambert, A.-M., Adler, P. A., Adler, P., & Detzner, D. F. (1995). Understanding and evaluating qualitative research. *Journal of Marriage and Family*, 57(4), 879–893.
- Amoa, A. B. (2017). *Annual Report 2017 Port Moresby General Hospital, Division of Obstetrics and Gynaecology*. Port Moresby: Port Moresby General Hospital.

- Anderson, J. (2015). Struggling with ‘this gender relations thing’ in the Papua New Guinea Church Partnership Program. *Gender, Place & Culture*, 22(10), 1357–1373.
doi:10.1080/0966369X.2014.970133
- Andrew, E. V., Pell, C., Angwin, A., Auwun, A., Daniels, J., Mueller, I., . . . Pool, R. (2014). Factors affecting attendance at and timing of formal antenatal care: Results from a qualitative study in Madang, Papua New Guinea. *PLoS One*, 9(5), e93025. doi:10.1371/journal.pone.0093025
- Archer, M., Decoteau, C., Gorski, P., Little, D., Porpora, D., Rutzou, T., . . . Vandenberghe, F. (2016, 23 December). What is critical realism? *Perspectives*, 38(2). Retrieved from <http://www.asatheory.org/current-newsletter-online/what-is-critical-realism>
- Arua, A., & Eka, D. J. (2002). Wantok system. *Melanesian Journal of Theology*, 18(2), 6–17.
- Ascroft, J., Sweeney, R., Samei, M., Semos, I., & Morgan, C. (2011). Strengthening church and government partnerships for primary health care delivery in Papua New Guinea: Lessons from the international experience. *Health Policy and Health Finance Knowledge Hub. Working Paper Series No 16, December*. Melbourne, Australia: The Nossal Institute for Global Health.
- Asian Development Bank. (2015). *ADB Civil Society Briefs. Papua New Guinea*. Retrieved from <http://www.adb.org/sites/default/files/publication/173264/csb-papua-new-guinea.pdf>
- Attard, J., Baldacchino, D. R., & Camilleri, L. (2014). Nurses’ and midwives’ acquisition of competency in spiritual care: A focus on education. *Nurse Education Today*, 34(12), 1460–1466. doi:10.1016/j.nedt.2014.04.015
- Auger, N., Delézire, P., Harper, S., & Platt, R. W. (2012). Maternal education and stillbirth: Estimating gestational-age-specific and cause-specific associations. *Epidemiology*, 23(2), 247–254. doi:10.1097/EDE.0b013e31824587bc
- Australia Awards Pacific Scholarships Papua New Guinea: Bachelor of Midwifery. (2015). Retrieved from <http://www.australiaawardspng.org/pacific/bachelor-of-midwifery/>

- Australian College of Midwives. (2018). ACM Philosophy for Midwifery. Retrieved from <https://www.midwives.org.au/midwifery-philosophy-values>
- Aveling, N. (2013). 'Don't talk about what you don't know': On (not) conducting research with/in Indigenous contexts. *Critical Studies in Education*, 54(2), 203–214. doi:10.1080/17508487.2012.724021
- Bäck, L. (2018). *Confidence in midwifery: Midwifery students and midwives' perspectives*. (Doctoral thesis, Mid Sweden University, Sundsvall, Sweden). Retrieved from <https://www.diva-portal.org/smash/get/diva2:1203814/FULLTEXT01.pdf>
- Bailey, J. (2016, October 17). Australia halts maternal child health initiative in PNG. *Papua New Guinea Post-Courier*. Retrieved from <http://postcourier.com.pg/australia-halts-maternal-child-health-initiative-in-png/>
- Bailey, P. E., Andualem, W., Brun, M., Freedman, L., Gbangbade, S., Kante, M., . . . Singh, K. (2017). Institutional maternal and perinatal deaths: A review of 40 low and middle income countries. *BMC Pregnancy and Childbirth*, 17(1), 295.
- Bainbridge, R., Whiteside, M., & McCalman, J. (2013). Being, knowing, and doing: A phronetic approach to constructing grounded theory with Aboriginal Australian partners. *Qualitative Health Research*, 23(2), 275–288. doi:10.1177/1049732312467853
- Baker, K. (2018). Great expectations: Gender and political representation in the Pacific Islands. *Government and Opposition*, 53(3), 542–568. doi:10.1017/gov.2016.54
- Barbour, R. (2007). *Doing focus groups*. London, United Kingdom: Sage.
- Barclay, L. (2008). Woman and midwives: Position, problems and potential. *Midwifery*, 24(1), 13–21. doi:10.1016/j.midw.2006.07.003
- Barker, J. (1989). Western medicine and the continuity of belief: The Maisin of Collingwood Bay, Oro Province. In S. Frankel & G. Lewis (Eds.), *A continuing trial of treatment: Medical*

pluralism in Papua New Guinea (pp. 69–93). Dordrecht; Netherlands: Kluwer Academic Publishers.

Baum, F. (2007). Health for all now! Reviving the spirit of Alma Ata in the twenty-first century: An introduction to the Alma Ata Declaration. *Social Medicine*, 2(1), 34–42.

Baxter, P., & Jack, S. (2008). Qualitative case study methodology: Study design and implementation for novice researchers. *Qualitative Report*, 13(4), 544–559. Retrieved from <http://nsuworks.nova.edu/tqr/vol13/iss4/2>

Begley, C. (2003). ‘I cried ... I had to ...’: Student midwives’ experiences of stillbirth, miscarriage and neonatal death. *Evidence-Based Midwifery*, 1, 20–26.

Bennett, A. M. (2014). *A model for direct entry midwifery education and deployment in Ethiopia: Transforming rural communities and health care to save lives*. (Unpublished master’s thesis, University of Technology, Sydney, Australia). Retrieved from <https://opus.lib.uts.edu.au/handle/10453/35958>

Bettioli, L., Griffin, E., Hogan, C., & Heard, S. (2004). Village birth attendants in Papua New Guinea. *Australian Family Physician*, 33(9), 764–765.

Bhabha, H. K. (1994). *The location of culture*. London; New York, NY: Routledge.

Bhaskar, R. (1978). *A realist theory of science* (2nd ed.). Hassocks, United Kingdom: Harvester Press.

Bhaskar, R. (1989). *Reclaiming reality: A critical approach to contemporary philosophy*. London, United Kingdom: Verso.

Bird, C. M. (2005). How I stopped dreading and learned to love transcription. *Qualitative Inquiry*, 11(2), 226–248. doi:10.1177/1077800404273413

Birks, M. (2014). Practical philosophy. In J. Mills & M. Birks (Eds.), *Qualitative methodology: A practical guide* (pp. 17–29). London, United Kingdom: Sage.

- Birks, M., & Mills, J. (2015). *Grounded theory: A practical guide* (2nd ed.). Thousand Oaks, CA; London: Sage.
- Bishop, J. (2014, May 18). Training midwives in PNG will save women's lives [Press release]. Retrieved from https://foreignminister.gov.au/releases/Pages/2014/jb_mr_140508b.aspx?ministerid=4
- Blencowe, H., Cousens, S., Jassir, F. B., Say, L., Chou, D., Mathers, C., . . . Lawn, J. E. (2016). National, regional, and worldwide estimates of stillbirth rates in 2015, with trends from 2000: A systematic analysis. *Lancet Global Health*, 4(2), e98–e108. doi:10.1016/s2214-109x(15)00275-2
- Brinkmann, S., & Kvale, S. (2015). *InterViews: Learning the craft of qualitative research interviewing* (3rd ed.). Thousand Oaks, CA: Sage.
- Browne, K. C. (2017). Rebuilding the triad: Including fathers in maternal-child health. *Pacific Journal of Reproductive Health*, 1(5), 214–217. doi:10.18313/pjrh.2017.900
- Bryant, A. (2009). Grounded theory and pragmatism: The curious case of Anselm Strauss. *Qualitative Social Research*, 10(3). Retrieved from <http://www.qualitative-research.net/index.php/fqs/article/viewFile/1358/2851>
- Bryant, A., & Charmaz, K. (2010). *The SAGE handbook of grounded theory*. Los Angeles, CA: Sage.
- Burr, V. (2015). *Social constructionism* (3rd ed.). New York, NY: Routledge.
- Buscatto, M., & Fusulier, B. (2013). Presentation. 'Masculinities' challenged in light of 'feminine' occupations *Recherches sociologiques et anthropologiques*, 44(2), 1a–19a. Retrieved from <http://journals.openedition.org/rso/1026>
- Cacciatore, J. (2013). Psychological effects of stillbirth. *Seminars in Fetal & Neonatal Medicine*, 18(2), 76–82. doi:10.1016/j.siny.2012.09.001

- Campbell, R., Pound, P., Morgan, M., Daker-White, G., Britten, N., Pill, R., . . . Donovan, J. (2011). Evaluating meta ethnography: Systematic analysis and synthesis of qualitative research. *Health Technology Assessment, 15*(43). doi:10.3310/hta15430
- Carolan, M., & Kruger, G. (2011). Undertaking midwifery studies: Commencing students' views. *Midwifery, 27*(5), 642–647. doi:10.1016/j.midw.2009.10.002
- Carter, S. M., & Little, M. (2007). Justifying knowledge, justifying method, taking action: Epistemologies, methodologies, and methods in qualitative research. *Qualitative Health Research, 17*(10), 1316–1328. doi:10.1177/1049732307306927
- Cartwright, P., & Read, S. (2005). Working with practitioners to develop training in peri-natal loss and bereavement: Evaluating three workshops. *Nurse Education in Practice, 5*(5), 266–273. doi:10.1016/j.nepr.2005.01.004/c
- Casey, D., & Houghton, C. (2010). Clarifying case study research: Examples from practice. *Nurse Researcher, 17*(3), 41–51.
- Catford, J. (2011). Ottawa 1986: Back to the future. *Health Promotion International, 26*(S2), ii163–ii167. doi:10.1093/heapro/dar081
- Cecil, R. (Ed.) (1996). *The anthropology of pregnancy loss: Comparative studies in miscarriage, stillbirth and neonatal death*. Oxford, United Kingdom: Berg.
- Charmaz, K. (2000). Grounded theory: Objectivist and constructivist methods. In N. K. Denzin & Y. S. Lincoln (Eds.), *The handbook of qualitative research* (2nd ed., pp. 505–535). Thousand Oaks, CA: Sage.
- Charmaz, K. (2006). *Constructing grounded theory: A practical guide through qualitative analysis*. London, United Kingdom: Sage.
- Charmaz, K. (2008a). Constructionism and the grounded theory method. In J. A. Holstein & J. F. Gubrium (Eds.), *Handbook of constructionist research* (pp. 397–412). New York, NY: Guilford Press.

- Charmaz, K. (2008b). Reconstructing grounded theory. In P. Alasuutari, L. Bickman, & J. Brannen (Eds.), *The SAGE handbook of social research methods* (pp. 461–478). London, United Kingdom: Sage.
- Charmaz, K. (2009). Shifting the grounds: Constructivist grounded theory methods. In J. M. Morse (Ed.), *Developing grounded theory: The second generation* (pp. 127–154). Walnut Creek, CA: Left Coast Press.
- Charmaz, K. (2011). Grounded theory methods in social justice research. In N. K. Denzin & Y. S. Lincoln (Eds.), *The SAGE handbook of qualitative research* (4th ed., pp. 359–380). Thousand Oaks, CA: Sage.
- Charmaz, K. (2012). The power and potential of grounded theory. *Medical Sociology Online*, 6(3), 2–15.
- Charmaz, K. (2014). *Constructing grounded theory* (2nd ed.). Thousand Oaks, CA: Sage.
- Charmaz, K. (2017). The power of constructivist grounded theory for critical inquiry. *Qualitative Inquiry*, 23(1), 34–45. doi:10.1177/1077800416657105
- Charmaz, K., & Belgrave, L. L. (2012). Qualitative interviewing and grounded theory analysis. In J. F. Gubrium, J. A. Holstein, A. B. Marvasti, & K. D. McKinney (Eds.), *The SAGE handbook of interview research: The complexity of the craft* (pp. 347–366). Thousand Oaks, CA: Sage.
- Charrier, P. (2011). Male midwives in France: An example of masculinizing a 'feminine' profession? *Culture, Society and Masculinities*, 3(2), 103–123.
- Cheek, J., Onslow, M., & Cream, A. (2009). Beyond the divide: Comparing and contrasting aspects of qualitative and quantitative research approaches. *Advances in Speech Language Pathology*, 6(3), 147–152. doi:10.1080/14417040412331282995
- Cheer, K. (2016). Asia-Pacific women's experiences of stillbirth: A metasynthesis of qualitative literature. *Health Care for Women International*, 37(8), 889–905. doi:10.1080/07399332.2015.1080261

- Cheer, K., MacLaren, D., & Tsey, K. (2016). The use of grounded theory in studies of nurses and midwives' coping processes: A systematic literature search. *Contemporary Nurse, 51*(2–3), 200–219. doi:10.1080/10376178.2016.1157445
- Cheung-Judge, M.-Y., & Holbeche, L. (2015). *Organization development: A practitioner's guide for OD and HR* (2nd ed.). London, United Kingdom: Kogan Page.
- Chilisa, B. (2012). *Indigenous research methodologies*. Thousand Oaks, CA: Sage.
- Chomba, E., Carlo, W. A., Goudar, S. S., Jehan, I., Tshetu, A., Garces, A., . . . First Breath Study Group. (2017). Effects of essential newborn care training on fresh stillbirths and early neonatal deaths by maternal education. *Neonatology, 111*(1), 61–67. doi:10.1159/000447421
- Clandinin, D. J., & Rosiek, J. (2007). Mapping a landscape of narrative inquiry: Borderland spaces and tensions. In D. J. Clandinin (Ed.), *Handbook of narrative inquiry: Mapping a methodology* (pp. 35–76). Thousand Oaks, CA: Sage.
- Clarke, A. E. (2003). Situational analyses: Grounded theory mapping after the postmodern turn. *Symbolic Interaction, 26*(4), 553–576.
- Congress of Aboriginal and Torres Strait Islander Nurses and Midwives, Australian College of Midwives, & CRANApus. (2016). *Birthing on country position statement*. Retrieved from <http://catsinam.org.au/static/uploads/files/birthing-on-countryposition-statement-endorsed-march-2016-wfaxpyhvmxrw.pdf>
- Connell, R. (2007). *Southern theory: The global dynamics of knowledge in social science*. Crows Nest, Australia: Allen & Unwin.
- Corbin, J., & Strauss, A. L. (2008). *Basics of qualitative research: Techniques and procedures for developing grounded theory* (3rd ed.). Thousand Oaks, CA: Sage.
- Corbin, J., & Strauss, A. L. (2015). *Basics of qualitative research: Techniques and procedures for developing grounded theory* (4th ed.). Thousand Oaks, CA: Sage.

- Cox, E., & Hendrickson, T. (2003). A moment in history: Mass training for women village health workers in East Sepik Province, Papua New Guinea. *Development*, 46(2), 101–104.
- Coyle, J. (2002). Spirituality and health: Towards a framework for exploring the relationship between spirituality and health. *Journal of Advanced Nursing*, 37(6), 589–597.
doi:10.1046/j.1365-2648.2002.02133.x
- Creswell, J. W. (2013). *Qualitative inquiry and research design: Choosing among five approaches* (3rd ed.). Thousand Oaks, CA: Sage.
- Creswell, J. W. (2014). *Research design: Qualitative, quantitative, and mixed methods approaches* (International Student ed.). Thousand Oaks, CA: Sage.
- Creswell, J. W., Hanson, W. E., Plano Clark, V. L., & Morales, A. (2007). Qualitative research design: Selection and implementation. *Counseling Psychologist*, 35(2), 236–264.
doi:10.1177/0011000006287390
- Creswell, J. W., & Poth, C. N. (2018). *Qualitative inquiry & research design: Choosing among five approaches* (4th ed.). Thousand Oaks, CA: Sage.
- Crotty, M. (1998). *The foundations of social research: Meaning and perspective in the research process*. St Leonards, Australia: Allen & Unwin.
- Cullen, D., Sidebotham, M., Gamble, J., & Fenwick, J. (2016). Young student's motivations to choose an undergraduate midwifery program. *Women and Birth*, 29(3), 234–239.
doi:10.1016/j.wombi.2015.10.012
- Danermark, B., Ekström, M., Jakobsen, L., & Karlsson, J. C. (2001). *Explaining society: An introduction to critical realism in the social sciences*. London, United Kingdom: Routledge.
- Davidson, C. (2009). Transcription: Imperatives for qualitative research. *International Journal of Qualitative Methods*, 8(2), 35–52. doi:10.1177/160940690900800206

- Davies, R. (2017, May 16). Five lean years: How Australia's aid program has tightened its belt. [Blog post]. Retrieved from <http://devpolicy.org/five-lean-years-australias-aid-program-tightened-belt/>
- Davis-Floyd, R. (2007). Daughter of time: The postmodern midwife (Part 1). *Revista da Escola de Enfermagem da USP*, 41(4), 705–710.
- Davis-Floyd, R. (2008). Daughter of time: The postmodern midwife (Part 2). *Revista da Escola de Enfermagem da USP*, 42(1), 168–172.
- Davis, J., Vaughan, C., Nankinga, J., Davidson, L., Kigodi, H., Alalo, E., . . . Luchters, S. (2018). Expectant fathers' participation in antenatal care services in Papua New Guinea: A qualitative inquiry. *BMC Pregnancy Childbirth*, 18(1), 138. doi:10.1186/s12884-018-1759-4
- Davy, C. P., & Patrickson, M. (2012). Implementation of evidence-based healthcare in Papua New Guinea. *International Journal of Evidence Based Healthcare*, 10(4), 361–368. doi:10.1111/j.1744-1609.2012.00294.x
- Dawson, A., Kililo, M., Geita, L., Mola, G., Brodie, P. M., Rumsey, M., . . . Homer, C. S. E. (2016). Midwifery capacity building in Papua New Guinea: Key achievements and ways forward. *Women and Birth*, 29, 180–188. doi:10.1016/j.wombi.2015.10.007
- Denscombe, M. (2014). *The good research guide: For small-scale social research projects* (5th ed.). Maidenhead, United Kingdom: McGraw-Hill Education.
- Denzin, N. K. (2010). Grounded and Indigenous theories and the politics of pragmatism. *Sociological Inquiry*, 80(2), 296–312. doi:10.1111/j.1475-682X.2010.00332.x
- Department of Foreign Affairs and Trade. (2017). Papua New Guinea country brief. Retrieved from <http://dfat.gov.au/geo/papua-new-guinea/Pages/papua-new-guinea-country-brief.aspx>
- Doherty, J., Coughlan, B., Casey, B., Lloyd, B., Sheehy, L., Brosnan, M., . . . Cullen, S. (2018). Student midwives' education needs and their experience of attending a bereavement

education workshop. *British Journal of Midwifery*, 26(8), 523–531.

doi:10.12968/bjom.2018.26.8.523

Doherty, J., Cullen, S., Casey, B., Lloyd, B., Sheehy, L., Brosnan, M., . . . Coughlan, B. (2018). Bereavement care education and training in clinical practice: Supporting the development of confidence in student midwives. *Midwifery*, 66, 1–9. doi:10.1016/j.midw.2018.06.026

Dooris, M. (2009). Holistic and sustainable health improvement: The contribution of the settings-based approach to health promotion. *Perspectives in Public Health*, 129(1), 29–36. doi:10.1177/1757913908098881

Douglas, B. (2000). *Weak states and other nationalisms: Emerging Melanesian paradigms? State, Society and Governance in Melanesia Program Discussion Paper 00/3*. Canberra, Australia: Australian National University, Research School of Pacific and Asian Studies. Retrieved from https://openresearch-repository.anu.edu.au/bitstream/1885/41823/3/nationalism_in_weak_states.pdf

Downe, S., Kingdon, C., Kennedy, R., Norwell, H., McLaughlin, M.-J., & Heazell, A. E. P. (2012). Post-mortem examination after stillbirth: Views of UK-based practitioners. *European Journal of Obstetrics & Gynecology and Reproductive Biology*, 162(1), 33–37. doi:10.1016/j.ejogrb.2012.02.002

Dumbaugh, M., Tawiah-Agyemang, C., Manu, A., ten Asbroek, G. H. A., Kirkwood, B., & Hill, Z. (2014). Perceptions of, attitudes towards and barriers to male involvement in newborn care in rural Ghana, West Africa: A qualitative analysis. *BMC Pregnancy and Childbirth*, 14(1), 269.

Dumo, K. (2017). *Annual Report 2017, ANGAU Memorial Hospital, Obstetrics and Gynaecology Division*. Lae, Papua New Guinea: ANGAU Memorial Hospital.

Dunne, C. (2011). The place of the literature review in grounded theory research. *International Journal of Social Research Methodology*, 14(2), 111–124. doi:10.1080/13645579.2010.494930

Dutta, M. (2016). Social context of health and diversity issues. In K. Olsen, R. Young, & I. Schultz (Eds.), *Handbook of qualitative health research for evidence-based practice* (pp. 7–20). New York, NY: Springer.

The Economist Intelligence Unit. (2018). The Global Liveability Index 2018. Retrieved from https://pages.eiu.com/rs/753-RIQ-438/images/The_Global_Liveability_Index_2018.pdf

Ellis, A., Chebsey, C., Storey, C., Bradley, S., Jackson, S., Flenady, V., . . . Siassakos, D. (2016). Systematic review to understand and improve care after stillbirth: A review of parents' and healthcare professionals' experiences. *BMC Pregnancy and Childbirth*, *16*(1), 16. doi:10.1186/s12884-016-0806-2

Ernst, L. M. (2015). A pathologists perspective on the perinatal autopsy. *Seminars in Perinatology*, *39*(1), 55–63. doi:10.1053/j.semperi.2014.10.008

Ertekin Pinar, S., Yildirim, G., & Sayin, N. (2018). Investigating the psychological resilience, self-confidence and problem-solving skills of midwife candidates. *Nurse Education Today*, *64*, 144–149. doi:10.1016/j.nedt.2018.02.014

Eves, R. (2008). Cultivating Christian civil society: Fundamentalist Christianity, politics and governance in Papua New Guinea. *State, Society & Governance in Melanesia. Discussion Paper 2008/08*. Retrieved from <http://bellschool.anu.edu.au/experts-publications/publications/1452/cultivating-christian-civil-society-fundamentalist>

Eves, R. (2010). 'In God's hands': Pentecostal Christianity, morality, and illness in a Melanesian society. *Journal of the Royal Anthropological Institute*, *16*(2), 496–514.

Eves, R. (2012). Resisting global AIDS knowledges: Born-again Christian narratives of the epidemic from Papua New Guinea. *Medical Anthropology*, *31*(1), 61–76. doi:10.1080/01459740.2011.594122

Fanon, F. (1963). *The wretched of the earth*. New York, NY: Grove Weidenfeld.

Fanon, F. (1967). *Black skin, white masks*. London, United Kingdom: Pluto Press.

- Fauk, N. K., Cahaya, I. B., Merry, M. S., Damayani, A. D., & Liana, D. S. (2017). Exploring determinants influencing the utilisation of antenatal care in Indonesia: A narrative systematic review. *Journal of Healthcare Communications, 2*(4), 69. doi:10.4172/2472-1654.100110
- Fenwick, J., Cullen, D., Gamble, J., & Sidebotham, M. (2016). Being a young midwifery student: A qualitative exploration. *Midwifery, 39*, 27–34. doi:10.1016/j.midw.2016.04.010
- Fenwick, J., Jennings, B., Downie, J., Butt, J., & Okanaga, M. (2007). Providing perinatal loss care: Satisfying and dissatisfying aspects for midwives. *Women and Birth, 20*(4), 153–160. doi:10.1016/j.wombi.2007.09.002
- Figley, C. R. (Ed.) (1995). *Compassion fatigue: Coping with secondary traumatic stress disorder in those who treat the traumatized*. London: Brunner-Routledge.
- Finlayson, K., & Downe, S. (2013). Why do women not use antenatal services in low- and middle-income countries? A meta-synthesis of qualitative studies. *PLoS Med, 10*(1), e1001373. doi:10.1371/journal.pmed.1001373
- Fiti-Sinclair, R. (2002). Childbirth in Papua New Guinean villages and in Port Moresby General Hospital. In V. Lukere & M. Jolly (Eds.), *Birth in the Pacific: Beyond tradition and modernity?* (pp. 56–78). Honolulu, HI: University of Hawaii Press.
- Flenady, V., Koopmans, L., Middleton, P., Frøen, J. F., Smith, G. C., Gibbons, K., . . . Ezzati, M. (2011). Major risk factors for stillbirth in high-income countries: A systematic review and meta-analysis. *Lancet, 377*(9774), 1331–1340. doi:10.1016/S0140-6736(10)62233-7
- Fletcher, A. J. (2017). Applying critical realism in qualitative research: Methodology meets method. *International Journal of Social Research Methodology, 20*(2), 181–194. doi:10.1080/13645579.2016.1144401
- Forbat, L., & Henderson, J. (2005). Theoretical and practical reflections on sharing transcripts with participants. *Qualitative Health Research, 15*(8), 1114–1128. doi:10.1177/1049732305279065

- Forsyth, M., & Eves, R. (Eds.). (2015). *Talking it through: Responses to sorcery and witchcraft beliefs and practices in Melanesia*. Canberra, Australia: Australian National University Press.
- Foucault, M. (1997). *Power: Essential works of Michel Foucault, 1954-1984*. London, United Kingdom: Allen Lane.
- Frankel, S., & Lewis, G. (1989). Patterns of continuity and change. In *A continuing trial of treatment: Medical pluralism in Papua New Guinea* (pp. 2–33). Dordrecht; Netherlands: Kluwer Academic Publishers.
- Frankenberg, R. (1993). *White women, race matters: The social construction of whiteness*. Minneapolis, MN: University of Minnesota Press.
- Frankin, K. J. (2010). Comments on sorcery in Papua New Guinea. *GIALens*, 4(2), 1–11. Retrieved from <http://www.gial.edu/documents/gialens/Vol4-3/Franklin-Comments-on-Sorcery-in-PNG.pdf>
- Fraser, D. M., Cooper, M. A., & Myles, M. F. (2009). *Myles textbook for midwives* (15th ed.). Edinburgh: Churchill Livingstone.
- Freire, P. (1993). *Pedagogy of the oppressed*. New York, NY: Continuum.
- Fretts, R. C. (2005). Etiology and prevention of stillbirth. *American Journal of Obstetrics and Gynecology*, 193(6), 1923–1935. doi:10.1016/j.ajog.2005.03.074
- Frøen, J. F., Cacciatore, J., McClure, E. M., Kuti, O., Jokhio, A. H., Islam, M., & Shiffman, J. (2011). Stillbirths 1: Why they matter. *Lancet*, 377(9774), 1353–1366. doi:10.1016/S0140-6736(10)62232-5
- Frøen, J. F., Friberg, I. K., Lawn, J. E., Bhutta, Z. A., Pattinson, R. C., Allanson, E. R., . . . Temmerman, M. (2016). Stillbirths: Progress and unfinished business. *Lancet*, 387(10018), 574–586. doi:10.1016/S0140-6736(15)00818-1

- Gair, S. (2012). Feeling their stories: Contemplating empathy, insider/outsider positionings, and enriching qualitative research. *Qualitative Health Research*, 22(1), 134–143.
doi:10.1177/1049732311420580
- Ganle, J. K., Obeng, B., Segbefia, A. Y., Mwinyuri, V., Yeboah, J. Y., & Baatiema, L. (2015). How intra-familial decision-making affects women's access to, and use of maternal healthcare services in Ghana: A qualitative study. *BMC Pregnancy Childbirth*, 15, 173.
doi:10.1186/s12884-015-0590-4
- Gardner, J. M. (1999). Perinatal death: Uncovering the needs of midwives and nurses and exploring helpful interventions in the United States, England and Japan. *Journal of Transcultural Nursing*, 10(2), 120–130.
- Geller, P. A., Psaros, C., & Kornfield, S. L. (2010). Satisfaction with pregnancy loss aftercare: Are women getting what they want? *Archives of Women's Mental Health*, 13(2), 111–124.
doi:10.1007/s00737-010-0147-5
- General Assembly of the United Nations. (2017). Speech by Hon. Peter O'Neill CMG MP Prime Minister, Seventy-Second General Debate Session of the United Nations General Assembly, 23 September 2017. Retrieved from https://gadebate.un.org/sites/default/files/gastatements/72/pg_en.pdf
- Gibbs, P. (2015). Practical church interventions on sorcery and witchcraft violence in the Papua New Guinea highlands. In M. Forsyth & R. Eves (Eds.), *Talking it through: Responses to sorcery and witchcraft beliefs and practices in Melanesia* (pp. 309–327). Canberra, Australia: Australian National University Press.
- Gill, P., Stewart, K., Treasure, E., & Chadwick, B. (2008). Methods of data collection in qualitative research: Interviews and focus groups. *British Dental Journal*, 204(6), 291–295.
- Gitobu, C. M., Gichangi, P. B., & Mwanda, W. O. (2018). The effect of Kenya's free maternal health care policy on the utilization of health facility delivery services and maternal and neonatal mortality in public health facilities. *BMC Pregnancy Childbirth*, 18(1), 77.
doi:10.1186/s12884-018-1708-2

- Glaser, B. G. (1978). *Theoretical sensitivity: Advances in the methodology of grounded theory*. Mill Valley, CA: Sociology Press.
- Glaser, B. G. (1998). *Doing grounded theory: Issues and discussions*. Mill Valley, CA: Sociology Press.
- Glaser, B. G., & Strauss, A. L. (1967). *The discovery of grounded theory: Strategies for qualitative research*. Chicago, IL: Aldine.
- Gold, K. J. (2007). Navigating care after a baby dies: A systematic review of parent experiences with health providers. *Journal of Perinatology*, 27(4), 230–237. doi:10.1038/sj.jp.7211676
- Government of Papua New Guinea. (2010). *National Health Plan 2011–2020: Volume 1*. Port Moresby, Papua New Guinea: Author.
- Government of Papua New Guinea. (2017). *Constitution of the independent state of Papua New Guinea*. Retrieved from <http://www.parliament.gov.pg/constitution-of-the-independent-state-of-papua-new-guinea>
- Gray, R. T., Vallely, A., Wilson, D. P., Kaldor, J., MacLaren, D., Kelly-Hanku, A., . . . Murray, J. M. (2014). Impact of male circumcision on the HIV epidemic in Papua New Guinea: A country with extensive foreskin cutting practices. *PLoS One*, 9(8), e104531. doi:10.1371/journal.pone.0104531
- Green, J., Franquiz, M., & Dixon, C. (1997). The myth of the objective transcript: Transcribing as a situated act. *TESOL Quarterly*, 31(1), 172–176.
- Greenhalgh, T., Annandale, E., Ashcroft, R., Barlow, J., Black, N., Bleakley, A., . . . Ziebland, S. (2016). An open letter to The BMJ editors on qualitative research. *BMJ*, 352, i563. doi:10.1136/bmj.i563
- Grix, J. (2010). *The foundations of research* (2nd ed.). New York: Palgrave Macmillan.

- Groenewald, T. (2008). Memos and memoing. In L. M. Given (Ed.), *The SAGE encyclopedia of qualitative research methods* (pp. 505–506). Thousand Oaks, CA: Sage.
- Guba, E. G., & Lincoln, Y. S. (1994). Competing paradigms in qualitative research. In N. K. Denzin & Y. S. Lincoln (Eds.), *Handbook of qualitative research* (pp. 105–117). Thousand Oaks, CA: Sage.
- Hall, J. J., & Taylor, R. (2003). Health for all beyond 2000: The demise of the Alma-Ata Declaration and primary health care in developing countries. *Medical Journal of Australia*, *178*(1), 17–20.
- Halperin, O., Goldblatt, H., Noble, A., Raz, I., Zvulunov, I., & Liebergall Wischnitzer, M. (2011). Stressful childbirth situations: A qualitative study of midwives. *Journal of Midwifery & Women's Health*, *56*(4), 388–394. doi:10.1111/j.1542-2011.2011.00030.x
- Hamnett, M. P., & Connell, J. (1981). Diagnosis and cure: The resort to traditional and modern medical practitioners in the North Solomons, Papua New Guinea. *Social Science & Medicine. Part B: Medical Anthropology*, *15*(4), 489–498. doi:10.1016/0160-7987(81)90023-5
- Harrison, H., Birks, M., Franklin, R., & Mills, J. (2017). Case study research: Foundations and methodological orientations. *Forum Qualitative Sozialforschung/Forum: Qualitative Social Research*, *18*(1), 1–12. Retrieved from <http://www.qualitative-research.net/index.php/fqs/article/view/2655/4079>
- Haslam, N. R. (2015). Post-mortem as preventative medicine in Papua New Guinea: A case in point. *Rural and Remote Health*, *15*(3228), 1–7.
- Hauck, V. A. (2010). The role of churches in creating social capital and improving governance in Papua New Guinea: Lessons for working in fragile situations. *Public Administration and Development*, *30*(1), 49–65. doi:10.1002/pad.546
- Haws, R. A., Mashasi, I., Mrisho, M., Schellenberg, J. A., Darmstadt, G. L., & Winch, P. J. (2010). 'These are not good things for other people to know': How rural Tanzanian women's

experiences of pregnancy loss and early neonatal death may impact survey data quality. *Social Science & Medicine*, 71(10), 1764–1772. doi:10.1016/j.socscimed.2010.03.051

Haydon, G., Browne, G., & van der Riet, P. (2018). Narrative inquiry as a research methodology exploring person centred care in nursing. *Collegian*, 25(1), 125–129. doi:10.1016/j.colegn.2017.03.001

Health Research Council of New Zealand. (2004). *Guidelines on Pacific health research* (2nd ed.). Wellington, New Zealand: Author.

Heazell, A. E. P., Siassakos, D., Blencowe, H., Burden, C., Bhutta, Z. A., Cacciatore, J., . . . Downe, S. (2016). Stillbirths: Economic and psychosocial consequences. *Lancet*, 387(10018), 604–616. doi:10.1016/S0140-6736(15)00836-3

Hentz, P. (2016). Overview of case study research. In M. De Chesnay (Ed.), *Nursing research using case studies* (pp. 1–10). New York, NY: Springer.

Herbst, F. A. (2017). *Biomedical entanglements: Conceptions of personhood in a Papua New Guinea society*. New York, NY: Berghahn Books.

Hewlett, B. S., & Amola, R. P. (2003). Cultural contexts of Ebola in Northern Uganda. *Emerging Infectious Diseases*, 9(10), 1242–1248.

High Commission of Papua New Guinea Canberra. (2001). About PNG: History. Retrieved from <http://www.pngcanberra.org/aboutpng/history.htm>

Hiller, H. H., & DiLuzio, L. (2004). The interviewee and the research interview: Analysing a neglected dimension in research. *Canadian Review of Sociology/Revue canadienne de sociologie*, 41(1), 1–26.

Hinton, R., & Earnest, J. (2009). Beyond risk factors to lived experiences: Young women's experiences of health in Papua New Guinea. *Rural and Remote Health*, 9(4), 1257.

- Hochschild, A. R. (1979). Emotion work, feeling rules, and social structure. *American Journal of Sociology*, 85(3), 551–575.
- Hochschild, A. R. (1983). *The managed heart: Commercialization of human feeling*. Berkeley, CA: University of California Press.
- Hochschild, A. (1989). Reply to Cas Wouters's review essay on *The managed heart*. *Theory, Culture & Society*, 6(3), 439–445. doi:10.1177/026327689006003005
- Hockey, N. (2010). Engaging postcolonialism. *Journal of Critical Realism*, 9(3), 353–383. doi:10.1558/jcr.v9i3.353
- Hodkinson, P. (2005). 'Insider research' in the study of youth cultures. *Journal of Youth Studies*, 8(2), 131–149. doi:10.1080/13676260500149238
- Holliday, A. (2016). *Doing and writing qualitative research* (3rd ed.). London, United Kingdom: Sage.
- Holmes, W., Wambo, G., Gabong, R., Kavang, E., Luana, S., Sawa, A., . . . Natoli, L. J. (2012). 'Because it is a joyful thing to carry a baby': Involving men in reproductive, maternal and newborn health in East New Britain, Papua New Guinea. *Papua New Guinea Medical Journal*, 55(1–4), 24–34.
- Homer, C. S. E., Brodie, P., & Leap, N. (2008). *Midwifery continuity of care: A practical guide*. Chatswood, Australia: Churchill Livingstone Elsevier.
- Homer, C. S. E., Malata, A., & ten Hoop-Bender, P. (2016). Supporting women, families, and care providers after stillbirths. *Lancet*, 387(10018), 516–517. doi:10.1016/S0140-6736(15)01278-7
- Homer, C. S. E., Turkmani, S., & Rumsey, M. (2017). The state of midwifery in small island Pacific nations. *Women and Birth*, 30(3), 193–199. doi:10.1016/j.wombi.2017.02.012

- Horton, R., & Samarasekera, U. (2016). Stillbirths: Ending an epidemic of grief. *Lancet*, 387(10018), 515–516. doi:10.1016/S0140-6736(15)01276-3
- Hsu, C. (2001). Making midwives: Postmodern conditions and midwifery training in Saint Lucia. *Medical Anthropology: Cross-Cultural Studies in Health and Illness*, 20(4), 313–344. doi:10.1080/01459740.2001.9966197
- Huicho, L., Molina, C., Diez-Canseco, F., Lema, C., Miranda, J. J., Huayanay-Espinoza, C. A., & Lescano, A. G. (2015). Factors behind job preferences of Peruvian medical, nursing and midwifery students: A qualitative study focused on rural deployment. *Human Resources for Health*, 13(1), 90. doi:10.1186/s12960-015-0091-6
- Hunter, B. (2009). ‘Mixed messages’: Midwives’ experiences of managing emotion. In B. Hunter & R. Deery (Eds.), *Emotions in midwifery and reproduction* (pp. 175–191). New York, NY: Palgrave.
- Hunter, B. (2010). Mapping the emotional terrain of midwifery: What can we see and what lies ahead? *International Journal of Work Organisation and Emotion*, 3(3), 253–269.
- Hutchison, A. J., Johnston, L., & Breckon, J. (2011). Grounded theory-based research within exercise psychology: A critical review. *Qualitative Research in Psychology*, 8(3), 247–272. doi:10.1080/14780880903304527
- International Confederation of Midwives. (2013). Essential competencies for basic midwifery practice. Retrieved from <https://internationalmidwives.org/what-we-do/education-core-documents/essential-competencies-basic-midwifery-practice/>
- International Confederation of Midwives. (2014). Core document. Philosophy and model of midwifery care. Retrieved from <http://internationalmidwives.org/who-we-are/policy-and-practice/code-of-ethics-philosophy-model-midwifery-care/>
- International Confederation of Midwives. (2017). Core document. Definition of the midwife. Retrieved from <http://internationalmidwives.org/who-we-are/policy-and-practice/icm-international-definition-of-the-midwife/>

- Ipis, N., Vince, J. D., & Mola, G. L. (2016). Sociocultural barriers to access and utilization of birth delivery services in a rural area of Papua New Guinea. *Papua New Guinea Medical Journal*, 59(3–4), 178–186.
- Jayasekara, R. S. (2012). Focus groups in nursing research: Methodological perspectives. *Nursing Outlook*, 60(6), 411–416. doi:10.1016/j.outlook.2012.02.001
- Jeffrey, P., & Jeffrey, R. (1996). Delayed periods and falling babies: The ethnophysiology and politics of pregnancy loss in rural North India. In R. Cecil (Ed.), *The anthropology of pregnancy loss: Comparative studies in miscarriage, stillbirth and neonatal death* (pp. 17–37). Oxford, United Kingdom: Berg.
- Jolly, M. (2005). Beyond the horizon? Nationalisms, feminisms, and globalization in the Pacific. *Ethnohistory*, 52(1), 137–166.
- Jonas-Simpson, C., Pilkington, F. B., MacDonald, C., & McMahon, E. (2013). Nurses' experiences of grieving when there is a perinatal death. *SAGE Open*, 3(2), 1–11. doi:10.1177/2158244013486116
- Jones, K., & Smythe, L. (2015). The impact on midwives of their first stillbirth. *New Zealand College of Midwives Journal*, 51, 17–22.
- Jordan, B. (1997). Authoritative knowledge and its construction. In R. E. Davis-Floyd & C. F. Sargent (Eds.), *Childbirth and authoritative knowledge: Cross-cultural perspectives* (pp. 55–79). Berkeley, CA: University of California Press.
- Kagawa-Singer, M., Dressler, W., George, S., Baquet, C. R., Bell, R. A., Burhansstipanov, L., . . . Garro, L. (2016). Culture: The missing link in health research. *Social Science and Medicine*, 170, 237–246. doi:10.1016/j.socscimed.2016.07.015
- Kamberelis, G., & Dimitriadis, G. (2013). *Focus groups: From structured interviews to collective conversations*. London, United Kingdom: Taylor & Francis.

- Kamblijambi, J. K., & Holroyd, E. (2017). Papua New Guinea midwives perspectives of the effect of a targeted village birth attendant education program. *Midwifery*, *52*, 11–18. doi:10.1016/j.midw.2017.04.007
- Kantrowitz-Gordon, I., Ellis, S. A., & McFarlane, A. (2014). Men in midwifery: A national survey. *Journal of Midwifery & Women's Health*, *59*(5), 516–522. doi:10.1111/jmwh.12191
- Kelly-Hanku, A., Aggleton, P., & Shih, P. (2018). *I shouldn't talk of medicine only*: Biomedical and religious frameworks for understanding antiretroviral therapies, their invention and their effects. *Global Public Health*, *13*(10), 1454–1467. doi:10.1080/17441692.2017.1377746
- Kenney, C. M. (2011). Midwives, women and their families: A Māori gaze: Towards partnerships for maternity care in Aotearoa New Zealand. *AlterNative: An International Journal of Indigenous Peoples*, *7*(2), 123–137. doi:10.1177/117718011100700205
- Kenworthy, D., & Kirkham, M. (2011). *Midwives coping with loss and grief: Stillbirth, professional and personal losses*. London, United Kingdom: Radcliffe Publishing.
- Khalil, D. (2009). Violence against midwives in Cape Town. *African Journal Of Midwifery And Women's Health*, *3*(1), 37–40.
- Kickbusch, I. (1996). Tribute to Aaron Antonovsky—‘What creates health’. *Health Promotion International*, *11*(1), 5–6. doi:10.1093/heapro/11.1.5
- Kiguli, J., Namusoko, S., Kerber, K., Peterson, S., & Waiswa, P. (2015). Weeping in silence: Community experiences of stillbirths in rural eastern Uganda. *Global Health Action*, *8*(1), 24011. doi:10.3402/gha.v8.24011
- Kildea, S., Tracy, S., Sherwood, J., Magick-Dennis, F., & Barclay, L. (2016). Improving maternity services for Indigenous women in Australia: Moving from policy to practice. *Medical Journal of Australia*, *205*(8), 374–379.

- Kincheloe, J. L., McLaren, P., & Steinberg, S. R. (2011). Critical pedagogy, and qualitative research: Moving to the bricolage. In N. K. Denzin & Y. S. Lincoln (Eds.), *The SAGE handbook of qualitative research* (4th ed., pp. 163–177). Thousand Oaks, CA: Sage.
- Koczberski, G., & Curry, G. N. (1999). *Sik bilong ples*: An exploration of meanings of illness and well-being amongst the Wosera Abelam of Papua New Guinea. *Australian Geographical Studies*, 37(3), 230–247. doi:10.1111/1467-8470.00081
- Koenig, H. G. (2009). Research on religion, spirituality, and mental health: A review. *Canadian Journal of Psychiatry*, 54(5), 283–291.
- Kovach, M. (2009). *Indigenous methodologies: Characteristics, conversations and contexts*. Canada: University of Toronto Press.
- Krauss, S. E. (2005). Research paradigms and meaning making: A primer. *Qualitative Report*, 10(4), 758–770. Retrieved from <http://nsuworks.nova.edu/tqr/vol10/iss4/7>
- Kula-Semos, M. A. (2014). An interpretation of the competing values framework in PNG's multicultural higher education landscape. *Contemporary PNG Studies: DWU Research Journal*, 21, 29–43.
- Kuper, A., Lingard, L., & Levinson, W. (2008). Critically appraising qualitative research. *BMJ*, 337(7671), 687–689. doi:10.1136/bmj.a1035
- Kuper, A., Reeves, S., & Levinson, W. (2008). An introduction to reading and appraising qualitative research. *BMJ*, 337(7666), 404–407. doi:10.1136/bmj.a288
- Kura, S., Vince, J., & Crouch-Chivers, P. (2013). Male involvement in sexual and reproductive health in the Mendi district, Southern Highlands province of Papua New Guinea: A descriptive study. *Reproductive Health*, 10(1), 46. doi:10.1186/1742-4755-10-46
- Kyakas, A., & Wiessner, P. (1992). *From inside the women's house: Enga women's lives and traditions*. Buranda, Australia: Robert Brown.

- The Lancet Ending Preventable Stillbirths Study Group. (2016). Ending preventable stillbirths: An executive summary for The Lancet's series. *Lancet*. Retrieved from <http://www.thelancet.com/pb/assets/raw/Lancet/stories/series/stillbirths2016-exec-sum.pdf>
- Langer, A., Meleis, A., Knaul, F. M., Atun, R., Aran, M., Arreola-Ornelas, H., . . . Frenk, J. (2015). Women and health: The key for sustainable development. *Lancet*, *386*(9999), 1165–1210. doi:10.1016/s0140-6736(15)60497-4
- Larsen, G. L., Lupiwa, S., Kave, H. P., Gillieatt, S., & Alpers, M. P. (2004). Antenatal care in Goroka: Issues and perceptions. *Papua New Guinea Medical Journal*, *47*(3–4), 202–214.
- Lawn, J. E., Blencowe, H., Oza, S., You, D., Lee, A. C. C., Waiswa, P., . . . Cousens, S. N. (2014). Every newborn: Progress, priorities, and potential beyond survival. *Lancet*, *384*(9938), 189–205. doi:10.1016/s0140-6736(14)60496-7
- Lawn, J. E., Blencowe, H., Pattinson, R., Cousens, S., Kumar, R., Ibiebele, I., . . . Stanton, C. (2011). Stillbirths: Where? When? Why? How to make the data count? *Lancet*, *377*(9775), 1448–1463. doi:10.1016/s0140-6736(10)62187-3
- Lawn, J. E., Blencowe, H., Waiswa, P., Amouzou, A., Mathers, C., Hogan, D., . . . Cousens, S. (2016). Stillbirths: Rates, risk factors, and acceleration towards 2030. *Lancet*, *387*(10018), 587–603. doi:10.1016/S0140-6736(15)00837-5
- Lawn, J. E., Gravett, M., Nunes, T., Rubens, C., Stanton, C., & The GAPPS Review Group. (2010). Global report on preterm birth and stillbirth (1 of 7): Definitions, description of the burden and opportunities to improve data. *BMC Pregnancy and Childbirth*, *10*(Suppl 1), 1–22. doi:10.1186/1471-2393-10-S1-S1
- Lawn, J. E., & Kinney, M. (2011). Stillbirths: An executive summary for The Lancet's series. *Lancet*, *377*(9775), 1–8.
- Leap, N. (2009). Woman-centred or women-centred care: Does it matter? *British Journal of Midwifery*, *17*(1), 12–16.

- Leinweber, J., Creedy, D. K., Rowe, H., & Gamble, J. (2017). A socioecological model of posttraumatic stress among Australian midwives. *Midwifery*, *45*, 7–13.
doi:10.1016/j.midw.2016.12.001
- Leinweber, J., & Rowe, H. J. (2010). The costs of ‘being with the woman’: Secondary traumatic stress in midwifery. *Midwifery*, *26*(1), 76–87. doi:10.1016/j.midw.2008.04.003
- Lempert, L. B. (2010). Asking questions of the data: Memo writing in the grounded theory tradition. In A. Bryant & K. Charmaz (Eds.), *The SAGE handbook of grounded theory* (pp. 245–264). Los Angeles, CA: Sage.
- Levers, M.-J. D. (2013). Philosophical paradigms, grounded theory, and perspectives on emergence. *SAGE Open*, *3*(4), 1–6. doi:10.1177/2158244013517243
- Lewis, E. (1979). Mourning by the family after a stillbirth or neonatal death. *Archives of Disease in Childhood*, *54*(4), 303–306.
- Liamputtong, P. (2010). Cross-cultural research and qualitative inquiry. *Turkish Online Journal of Qualitative Inquiry*, *1*(1), 16–29.
- Liamputtong, P. (2011). *Focus group methodology: Principles and practice*. London, United Kingdom: Sage.
- Liamputtong, P. (2013). *Qualitative research methods* (4th ed.). South Melbourne, Australia: Oxford University Press.
- Liese, K. L., & Maeder, A. B. (2018). Safer Muslim motherhood: Social conditions and maternal mortality in the Muslim world. *Global Public Health*, *13*(5), 567–581.
doi:10.1080/17441692.2017.1373837
- Lincoln, Y. S., & Guba, E. G. (1985). *Naturalistic inquiry*. Newbury Park, CA: Sage.

- Lincoln, Y. S., Lynham, S. A., & Guba, E. G. (2011). Paradigmatic controversies, contradictions, and emerging confluences, revisited. In N. K. Denzin & Y. S. Lincoln (Eds.), *The SAGE handbook of qualitative research* (4th ed., pp. 97–128). Thousand Oaks, CA: Sage.
- Linhares, C. H. (2012). The lived experiences of midwives with spirituality in childbirth: Mana from heaven. *Journal of Midwifery & Women's Health*, 57(2), 165–171. doi:10.1111/j.1542-2011.2011.00133.x
- Lockey, R. (2011). Introducing tupela twins. *Australian Midwifery News*, 11(4), 28–29. Retrieved from https://issuu.com/austcollegemidwives/docs/midwifery_news_summer_2011_final
- Lowell, A., Kildea, S., Liddle, M., Cox, B., & Paterson, B. (2015). Supporting aboriginal knowledge and practice in health care: Lessons from a qualitative evaluation of the strong women, strong babies, strong culture program. *BMC Pregnancy Childbirth*, 15(1), 19. doi:10.1186/s12884-015-0433-3
- Macfarlane, J. (2005). *The relationship between cultural beliefs and treatment-seeking behaviour in Papua New Guinea: Implications for the incorporation of traditional medicine into the health system*. (Doctoral Thesis, Curtin University of Technology, Perth, Australia). Retrieved from https://espace.curtin.edu.au/bitstream/handle/20.500.11937/738/128273_Macfarlane%20full.pdf?sequence=2&isAllowed=y
- Macfarlane, J. (2009). Common themes in the literature on traditional medicine in Papua New Guinea. *Papua New Guinea Medical Journal*, 52(1–2), 44–53.
- MacLaren, D., Tommbe, R., Mafile'o, T., Manineng, C., Fregonese, F., Redman-MacLaren, M., . . . McBride, W. J. (2013). Foreskin cutting beliefs and practices and the acceptability of male circumcision for HIV prevention in Papua New Guinea. *BMC Public Health*, 13, 818. doi:10.1186/1471-2458-13-818
- Mahato, P. K., van Teijlingen, E., Simkhada, P., Sheppard, Z. A., & Silwal, R. C. (2017). Factors related to choice of place of birth in a district in Nepal. *Sexual & Reproductive Healthcare*, 13, 91–96. doi:10.1016/j.srhc.2017.07.002

- Mander, R. (2009). Good grief: Staff responses to childbearing loss. *Nurse Education Today*, 29(1), 117–123. doi:10.1016/j.nedt.2008.07.005/c
- Manning, V. (2017). Health promotion: A core role of the midwife. In J. Bowden & V. Manning (Eds.), *Health promotion in midwifery: Principles and practice* (3rd ed., pp. 19–31). Boca Raton, FL: CRC Press.
- Markle, D. T., West, R. E., & Rich, P. J. (2011). Beyond transcription: Technology, change, and refinement of method. *Forum Qualitative Sozialforschung/Forum: Qualitative Social Research*, 12(3), 1–22.
- Marme, G. D. (2018). Barriers and facilitators to effective tuberculosis infection control practices in Madang Province, PNG – a qualitative study. *Rural and Remote Health*, 18(3), 4401. doi:10.22605/RRH4401
- Marmot, M. (2007). Achieving health equity: From root causes to fair outcomes. *Lancet*, 370(9593), 1153–1163. doi:10.1016/S0140-6736(07)61385-3
- Mårtensson, P., Fors, U., Wallin, S.-B., Zander, U., & Nilsson, G. H. (2016). Evaluating research: A multidisciplinary approach to assessing research practice and quality. *Research Policy*, 45(3), 593–603. doi:10.1016/j.respol.2015.11.009
- Matua, G. A., & Van Der Wal, D. M. (2015). Differentiating between descriptive and interpretive phenomenological research approaches. *Nurse Researcher*, 22(6), 22–27. doi:10.7748/nr.22.6.22.e1344
- Maxwell, J. A. (2012). *A realist approach for qualitative research*. London, United Kingdom: Sage.
- Maxwell, J. A. (2013). *Qualitative research design: An interactive approach* (3rd ed.). Thousand Oaks, CA: Sage.
- McCool, W., Guidera, M., Stenson, M., & Dauphinee, L. (2009). The pain that binds us: Midwives' experiences of loss and adverse outcomes around the world. *Health Care for Women International*, 30(11), 1003–1013. doi:10.1080/07399330903134455

- McCreight, B. S. (2005). Perinatal grief and emotional labour: A study of nurses' experiences in gynae wards. *International Journal of Nursing Studies*, 42(4), 439–448.
doi:10.1016/j.ijnurstu.2004.07.004
- McIntosh, T., Fraser, D. M., Stephen, N., & Avis, M. (2013). Final year students' perceptions of learning to be a midwife in six British universities. *Nurse Education Today*, 33(10), 1179–1183. doi:10.1016/j.nedt.2012.05.020
- McKenna, H. P., Pajnkihar, M., & Murphy, F. A. (2014). *Fundamentals of nursing models: Theories and practice* (2nd ed.). Somerset, United Kingdom: Wiley-Blackwell.
- McKenna, L., & Boyle, M. (2016). Midwifery student exposure to workplace violence in clinical settings: An exploratory study. *Nurse Education in Practice*, 17, 123–127.
doi:10.1016/j.nepr.2015.11.004
- McKenna, L., & Rolls, C. (2011). Undergraduate midwifery students' first experiences with stillbirth and neonatal death. *Contemporary Nurse*, 38(1–2), 76–83.
- McNamara, K., Meaney, S., O'Connell, O., McCarthy, M., Greene, R. A., & O'Donoghue, K. (2017). Healthcare professionals' response to intrapartum death: A cross-sectional study. *Archives of Gynecology and Obstetrics*, 295(4), 845–852. doi:10.1007/s00404-017-4309-9
- Mead, M. (1933). The Marsalai cult among the Arapesh, with special reference to the rainbow serpent beliefs of the Australian aboriginals. *Oceania*, 4(1), 37–53.
- Miers, M. E., Rickaby, C. E., & Pollard, K. C. (2007). Career choices in health care: Is nursing a special case? A content analysis of survey data. *International Journal of Nursing Studies*, 44(7), 1196–1209. doi:10.1016/j.ijnurstu.2006.04.010
- Mills, J. (2014). Methodology and methods. In J. Mills & M. Birks (Eds.), *Qualitative methodology: A practical guide* (pp. 31–47). London, United Kingdom: Sage.
- Mills, J., & Birks, M. (Eds.). (2014). *Qualitative methodology: A practical guide*. London, United Kingdom: Sage.

- Mills, J., Bonner, A., & Francis, K. (2006). Adopting a constructivist approach to grounded theory: Implications for research design. *International Journal of Nursing Practice*, *12*(1), 8–13. doi:10.1111/j.1440-172X.2006.00543.x
- Mitchell, M. (2005). Preparing student midwives to care for bereaved parents. *Nurse Education in Practice*, *5*(2), 78–83. doi:10.1016/j.nepr.2004.03.005/c
- Mitchell, M., & Hall, J. (2007). Teaching spirituality to student midwives: A creative approach. *Nurse Education in Practice*, *7*(6), 416–424. doi:10.1016/j.nepr.2007.02.007
- Modiba, L., & Nolte, A. G. W. (2007). The experiences of mothers who lost a baby during pregnancy. *Health SA Gesondheid*, *12*(2), 3–13. doi:10.4102/hsag.v12i2.245
- Modiba, L. M. (2008). Experiences and perceptions of midwives and doctors when caring for mothers with pregnancy loss in a Gauteng hospital. *Health SA Gesondheid*, *13*(4), 29–40. doi:10.4102/hsag.v13i4.402
- Moher, D., Liberati, A., Tetzlaff, J., & Altman, D. G. (2009). Preferred reporting items for systematic reviews and meta-analyses: The PRISMA statement. *BMJ*, *339*, b2535.
- Mola, G. (2018, May 22). Severe drug and equipment shortages at Port Moresby General Hospital. Retrieved from <http://www.devpolicy.org/severe-drug-and-equipment-shortages-port-moresby-general-hospital-20180523/>
- Moore, A., Catling, C., West, F., Neill, A., Rumsey, M., Samor, M. K., & Homer, C. S. E. (2015). What motivates midwifery students to study midwifery in Papua New Guinea? *Pacific Journal of Reproductive Health*, *1*(2), 60–67. doi:10.18313/pjrh.2015.911
- Moore, A., Puawe, P., Buasi, N., West, F., Samor, M. K., Joseph, N., . . . Homer, C. S. E. (2016). Education, employment and practice: Midwifery graduates in Papua New Guinea. *Midwifery*, *41*, 22–29. doi:10.1016/j.midw.2016.07.006
- Morake, V. V. V. (2013). *Nursing learners' experiences with regard to caring for mothers after stillbirth deliveries at public hospitals in Gauteng province*. (Master's thesis, University of

Pretoria, South Africa). Retrieved from

<https://repository.up.ac.za/bitstream/handle/2263/24509/dissertation.pdf;sequence=1>

Morgan, D. L. (1996). Focus groups. *Annual Review of Sociology*, 22, 129–152.

Morgan, D. L. (1997). *Focus groups as qualitative research*. Thousand Oaks, CA: Sage.

Morgan, D. L., & Spanish, M. T. (1984). Focus groups: A new tool for qualitative research. *Qualitative Sociology*, 7(3), 253–270.

Morse, J. M. (1999). The armchair walkthrough. *Qualitative Health Research*, 9(4), 435–436.

Morse, J. M. (2001). Situating grounded theory within qualitative inquiry. In R. S. Schreiber & P. N. Stern (Eds.), *Using grounded theory in nursing* (pp. 1–15). New York, NY: Springer.

Nakata, M. (2002). Indigenous knowledge and the cultural interface: Underlying issues at the intersection of knowledge and information systems. *IFLA Journal*, 28(5–6), 281–291.

Nakata, M. (2006). Australian Indigenous studies: A question of discipline. *Australian Journal of Anthropology*, 17(3), 265–275.

Nakata, M. N. (2007). *Disciplining the savages, savaging the disciplines*. Canberra, Australia: Aboriginal Studies Press.

Nakata, M., Nakata, V., Keech, S., & Bolt, R. (2012). Decolonial goals and pedagogies for Indigenous studies. *Decolonization: Indigeneity, Education & Society*, 1(1), 120–140.

Nallen, K. (2006). Midwives' needs in relation to the provision of bereavement support to parents affected by perinatal death. Part one. *MIDIRS Midwifery Digest*, 16(4), 537–542.

Nallen, K. (2007). Midwives' needs in relation to the provision of bereavement support to parents affected by perinatal death. Part two. *MIDIRS Midwifery Digest*, 17(1), 105–112.

- Narokobi, B. (1983). *The Melanesian way* (Rev. ed.). Boroko, PNG; Suva, Fiji: Institute of Papua New Guinea Studies; Institute of Pacific Studies University of the South Pacific.
- National Department of Health Papua New Guinea. (2014). *National Sexual & Reproductive Health Policy*. Port Moresby, Papua New Guinea: Government of Papua New Guinea.
- National Department of Health Papua New Guinea. (2017). *Assessment of sector performance 2012-2016. National report*. Port Moresby, Papua New Guinea: Government of Papua New Guinea.
- National Statistics Office Papua New Guinea. (2015). *Papua New Guinea 2011 national report*. Retrieved from <http://sdd.spc.int/en/resources/document-library?view=preview&format=raw&fileId=218>.
- Ndikwetepo, M., & Strumpher, N. (2017). Midwives' experiences of stress due to emergency childbirths in a Namibian regional hospital. *Africa Journal of Nursing and Midwifery*, 19(1), 105–117. doi:10.25159/2520-5293/807
- Neill, A., Homer, C., Rumsey, M., Kililo, M., & WHO Collaborating Centre for Nursing Midwifery and Health Development University of Technology Sydney. (2016). *PNG Maternal and Child Health Initiative Phase II: Final report*. Retrieved from <https://www.uts.edu.au/sites/default/files/PNG%20MCHI%20Phase%20II%20M%20and%20E%20Final%20Report%20June%202016%20%282%29.pdf>
- Newton, B. J., Rothlingova, Z., Gutteridge, R., LeMarchand, K., & Raphael, J. H. (2012). No room for reflexivity? Critical reflections following a systematic review of qualitative research. *Journal of Health Psychology*, 17(6), 866–885. doi:10.1177/1359105311427615
- Noblit, G. W., & Hare, R. D. (1988). *Meta-ethnography: Synthesizing qualitative studies*. Newbury Park, CA: Sage.
- O'Brien, B. C., Harris, I. B., Beckman, T. J., Reed, D. A., & Cook, D. A. (2014). Standards for reporting qualitative research: A synthesis of recommendations. *Academic Medicine*, 89(9), 1245–1251. doi:10.1097/ACM.0000000000000388

- O'Keefe, D., Davis, J., Yakuna, G., Van Gemert, C., & Morgan, C. (2011). Formal and informal maternal health care: Comparing the service provision of health facilities and village health volunteers in East Sepik Province. *Papua New Guinea Medical Journal*, 54(3–4), 147–153.
- Obermeyer, C. M. (2000). Pluralism and pragmatism: Knowledge and practice of birth in Morocco. *Medical Anthropology Quarterly*, 14(2), 180–201.
- Oliver, C. (2012). Critical realist grounded theory: A new approach for social work research. *British Journal of Social Work*, 42(2), 371–387. doi:10.1093/bjsw/bcr064
- Onagi, G. (2015). Foreword: Sorcery-and witchcraft-related killings in Papua New Guinea. In M. Forsyth & R. Eves (Eds.), *Talking it through. Responses to sorcery and witchcraft beliefs and practices in Melanesia* (pp. vii–ix). Canberra, Australia: Australian National University Press.
- Pacific Adventist University. (n.d.). Preparing the best graduates in an atmosphere of care. Retrieved from <https://www.pau.ac.pg/vision-mission>
- Pacific Adventist University. (2012). Student policy handbook 2012. July. Retrieved from https://www.pau.ac.pg/uploaded_assets/371118-Student_Handbook_2012-2.pdf?thumbnail=original&1431991469
- Pacific Adventist University. (2014). *Bachelor of Midwifery Degree Curriculum Document*. Port Moresby, Papua New Guinea: Author.
- Papua New Guinea Nursing Council. (2002–2014). Papua New Guinea Nursing Competency Standards. Retrieved from https://www.health.gov.pg/publications/PNGNC&NC_2014.pdf
- Papua New Guinea Nursing Council. (2003–2014). Papua New Guinea Specialist Nursing Competency Standards Midwifery. Retrieved from https://www.health.gov.pg/publications/PNGNCMCS_2014.pdf
- Park, C. L. (2005). Religion as a meaning-making framework in coping with life stress. *Journal of Social Issues*, 61(4), 707–729.

Parliament of Australia. (2018). Select Committee on Stillbirth Research and Education. Retrieved from https://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Stillbirth_Research_and_Education

Pauka, S., Treagust, D. F., & Waldrip, B. (2005). Village elders' and secondary school students' explanations of natural phenomena in Papua New Guinea. *International Journal of Science and Mathematics Education*, 3(2), 213–238.

Peek, L., & Fothergill, A. (2009). Using focus groups: Lessons from studying daycare centers, 9/11, and Hurricane Katrina. *Qualitative Research*, 9(1), 31–59. doi:10.1177/1468794108098029

Pembroke, N. F., & Pembroke, J. J. (2008). The spirituality of presence in midwifery care. *Midwifery*, 24(3), 321–327. doi:10.1016/j.midw.2006.10.004

Pendleton, J. (2015). 'What's it like being a male midwife?'. *British Journal of Midwifery*, 23(7), 466–468.

Perez-Botella, M., Downe, S., Magistretti, C. M., Lindstrom, B., & Berg, M. (2015). The use of salutogenesis theory in empirical studies of maternity care for healthy mothers and babies. *Sexual & Reproductive Healthcare*, 6(1), 33–39. doi:10.1016/j.srhc.2014.09.001

Petrites, A. D., Mullan, P., Spangenberg, K., & Gold, K. J. (2016). You have no choice but to go on: How physicians and midwives in Ghana cope with high rates of perinatal death. *Maternal & Child Health Journal*, 20(7), 1448–1455. doi:10.1007/s10995-016-1943-y

Petty, N. J., Thomson, O. P., & Stew, G. (2012). Ready for a paradigm shift? Part 1: Introducing the philosophy of qualitative research. *Manual Therapy*, 17(4), 267–274. doi:10.1016/j.math.2012.03.006

Pezaro, S., Clyne, W., Turner, A., Fulton, E. A., & Gerada, C. (2016). 'Midwives overboard!' Inside their hearts are breaking, their makeup may be flaking but their smile still stays on. *Women and Birth*, 29(3), e59–66. doi:10.1016/j.wombi.2015.10.006

- Pilkenton, D., & Shorn, M. N. (2008). Midwifery: A career for men in nursing. *Men in Nursing*, 3, 29–33.
- Potter, G., & Lopez, J. (2001). After postmodernism: The new millennium. In J. Lopez & G. Potter (Eds.), *After postmodernism: An introduction to critical realism* (pp. 3–16). London: Athlone.
- Power, A., & Mullan, J. (2017). Vicarious birth trauma and posttraumatic stress disorder: Preparing and protecting student midwives. *British Journal of Midwifery*, 25(12), 799–802.
- Pratt, M. L. (1991). Arts of the contact zone. *Profession*, 33–40.
- PricewaterhouseCoopers (Australia), & Stillbirth Foundation Australia. (2016). *The economic impacts of stillbirth in Australia*. Retrieved from <http://stillbirthfoundation.org.au/wp-content/uploads/2016/10/Economic-Impacts-of-Stillbirth-2016-PwC.pdf>
- Puia, D. M., Lewis, L., & Beck, C. T. (2013). Experiences of obstetric nurses who are present for a perinatal loss. *Journal of Obstetric, Gynecologic & Neonatal Nursing*, 42(3), 321–331. doi:10.1111/1552-6909.12040
- Pulsford, R. L., & Cawte, J. (1972). *Health in a developing country: Principles of medical anthropology in Melanesia*. Milton, Australia: Jacaranda Press.
- Råheim, M., Magnussen, L. H., Sekse, R. J. T., Lunde, Å., Jacobsen, T., & Blystad, A. (2016). Researcher–researched relationship in qualitative research: Shifts in positions and researcher vulnerability. *International Journal of Qualitative Studies on Health and Well-being*, 11, 1–12. doi:10.3402/qhw.v11.30996
- Ramalho, R., Adams, P., Huggard, P., & Hoare, K. (2015). Literature review and Constructivist Grounded Theory methodology. *Forum Qualitative Sozialforschung/Forum: Qualitative Social Research*, 16(3), 1–9.
- Raman, S., Nicholls, R., Ritchie, J., Razee, H., & Shafiee, S. (2016). How natural is the supernatural? Synthesis of the qualitative literature from low and middle income countries on

cultural practices and traditional beliefs influencing the perinatal period. *Midwifery*, 39, 87–97. doi:10.1016/j.midw.2016.05.005

Raphael, D. (2006). Social determinants of health: Present status, unanswered questions, and future directions. *International Journal of Health Services*, 36(4), 651–677. doi:10.2190/3mw4-1ek3-dgrq-2crf

Ravaldi, C., Levi, M., Angeli, E., Romeo, G., Biffino, M., Bonaiuti, R., & Vannacci, A. (2018). Stillbirth and perinatal care: Are professionals trained to address parents' needs? *Midwifery*, 64, 53–59. doi:10.1016/j.midw.2018.05.008

Razee, H., Whittaker, M., Jayasuriya, R., Yap, L., & Brentnall, L. (2012). Listening to the rural health workers in Papua New Guinea – The social factors that influence their motivation to work. *Social Science & Medicine*, 75(5), 828–835. doi:10.1016/j.socscimed.2012.04.013

Redman-MacLaren, M. (2015a). Field notes: Papua New Guinea – Australia partnerships strengthen capacity in HIV research. Retrieved from <https://auspng.lowyinstitute.org/article/field-notes-papua-new-guinea-australia-partnerships-strengthen-hiv-research-capacity/>

Redman-MacLaren, M. (2015b). *The implications of male circumcision practices for women in Papua New Guinea, including for HIV prevention*. (Doctoral thesis, James Cook University, Cairns, Australia). Retrieved from <https://researchonline.jcu.edu.au/42315/>

Redman-MacLaren, M. L., Api, U. K., Darius, M., Tommbe, R., Mafile'o, T. A., & MacLaren, D. J. (2014). Co-interviewing across gender and culture: Expanding qualitative research methods in Melanesia. *BMC Public Health*, 14, 922. doi:10.1186/1471-2458-14-922

Redman-MacLaren, M., & Mills, J. (2015). Transformational grounded theory: Theory, voice, and action. *International Journal of Qualitative Methods*, 14(3), 1–12.

Redman-MacLaren, M., Mills, J., & Tommbe, R. (2014). Interpretive focus groups: A participatory method for interpreting and extending secondary analysis of qualitative data. *Global Health Action*, 7, 25214. doi:10.3402/gha.v7.25214

- Redman-MacLaren, M., Mills, J., Tommbe, R., MacLaren, D., Speare, R., & McBride, W. J. H. (2017). Implications of male circumcision for women in Papua New Guinea: A transformational grounded theory study. *BMC Women's Health*, 17(1), 53. doi:10.1186/s12905-017-0406-y
- Rice, H., & Warland, J. (2013). Bearing witness: Midwives experiences of witnessing traumatic birth. *Midwifery*, 29(9), 1056–1063. doi:10.1016/j.midw.2012.12.003
- Rice, P. L., & Ezzy, D. (1999). *Qualitative research methods: A health focus*. Melbourne, Australia: Oxford University Press.
- Richards, L., & Morse, J. M. (2013). *README FIRST for a user's guide to qualitative methods* (3rd ed.). Thousand Oaks, CA: Sage.
- Richardson, L., & St. Pierre, E. A. (2005). Writing: A method of inquiry. In N. K. Denzin & Y. S. Lincoln (Eds.), *The SAGE handbook of qualitative research* (3rd ed., pp. 959–978). Thousand Oaks, CA: Sage.
- Ritchie, J. [Jan]. (2001). Not everything can be reduced to numbers. In C. A. Berglund (Ed.), *Health research* (pp. 149–173). South Melbourne, Australia: Oxford University Press.
- Ritchie, J. [Jane], & Lewis, J. (Eds.). (2003). *Qualitative research practice: A guide for social science students and researchers*. London, United Kingdom: Sage.
- Robbins, J. (2004). *Becoming sinners: Christianity and moral torment in a Papua New Guinea society*. Berkeley; Palo Alto: University of California Press.
- Roehrs, C., Masterson, A., Alles, R., Witt, C., & Rutt, P. (2008). Caring for families coping with perinatal loss. *Journal of Obstetric, Gynecologic & Neonatal Nursing*, 37(6), 631–639. doi:10.1111/j.1552-6909.2008.00290.x
- Rolls, C., & McKenna, L. (2010). Stillbirth and neonatal death: Preparing midwifery students for their first encounter. *Focus on Health Professional Education*, 12(1), 52–59.

- Roos, N., Tunçalp, Ö., Kerber, K., Allanson, E., Costello, A., Askew, I., & Mathai, M. (2016). Learning from every stillbirth and neonatal death. *Lancet*, 388(10046), 741–743.
- Rosenthal, M. (2016). Qualitative research methods: Why, when, and how to conduct interviews and focus groups in pharmacy research. *Currents in Pharmacy Teaching and Learning*, 8(4), 509–516. doi:10.1016/j.cptl.2016.03.021
- Ross, L., van Leeuwen, R., Baldacchino, D., Giske, T., McSherry, W., Narayanasamy, A., . . . Schep-Akkerman, A. (2014). Student nurses perceptions of spirituality and competence in delivering spiritual care: A European pilot study. *Nurse Education Today*, 34(5), 697–702. doi:10.1016/j.nedt.2013.09.014
- Rousseau, G. G., & Venter, D. J. L. (2009). Investigating the importance of factors related to career choice. *Management Dynamics*, 18(3), 2–14.
- Russell, B. (1970). *An outline of philosophy*. London, United Kingdom: Unwin.
- Sadak, B. B., & Weiser, L. (2017). Acknowledging the archetypal elements of grief. *Psychological Perspectives*, 60(4), 434–444. doi:10.1080/00332925.2017.1386987
- Saldaña, J. (2012). *The coding manual for qualitative researchers* (2nd ed.). London; Thousand Oaks, CA: Sage.
- Savage, O. M. N. (1996). ‘Children of the rope’ and other aspects of pregnancy loss in Cameroon. In R. Cecil (Ed.), *The anthropology of pregnancy loss: Comparative studies in miscarriage, stillbirth and neonatal death* (pp. 95–109). Oxford, United Kingdom: Berg.
- Save the Children. (2014). *Ending newborn deaths: Ensuring every baby survives*. Retrieved from http://www.savethechildren.org/site/c.8rKLIXMGIpI4E/b.8989373/k.E376/Ending_Newborn_Deaths_Ensuring_Every_Baby_Survives.htm
- Sayer, A. (1999). *Realism and social science*. London, United Kingdom: Sage.

- Scaletta, N. M. (1986). Childbirth: A case history from West New Britain, Papua New Guinea. *Oceania*, 57(1), 33–52.
- Schrøder, K., Jørgensen, J. S., Lamont, R. F., & Hvidt, N. C. (2016). Blame and guilt – a mixed methods study of obstetricians’ and midwives’ experiences and existential considerations after involvement in traumatic childbirth. *Acta Obstetricia et Gynecologica Scandinavica*, 95(7), 735–745. doi:10.1111/aogs.12897
- Scotland, J. (2012). Exploring the philosophical underpinnings of research: Relating ontology and epistemology to the methodology and methods of the scientific, interpretive, and critical research paradigms. *English Language Teaching*, 5(9), 9–16. doi:10.5539/elt.v5n9p9
- Scully, A. (2018, July 12). Male midwife breaks down gender barriers and says men need to bring their A-game every day. *ABC News*. Retrieved from <http://www.abc.net.au/news/2018-07-12/midwife-breaks-gender-barriers-says-men-need-to-bring-a-game/9944964>
- Seibold, C. (2005). The experiences of a first cohort of Bachelor of Midwifery students, Victoria, Australia. *Australian Midwifery*, 18(3), 9–16. doi:10.1016/S1448-8272(05)80024-0
- Sharma, B., Hildingsson, I., Johansson, E., Prakasamma, M., Ramani, K. V., & Christensson, K. (2015). Do the pre-service education programmes for midwives in India prepare confident ‘registered midwives’? A survey from India. *Global Health Action*, 8(1), 29553. doi:10.3402/gha.v8.29553
- Sharp, P. T. (1982). Ghosts, witches, sickness and death: The traditional interpretation of injury and disease in a rural area of Papua New Guinea. *Papua New Guinea Medical Journal*, 25(2), 108–115.
- Sheen, K., Spiby, H., & Slade, P. (2016). The experience and impact of traumatic perinatal event experiences in midwives: A qualitative investigation. *International Journal of Nursing Studies*, 53, 61–72. doi:10.1016/j.ijnurstu.2015.10.003
- Shelley, F. M. (2013). *Nation shapes: The story behind the world’s borders*. Santa Barbara, CA: ABC-CLIO.

- Shih, P., Worth, H., Travaglia, J., & Kelly-Hanku, A. (2017). Pastoral power in HIV prevention: Converging rationalities of care in Christian and medical practices in Papua New Guinea. *Social Science & Medicine*, *193*, 51–58. doi:10.1016/j.socscimed.2017.09.049
- Shorey, S., André, B., & Lopez, V. (2017). The experiences and needs of healthcare professionals facing perinatal death: A scoping review. *International Journal of Nursing Studies*, *68*, 25–39. doi:10.1016/j.ijnurstu.2016.12.007
- Simkhada, B., Porter, M. A., & van Teijlingen, E. R. (2010). The role of mothers-in-law in antenatal care decision-making in Nepal: A qualitative study. *BMC Pregnancy and Childbirth*, *10*(1), 34. doi:10.1186/1471-2393-10-34
- Sisay, M. M., Yirgu, R., Gobeze, A. G., & Sibley, L. M. (2014). A qualitative study of attitudes and values surrounding stillbirth and neonatal mortality among grandmothers, mothers, and unmarried girls in rural Amhara and Oromiya regions, Ethiopia: Unheard souls in the backyard. *Journal of Midwifery & Women's Health*, *59*(s1), S110–S117. doi:10.1111/jmwh.12156
- Sloane, T. (2001). *One thousand one Papua New Guinean nights: Ancestor stories from Wantok newspaper. Volume 1: Tales from 1972-1985*. Oakland, CA: Masalai Press.
- Smith, L. T. (1999). *Decolonizing methodologies: Research and Indigenous peoples*. Dunedin, New Zealand: University of Otago Press.
- Smith, R., Homer, C. S. E., Homer, A., & Homer, D. (2011). Learning about grief and loss through Harper's story. *MIDIRS Midwifery Digest*, *21*(1), 19–22.
- Sobo, E. J. (1996). Cultural explanations for pregnancy loss in rural Jamaica. In R. Cecil (Ed.), *The anthropology of pregnancy loss: Comparative studies in miscarriage, stillbirth and neonatal death* (pp. 39–58). Oxford, United Kingdom: Berg.
- Squires, A. (2008). Language barriers and qualitative nursing research: Methodological considerations. *International Nursing Review*, *55*(3), 265–273.

- Strauss, A. L. (1987). *Qualitative analysis for social scientists*. Cambridge [Cambridgeshire]: Cambridge University Press.
- Strauss, A. L., & Corbin, J. M. (1990). *Basics of qualitative research: Grounded theory procedures and techniques*. Newbury Park, CA: Sage.
- Street, A. (2010). Belief as relational action: Christianity and cultural change in Papua New Guinea. *Journal of the Royal Anthropological Institute*, 16(2), 260–278.
- Street, A. (2014). *Biomedicine in an unstable place: Infrastructure and personhood in a Papua New Guinean hospital*. Durham, North Carolina: Duke University Press.
- Sychareun, V., Hansana, V., Somphet, V., Xayavong, S., Phengsavanh, A., & Popenoe, R. (2012). Reasons rural Laotians choose home deliveries over delivery at health facilities: A qualitative study. *BMC Pregnancy and Childbirth*, 12(1), 86.
- Sychareun, V., Phengsavanh, A., Hansana, V., Somphet, V., & Menorah, S. (2009). *Cultural beliefs and traditional rituals about child birth practices in Lao PDR*. Kuala Lumpur, Malaysia: The Asian-Pacific Resource & Research Centre for Women.
- Tanyi, R. A. (2002). Towards clarification of the meaning of spirituality. *Journal of Advanced Nursing*, 39(5), 500–509. doi:10.1046/j.1365-2648.2002.02315.x
- Thomas, J. (2011). Grief and bereavement. In S. Macdonald & J. Magill-Cuerden (Eds.), *Mayes' midwifery: A textbook for midwives* (14th ed., pp. 953–968). Edinburgh, United Kingdom: Baillière-Tindale/Elsevier.
- Thompson, S. R., Watson, M. C., & Tilford, S. (2018). The Ottawa Charter 30 years on: Still an important standard for health promotion. *International Journal of Health Promotion and Education*, 56(2), 73–84. doi:10.1080/14635240.2017.1415765
- Tietjen, A. M. (1984). Infant care and feeding practices and the beginnings of socialization among the Maisin of Papua New Guinea. *Ecology of Food and Nutrition*, 15(1), 39–48.

- Tobin, G. A., & Begley, C. M. (2004). Methodological rigour within a qualitative framework. *Journal of Advanced Nursing*, 48(4), 388–396. doi:10.1111/j.1365-2648.2004.03207.x
- Tokhi, M., Comrie-Thomson, L., Davis, J., Portela, A., Chersich, M., & Luchters, S. (2018). Involving men to improve maternal and newborn health: A systematic review of the effectiveness of interventions. *PLoS One*, 13(1), e0191620. doi:10.1371/journal.pone.0191620
- Tomme, R., MacLaren, D. J., Redman-MacLaren, M. L., Mafile'o, T. A., Asugeni, L., & McBride, W. J. H. (2013). Researching male circumcision for HIV prevention in Papua New Guinea: A process that incorporates science, faith and culture. *Health Research Policy and Systems*, 11, 44. doi:10.1186/1478-4505-11-44
- Tong, A., Sainsbury, P., & Craig, J. (2007). Consolidated criteria for reporting qualitative research (COREQ): A 32-item checklist for interviews and focus groups. *International Journal for Quality in Health Care*, 19(6), 349-357. doi:10.1093/intqhc/mzm042
- Tracy, S. J. (2012). *Qualitative research methods: Collecting evidence, crafting analysis, communicating impact*. Chichester, United Kingdom: Wiley.
- Trusted, J. (1997). *An introduction to the philosophy of knowledge* (2nd ed.). London, United Kingdom: Macmillan.
- Ulrich, S. (2009). Applicants to a nurse-midwifery education program disclose factors that influence their career choice. *Journal of Midwifery & Women's Health*, 54(2), 127–132. doi:10.1016/j.jmwh.2008.09.002
- United Nations Children's Fund. (2013). *Every child's birth right: Inequities and trends in birth registration*. Retrieved from http://www.unicef.org/publications/index_71514.html
- United States Department of State. (2017). *Papua New Guinea 2017 International Religious Freedom Report*. [United States]: United States Department of State Bureau of Democracy, Human Rights, and Labor. Retrieved from <https://www.state.gov/j/drl/rls/irf/religiousfreedom/index.htm#wrapper>

- Vallance, R. J. (2007). Is there a Melanesian research methodology? *Contemporary PNG Studies: DWU Research Journal*, 7, 1–15.
- Vallely, A. J., MacLaren, D., David, M., Toliman, P., Kelly-Hanku, A., Toto, B., . . . Kaldor, J. M. (2017). Dorsal longitudinal foreskin cut is associated with reduced risk of HIV, syphilis and genital herpes in men: A cross-sectional study in Papua New Guinea. *Journal of the International AIDS Society*, 20(1), 21358. doi:10.7448/IAS.20.01/21358
- Vallely, L. M., Homiehombo, P., Kelly, A. M., Vallely, A., Homer, C. S., & Whittaker, A. (2013). Exploring women's perspectives of access to care during pregnancy and childbirth: A qualitative study from rural Papua New Guinea. *Midwifery*, 29(10), 1222–1229. doi:10.1016/j.midw.2013.03.011
- Vallely, L. M., Homiehombo, P., Kelly-Hanku, A., Vallely, A., Homer, C. S. E., & Whittaker, A. (2015). Childbirth in a rural highlands community in Papua New Guinea: A descriptive study. *Midwifery*, 31(3), 380–387. doi:10.1016/j.midw.2014.11.002
- Voigt, M. (2001). The change from general nurse education to a nursing diploma in Papua New Guinea. *Contemporary Nurse*, 10(3–4), 142–146. doi:10.5172/conu.10.3-4.142
- Wahyuni, D. (2012). The research design maze: Understanding paradigms, cases, methods and methodologies. *Journal of Applied Management Accounting Research*, 10(1), 69–80.
- Walker, D., & Myrick, F. (2006). Grounded theory: An exploration of process and procedure. *Qualitative Health Research*, 16(4), 547–559. doi:10.1177/1049732305285972
- Wallbank, S., & Robertson, N. (2008). Midwife and nurse responses to miscarriage, stillbirth and neonatal death: A critical review of qualitative research. *Evidence Based Midwifery*, 6(3), 100–106.
- Wallbank, S., & Robertson, N. (2013). Predictors of staff distress in response to professionally experienced miscarriage, stillbirth and neonatal loss: A questionnaire survey. *International Journal of Nursing Studies*, 50(8), 1090–1097. doi:10.1016/j.ijnurstu.2012.11.022

- Wang, C. C. (2017). Conversation with presence: A narrative inquiry into the learning experience of Chinese students studying nursing at Australian universities. *Chinese Nursing Research*, 4(1), 43–50. doi:10.1016/j.cnre.2017.03.002
- Wang, C. C., & Geale, S. K. (2015). The power of story: Narrative inquiry as a methodology in nursing research. *International Journal of Nursing Sciences*, 2(2), 195–198. doi:10.1016/j.ijnss.2015.04.014
- Warland, J., & Glover, P. (2018). Tertiary education regarding stillbirth for student midwives: The tears 4 SMS project. *Women and Birth*. Advance online publication. doi:10.1016/j.wombi.2018.07.018
- Webb, C., & Kevern, J. (2001). Focus groups as a research method: A critique of some aspects of their use in nursing research. *Journal of Advanced Nursing*, 33(6), 798–805.
- Weitzman, A. (2017). The effects of women's education on maternal health: Evidence from Peru. *Social Science & Medicine*, 180, 1–9. doi:10.1016/j.socscimed.2017.03.004
- Wembah-Rashid, J. A. R. (1996). Explaining pregnancy loss in matrilineal southeast Tanzania. In R. Cecil (Ed.), *The anthropology of pregnancy loss: Comparative studies in miscarriage, stillbirth and neonatal death* (pp. 75–93). Oxford, United Kingdom: Berg.
- West, F., Dawson, A., & Homer, C. S. E. (2017). Building midwifery educator capacity using international partnerships: Findings from a qualitative study. *Nurse Education in Practice*, 25(Supplement C), 66–73. doi:10.1016/j.nepr.2017.05.003
- White, C., Woodfield, K., & Ritchie, J. (2003). Reporting and presenting qualitative data. In J. Ritchie & J. Lewis (Eds.), *Qualitative research practice: A guide for social science students and researchers* (pp. 287–320). London, United Kingdom: Sage.
- Whittaker, M., Piliwas, L., Agale, J., & Yaipupu, J. (2009). Beyond the numbers: Papua New Guinean perspectives on the major health conditions and programs of the country. *Papua New Guinea Medical Journal*, 52(3–4), 96–113.

- Wilding, C., & Whiteford, G. (2005). Phenomenological research: An exploration of conceptual, theoretical, and practical issues. *OTJR: Occupation, Participation and Health*, 25(3), 98–104.
- Williams, J. (2006). Why women choose midwifery: A narrative analysis of motivations and understandings in a group of first-year student midwives. *Evidence-Based Midwifery*, 4(2), 46–52.
- Wilson, S. (2001). What is Indigenous research methodology? *Canadian Journal of Native Education*, 25(2), 175–179.
- Wilson, S. (2008). *Research is ceremony: Indigenous research methods*. Black Point, Nova Scotia: Fernwood.
- Wilson, S. (2013). Using indigenist research to shape our future. In M. Gray, J. Coates, M. Yellow Bird, & T. Hetherington (Eds.), *Decolonizing social work* (pp. 229-237). London, United Kingdom: Routledge.
- Winkvist, A. (1996). Water spirits, medicine-men and witches: Avenues to successful reproduction among the Abelam, Papua New Guinea. In R. Cecil (Ed.), *The anthropology of pregnancy loss: Comparative studies in miscarriage, stillbirth and neonatal death* (pp. 59–74). Oxford, United Kingdom: Berg.
- Wood, W., & Eagly, A. H. (2015). Two traditions of research on gender identity. *Sex Roles*, 73(11–12), 461–473. doi:10.1007/s11199-015-0480-2
- World Health Organization. (1978). Declaration of Alma-Ata. International Conference on Primary Health Care, Alma-Ata, USSR, 6–12 September 1978. Retrieved from http://www.who.int/publications/almaata_declaration_en.pdf?ua=1&ua=1
- World Health Organization. (2006). *Strengthening midwifery toolkit: Guidelines for policy maker and planners to strengthen the regulation, accreditation and education of midwives, final draft*. Geneva, Switzerland: Author.

- World Health Organization. (2009). *Milestones in health promotion: Statements from global conferences*. Geneva, Switzerland: Author.
- World Health Organization. (2011a). *Strengthening midwifery toolkit: Module 1—Strengthening midwifery: A background paper*. Retrieved from http://whqlibdoc.who.int/publications/2011/9789241501965_module1_eng.pdf
- World Health Organization. (2011b). *Strengthening midwifery toolkit: Module 5—Developing a midwifery curriculum for safe motherhood: Guidelines for midwifery education programmes*. Retrieved from http://whqlibdoc.who.int/publications/2011/9789241501965_module5_eng.pdf
- World Health Organization. (2012). Papua New Guinea health service delivery profile. Retrieved from http://www.wpro.who.int/health_services/service_delivery_profile_papua_new_guinea.pdf
- World Health Organization. (2013a). *Framework of action for revitalization of Healthy Islands in the Pacific*. Retrieved from <http://iris.wpro.who.int/handle/10665.1/7832>
- World Health Organization. (2013b). *Western Pacific Region nursing/midwifery databank. Country: Papua New Guinea*. Retrieved from http://www.wpro.who.int/hrh/about/nursing_midwifery/db_png_2013.pdf?ua=1
- World Health Organization. (2014a). *Basic documents* (48th ed.). Geneva, Switzerland: Author.
- World Health Organization. (2014b). Global health expenditure database. Health system financing profile by country. Retrieved from <http://apps.who.int/nha/database/Select/Indicators/en>
- World Health Organization. (2015a). Maternal and perinatal health. Retrieved from http://www.who.int/maternal_child_adolescent/topics/maternal/maternal_perinatal/en/
- World Health Organization. (2015b). Papua New Guinea: WHO statistical profile. Retrieved from <http://www.who.int/gho/countries/png.pdf?ua=1>

- World Health Organization. (2016a). *Making every baby count: Audit and review of stillbirths and neonatal deaths*. Retrieved from <http://apps.who.int/iris/bitstream/10665/249523/1/9789241511223-eng.pdf>
- World Health Organization. (2016b). *Papua New Guinea-WHO country cooperation strategy 2016-2020*. Retrieved from <http://iris.wpro.who.int/bitstream/handle/10665.1/13444/WPRO-2016-DPM-005-eng.pdf>
- World Health Organization. (2018). Gender. Retrieved from <http://www.who.int/gender-equity-rights/understanding/gender-definition/en/>
- World Health Organization. Regional Office for the Western Pacific. (2002). *The vision of healthy islands for the 21st century: Regional implementation guidelines*. Manila, Philippines: Author.
- World Health Organization. Regional Office for the Western Pacific. (2015). *The first 20 years of the journey towards the vision of healthy islands in the Pacific*. Retrieved from <http://iris.wpro.who.int/handle/10665.1/10928>
- World Health Organization & the United Nations Children's Fund. (2018). Declaration of Astana. Retrieved from <https://www.who.int/docs/default-source/primary-health/declaration/gcphc-declaration.pdf>
- Yang, Y.-M., Hsiao, S.-H., Chou, F.-H., Hou, L., Lee, S.-L., & Lin, Y.-H. (2016). Health care providers' perceptions of maternal health concerns in the Solomon Islands. *Journal of Transcultural Nursing*, 27(1), 49–56. doi:10.1177/1043659614526256
- Yargawa, J., & Leonardi-Bee, J. (2015). Male involvement and maternal health outcomes: Systematic review and meta-analysis. *Journal of Epidemiology & Community Health*, 69(6), 604–612. doi:10.1136/jech-2014-204784
- Yin, R. K. (2014). *Case study research: Design and methods* (5th ed.). Thousand Oaks, CA: Sage.

Yoshida, Y., & Sandall, J. (2013). Occupational burnout and work factors in community and hospital midwives: A survey analysis. *Midwifery*, 29(8), 921–926. doi:10.1016/j.midw.2012.11.002

Zakar, M. Z., Zakar, R., Mustafa, M., Jalil, A., & Fischer, F. (2018). Underreporting of stillbirths in Pakistan: Perspectives of the parents, community and healthcare providers. *BMC Pregnancy and Childbirth*, 18(1), 302–310.

Appendices

Appendix A: Asia-Pacific women's experiences of stillbirth

Cheer, K. (2016). Asia-Pacific women's experiences of stillbirth: A metasynthesis of qualitative literature. *Health Care for Women International*, 37(8), 889–905.
doi:10.1080/07399332.2015.1080261



Health Care for Women International



ISSN: 0739-9332 (Print) 1096-4665 (Online) Journal homepage: <http://www.tandfonline.com/loi/uhcw20>

Asia-Pacific women's experiences of stillbirth: A metasynthesis of qualitative literature

Karen Cheer

To cite this article: Karen Cheer (2016) Asia-Pacific women's experiences of stillbirth: A metasynthesis of qualitative literature, *Health Care for Women International*, 37:8, 889-905, DOI: [10.1080/07399332.2015.1080261](https://doi.org/10.1080/07399332.2015.1080261)

To link to this article: <https://doi.org/10.1080/07399332.2015.1080261>



Accepted author version posted online: 17 Aug 2015.
Published online: 16 Oct 2015.



Submit your article to this journal [↗](#)



Article views: 214



View Crossmark data [↗](#)



Citing articles: 2 View citing articles [↗](#)

Full Terms & Conditions of access and use can be found at
<http://www.tandfonline.com/action/journalInformation?journalCode=uhcw20>

Asia-Pacific women's experiences of stillbirth: A metasynthesis of qualitative literature

Karen Cheer

College of Arts, Society and Education, James Cook University, Cairns, Queensland, Australia

ABSTRACT

Literature related to Asia-Pacific women's lived experiences of stillbirth was reviewed through metasynthesis of selected empirical studies. An overarching construct of "interconnectedness" between complex experiences influenced by cultural and systemic factors became apparent. Four experiential themes emerged: "acts of accusation," "rocky relationships," "entangled emotions," and "routines of reconciliation." These were influenced by two systemic factors: "contexts of culture" and "health care matters." Women's sociocultural experiences and their engagement with health care systems influenced how they managed and reconciled their loss. This study contributes to the literature on women's experiences of stillbirth, furthering theory creation and generating future research agendas.

ARTICLE HISTORY

Received 18 December 2014
Accepted 3 August 2015

Content has been removed
due to copyright restrictions

Content has been removed
due to copyright restrictions

Content has been removed
due to copyright restrictions

Content has been removed
due to copyright restrictions

Content has been removed
due to copyright restrictions

Content has been removed
due to copyright restrictions

Content has been removed
due to copyright restrictions

Content has been removed
due to copyright restrictions

Content has been removed
due to copyright restrictions

Content has been removed
due to copyright restrictions

Content has been removed
due to copyright restrictions

Content has been removed
due to copyright restrictions

Content has been removed
due to copyright restrictions

Content has been removed
due to copyright restrictions

Content has been removed
due to copyright restrictions

Content has been removed
due to copyright restrictions

Content has been removed
due to copyright restrictions

Appendix B: Ethics approvals

This administrative form
has been removed

This administrative form
has been removed

Appendix C: Unpublished manuscript: Use of interviews and focus group discussions in constructivist grounded theory health care studies

Cheer, K., Kelly, J., MacLaren, D., & Tsey, K. Combining the use of interviews and focus group discussions in constructivist grounded theory healthcare studies: A scoping review.

Abstract

Background: Individual interviews and focus group discussions are commonly used methods to collect data for qualitative grounded theory health care studies. However, the reasons for the order of use and the specific ways in which one method and one data set inform the other are seldom explained.

Aim: To review the literature on the use of individual interviews and focus group discussions in constructivist grounded theory studies of health care.

Discussion: A systematic search of the Cumulative Index to Nursing and Allied Health Literature database for the period 2011–2016 identified seven studies for assessment. Constructivist grounded theory studies of health care that used both individual interviews and focus group discussions were not widely reported. In the studies that did use both methods, most researchers utilised focus group discussions prior to conducting individual interviews. Most studies failed to provide a rationale for method selection and sequencing.

Conclusion: To improve research design and increase our methodological understanding of the use of individual interviews and focus group discussions in constructivist grounded theory studies in health care research, authors need to explicate the decision-making process and use of individual interviews and focus group discussions for data collection.

Implications for practice: To improve research quality, nurses and other novice health care researchers using focus group discussions and interviews should consider appropriate reporting standards to justify method selection and use.

Keywords: constructivist grounded theory; focus group discussions; individual interviews; qualitative research; research design

Introduction

Constructivist grounded theory methodology has evolved from the objectivist grounded theory approach that Glaser and Strauss (1967) introduced (Charmaz, 2014). Constructivist grounded theory is a methodological approach that aims to explain and incorporate the underlying social processes related to a phenomenon through the researcher's interactions with people, perspectives and research practices (Charmaz, 2014). Therefore, this theory is built on the theoretical position of symbolic interactionism and acknowledges multiple forms of knowledge and varying perspectives of reality in settings influenced by, but different from, the past (Charmaz, 2011, 2014). Rich descriptive data are collected to gain in-depth understanding of an event from the perspective of those who experienced it (Mills & Birks, 2014).

Individual interviews are arguably the most popular data collection method in qualitative health studies (Peters & Halcomb, 2015; Rice & Ezzy, 1999). An interview is a purposeful, semi-structured conversation between a researcher and interviewee where interaction enables knowledge construction (Brinkmann & Kvale, 2015). Researchers have used individual interviews to collect qualitative data since written records began in ancient Greece (Brinkmann & Kvale, 2015).

Focus group discussions (FGDs) are growing in popularity as a data collection method. FGDs are used to explore a specific topic or phenomenon among a group of selected participants, with the researcher asking a series of open-ended questions to guide the discussion (Liamputtong, 2011; Rice & Ezzy, 1999; Tong, Sainsbury, & Craig, 2007). Data collection from group conversations can be traced to the work of cultural anthropologist Bronislaw Malinowski in the early twentieth century, although the use of FGDs was not documented in research literature until the 1940s (Liamputtong, 2011). Associated with market research since the 1950s, FGDs are regularly used in the social, political and health sciences currently (Bloor, 2001; Rice & Ezzy, 1999).

Individual interviews and FGDs share a similar structure of inquiry in that they both seek to gain insight into the views, experiences, beliefs, understandings and knowledge of participants on a selected topic through conversation (Khan & Manderson, 1992; Rosenthal, 2016). A difference between the two methods is in the data collection procedure (Wilkinson, 1998). Both methods involve interaction between the researcher and participants; however, FGD participants also interact with other group members (Wilkinson, 1998). Another difference is that FGDs seek consensus and/or divergent views from participant interplay, 'the hallmark of focus groups is their explicit use of group interaction to produce data and insights that would be less accessible without the interaction found in a group' (Morgan, 1997, p. 2). By definition, individual interviews are unable to collect and discuss such opinions in real time.

A combination of individual interviews and FGDs are commonly used in qualitative studies, yet the reasons for the order of use and the specific ways in which one method and one data set inform the other are seldom explained. Some qualitative researchers have used FGDs to confirm interview data analysis, while others have used interviews to explore in-

depth areas of interest raised in FGDs (Morgan, 1996). In our experience in graduate student seminars and conferences, it is common for students using grounded theory methodology to claim the use of multiple data sources, frequently a combination of FGDs and interviews. However, the nuance and sophisticated interplay between these two are rarely articulated.

A scoping review is a ‘type of research synthesis that aims to map the literature on a particular topic or research area and provide an opportunity to identify key concepts; gaps in the research; and types and sources of evidence to inform practice, policymaking, and research’ (Pham et al., 2014, p. 373). This type of review is a valuable first step for researchers to gain a deeper understanding of the character and scope of the literature, especially in areas where few published studies exist (Wilson, Lavis, & Guta, 2012). In this paper, we present a scoping review to explore the question: How have authors used FGDs and interviews in constructivist grounded theory studies? The aim of the review was to add to the body of grounded theory literature by investigating the ways in which authors of constructivist grounded theory studies have used FGDs and interviews. The purpose of the review was twofold: (i) to improve our methodological understanding of the approach to identify implications of the use of interviews and FGDs for data collection in constructivist grounded theory studies; and (ii) to motivate grounded theory researchers, including novice researchers, to clearly articulate the rationale for using multiple data sources and illustrate how one method informs another.

Method

Search strategy

The search strategy utilised for this review is summarised in Figure C1. The Cumulative Index to Nursing and Allied Health Literature (CINAHL) database was searched using a combination of the terms focus group*, interview* and constructivist grounded

theory. Evaluation of the retrieved studies was undertaken by reviewing the title and abstract, followed by a detailed reading of each article.

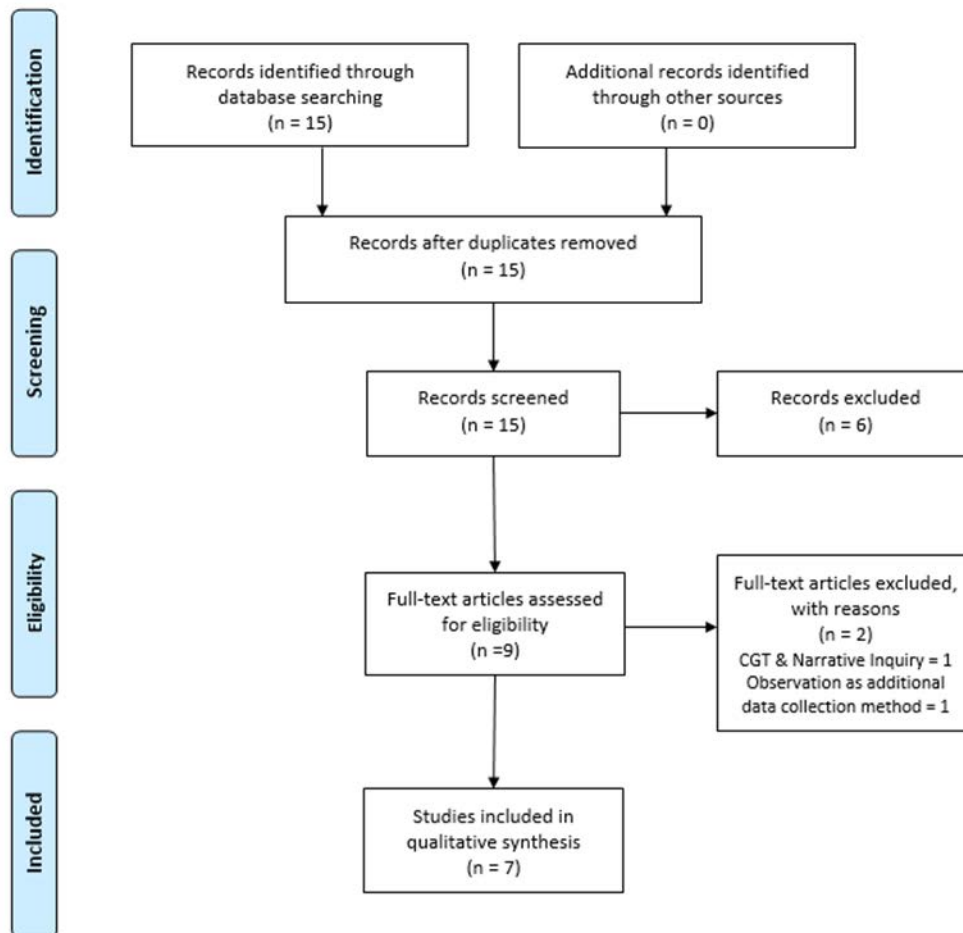


Figure C1. PRISMA flowchart representing the selection process for included studies.

Inclusion/exclusion criteria

Established criteria were applied to the retrieved studies. Papers were included where:

- a constructivist grounded theory approach was used as the theoretical framework
- FGDs and interviews were used as data collection methods
- papers were published between 2011 and 2016 in peer-reviewed journals
- papers were available in English.

Papers that used multiple qualitative approaches, qualitative data collection methods other than FGDs and interviews or additional quantitative data collection methods were excluded.

Limitations

There were no geographical limitations on the search. Publication dates were limited to obtain the most current research and ensure the number of retrieved papers could be reviewed within the limits of the available resources for the review. Given that qualitative health care research was the focus of the search, the CINAHL database was used. Access to the full text of papers relied on institutional database subscriptions. The small number of identified studies in this scoping review provides preliminary data for future research.

Data extraction

Data extraction from the selected papers was informed by the PRISMA checklist (Moher, Liberati, Tetzlaff, & Altman, 2009). Study characteristics were categorised by (1) author and publication year; (2) study focus; (3) study location; (4) study population; (5) sample size; (6) number of FGDs conducted and participants; (7) number of interviews conducted; (8) description of data collection methods; (9) reported rationale for combining FGDs and interviews; and (10) reported outcomes. Studies were compared and contrasted to examine how interviews and FGDs were utilised and to determine the studies that used FGDs to inform subsequent interviews. Table C1 provides a summary of the characteristics of the included studies.

Table C1. Characteristics of the included studies

Author/Year	Focus	Location	Population	Sample size	No. of focus groups/ participants	No. of individual interviews	Description of data collection methods	Reported rationale for combining focus groups and interviews	Reported outcomes
Horne, Seymour & Payne (2012)	End-of-life care, treatment preferences and wishes of lung cancer patients	UK	Lung cancer patients and family members	44	2/19	27 (incl. 2 second interviews)	The order of data collection methods was not reported. 'Interviews were conducted in two phases and were selected as a method of data collection because they provide a flexible and negotiated approach for exploring the perspectives of people ... as well as being useful for collecting sensitive information... A semi-structured interview guide was developed'. (p. 720)	Not reported	A theory 'maintaining integrity in the face of death' was proposed. In addition to providing physical care, nurses should develop strategies to assist patients with the social aspects of death and dying. (p. 718)
Johnston, Lundy, McCullough & Gormley (2013)	How standardised patients (SPs) award ratings in Objective Structured Clinical Examinations (OSCEs)	UK	SPs and examiners	42	7/Not reported	7	'As part of theoretical sampling, follow-up data collection involved a mixture of focus groups and individual semi-structured interviews. Four individual interviews with examiners were included in this phase as a way of confirming the researchers' understanding of the role of examiners as it pertained to this research'. (p. 901)	Not reported	In the objective assessment process, ratings awarded by SPs are socially constructed. Understanding SP ratings can benefit the development of assessment that includes both subjective and objective data, as

									well as promoting the role of SPs in medical education. (p. 908)
Kirsh, Slack & King (2012)	Experiences of stigma and its consequences for injured workers	Canada	Injured workers	28	4/28	18	Focus groups were conducted prior to individual interviews. 'Focus group discussions centered around what it means to be an injured worker, treatment experienced as an injured worker, and attitudes encountered as an injured worker... Individual interviews ... focused on living as an injured worker, the nature of engagement in work, community and social activities, how needs are addressed, as well as experiences with services, supports and community members. A semi-structured interview guide was used to ensure the same topics were discussed, while still allowing flexibility to further probe areas of interest'. (pp. 145–146)	Not reported	Intervention strategies that support workers to safely return to the workforce with respect and dignity, while negating stereotypes of the legitimacy of injured workers should be developed in a collaborative process between employers and workers. (p. 153)

MacKay, Sale, Badley, Jaglal & Davis (2016)	Knee symptoms in adults 35–65 years and implications for treatment	Canada	Adults with self-reported knee osteoarthritis (OA) or reported knee symptoms	51	6/41	10	Focus groups were used to explore the range of participants' experiences; individual interviews contributed to the detailing of the experiences... A focus group guide was used to facilitate discussions. Following the focus groups, semi-structured interviews were conducted. The interview guide was refined based on the analysis from the focus groups'. (p. 342)	Not reported	Participants perceived the potential to prevent onset and progression of knee symptoms. This has implications for health care providers in the prevention and management of knee OA. (p. 346)
Martinez-Marcos & Cuesta-Benjumea (2014)	Women caregivers' management of their chronic illness	Spain	Women caregivers with chronic illness	39	2/6 & 10	23	'Semi-structured interviews were conducted followed by two focus groups...As data collection developed the interview focused on the mechanisms that women caregivers used to manage their health condition. Once categories emerged from the interviews, two focus groups were conducted ... to examine the relevance of the study findings and refine emerging categories. During these groups rich data was obtained about how participants manage their illnesses and their experience of living with their chronic condition while caring. Categories	Not reported	Women caregivers integrate care provision with self-management of their own chronic illness. Perceived by others as capable carers, their own health needs suffer. Identifying women caregivers' health care needs will enable health professionals to provide appropriate, effective resources and

							were saturated and data collection ended after the focus groups'. (p. 1559)		services to improve quality of life. (p. 1564)
Watling, Driessen, Cees, Vanstone & Lingard (2013a)	Influence of professional culture on feedback in learning	Canada	Students and residents in medicine, music and teaching	50	12/41	9	'Focus groups were selected as the primary data collection method in anticipation that interactions among participants might be usefully revealing of culture... interviewed key informants in advance of focus groups to obtain necessary background information...conducted additional individual interviews later in the research process to elaborate early focus group findings... Focus groups and interviews were semi-structured'. (p. 587)	Not reported	Feedback for learning incorporates contextual cultural, personal and interpersonal factors. In medical education, productive feedback can be enhanced by creating contexts for credibility and constructiveness in the teacher-learner relationship. (pp. 592–593)
Watling, Driessen, Cees, Vanstone & Lingard (2013b)	Comparative analysis of learning cultures in music and medicine	Canada	Students and educators in medicine and music	37	9/33 (3–5 per group)	4	Focus groups were conducted prior to individual interviews. To further enrich the data... conducted four individual interviews based on purposive sampling of individuals .. [who] might illuminate developing	Not reported	Learning cultures in medicine and music differ in the values placed on student competency, teaching skills and abilities and assessment.

							<p>notions about professional culture... Focus groups and interviews were semi-structured, guided by probes designed to elicit discussion and elaboration of key aspects of the experience of learning within a particular disciplinary culture. (p. 844)</p>		<p>Medical educational practices may be improved by borrowing and adapting elements from the signature pedagogies of other professions. (pp. 848–849)</p>
--	--	--	--	--	--	--	---	--	---

Findings

Study characteristics

Seven articles from six studies were identified for inclusion. Four (57%) of the studies were undertaken in Canada (Kirsh, Slack, & King, 2012; MacKay, Sale, Badley, Jaglal & Davis, 2016; Watling, Driessen, Cees, Vanstone, & Lingard, 2013a, 2013b), two (29%) in the United Kingdom (Horne, Seymour, & Payne, 2012; Johnston, Lundy, McCullough, & Gormley, 2013) and one (14%) in Spain (Martinez-Marcos & De la Cuesta-Benjumea, 2015; Table C1, Column 3).

Data collection method

All studies reported the use of interviews and FGDs as data collection methods. While in two (29%) studies, study participants were asked to complete questionnaires, these were stated as being either for descriptive purposes (Kirsh et al., 2012) or for situating study findings within the broader subject context (MacKay et al., 2016).

Sample sizes ranged from 28 to 51. (Table C1, Column 5). Six (86%) of the studies reported conducting fewer than 10 FGDs: Only one (14%) study reported conducting more than 10 FGDs. The overall number of participants in the groups ranged from 16 to 41. Two (29%) studies reported participant numbers per FGD ranged between three and 10 (Martinez-Marcos & De la Cuesta-Benjumea, 2015; Watling et al., 2013b; Table C1, Column 6). Four (57%) of the studies reported conducting 4–10 individual interviews. In the remaining three (43%) studies, individual interviews were conducted with 18–27 participants (Table C1, Column 7).

Reported use of FGDs and interviews

Three (43%) of the selected studies reported using FGDs prior to interviews (Kirsh et al., 2012; MacKay et al., 2016; Watling et al., 2013b; Table C1, Column 8). One (14%) study reported using FGDs to gain insight into the learning cultures of participants, with subsequent individual interviews used to enrich FGD data and develop ideas (Watling et al., 2013a). One (14%) study reported using FGDs to explore participants' varied experiences and using individual interviews for detailed discussions of participants' experiences (MacKay et al., 2016). One (14%) study reported examining particular aspects of the phenomenon in the FGDs and differing aspects in the following individual interviews (Kirsh et al., 2012; Table C1, Column 8).

Two (29%) studies reported conducting interviews prior to FGDs (Martinez-Marcos & De la Cuesta-Benjumea, 2015; Watling et al., 2013a; Table C1, Column 8). Of these studies, one used FGDs to check the relevance of interview findings and refine categories (Martinez-Marcos & De la Cuesta-Benjumea, 2015). The second study reported using interviews in two distinct ways: first, to provide background information prior to undertaking FGDs, and subsequently, to expand upon the findings from the FGDs (Watling et al., 2013a; Table C1, Column 8).

One (14%) study indicated interviews and FGDs were undertaken concurrently, as part of theoretical sampling. Interviews with participants from one homogenous group were utilised to confirm the researchers' understanding of the roles of these participants in relation to the study (Johnston et al., 2013; Table C1, Column 8).

Only one (14%) study did not state the order in which interviews and FGDs were undertaken (Table C1, Column 8). The study reported that interviews were a 'flexible and

negotiated' method chosen to explore participant views and appropriate for collecting sensitive data (Horne et al., 2012; Table C1, Column 8).

All studies reported that interviews were semi-structured; however, only three (43%) studies reported the use of semi-structured guides for FGDs (MacKay et al., 2016; Watling et al., 2013a, 2013b; Table C1, Column 8).

5.3.5 Discussion

In the reviewed papers, the most common sequencing of data collection methods was FGDs prior to interviews. FGDs were reported as the means to explore the range of participant experiences, with subsequent interviews conducted to explore issues at depth. Interestingly, although reporting a semi-structured interview format, only one study reported using FGD data to inform the interview guide (MacKay et al., 2016). Preliminary use of FGDs can increase the efficacy of interviews by allowing the researcher to develop an interview guide grounded in participant views and understanding of the research topic (Morgan & Spanish, 1984). In constructivist grounded theory, FGDs can be used for initial sampling, 'a point of departure' directed by the research question: Subsequent interviews provide the opportunity for theoretical sampling to explicate categories and concepts (Charmaz, 2006, p. 100).

It was evident from the review that authors sequenced individual interviews and FGDs in varying order. Debate surrounds the order of method use: According to some, FGDs are best conducted after previous research; others state FGDs can be conducted at any stage of the research, or simultaneously with individual interviews (Peek & Fothergill, 2009). The aim of multimethod studies is that each method should contribute in its own distinct way to the understanding of the studied phenomenon (Morgan, 1997). The use of multiple data collection methods in grounded theory studies can substantiate research findings, thus adding

value to the grounded theory (Cheer, MacLaren, & Tsey, 2016). The selection of the most useful methods should come from, but not be driven by, the research question and to where it leads (Charmaz, 2014). The peculiarities of the research setting and the level of researcher engagement within that setting help to shape the choice and use of data collection methods over the course of the research (Charmaz, 2014; Morgan, 1997).

Most of the reviewed studies conducted less than 10 FGDs. The number of participants within the discrete groups reported in two of the studies (Martinez-Marcos & De la Cuesta-Benjumea, 2015; Watling et al., 2013) just exceeded the recommended FGD size of between four and eight participants (Kitzinger, 1995). Participant diversity and recruitment, the extent to which the groups are structured and the point at which data saturation is reached are important considerations in determining the number of FGDs to run as well as participant numbers (Morgan, 1996).

None of the reviewed studies provided an explanation as to why both interviews and FGDs were chosen over other qualitative data collection methods. Justification of the selection of data collection methods to meet research aims—not just a description of their use in the research—together with references to supporting literature, assists readers in assessing overall research quality (Kuper, Lingard, & Levinson, 2008; Tobin & Begley, 2004; Webb & Kevern 2001; White, Woodfield, & Ritchie, 2003). Explication may also be of pedagogical benefit for novice researchers, or those looking to build upon existing studies or adapt research practices (Morgan, 1996; Tracy, 2012). There are challenges and concerns surrounding the creation of appropriate standards for reporting across the range of methodological approaches used in qualitative research; nevertheless, reporting standards have been developed, including specifically for the use of FGDs and interviews (e.g., Standards for Reporting Qualitative Research; Consolidated Criteria for Reporting

Qualitative Research; Carter & Little, 2007; O'Brien, Harris, Beckman, Reed, & Cook, 2014; Tong et al., 2007). The reasons authors of the selected studies did not provide a rationale for the combination of data collection methods is unknown but lack of detail has been attributed to limitations in manuscript submission or disengagement with concepts surrounding methodology and method use (Carter & Little, 2007; Hutchison, Johnston, & Breckon, 2011).

In studies that reported using concurrent or preliminary interviews, FGDs were conducted to refine or confirm categories and triangulate findings (Horne et al., 2012; Johnston et al., 2013; Martinez-Marcos & De la Cuesta-Benjumea, 2015). However, arguments against the objective origin of triangulation as a means to establish research validity exist in the literature, since 'There is no one reality against which results can be verified or falsified, but that research is dealing with different versions of the world' (Flick, 1992, p. 194). In more recent studies, authors contend that triangulation allows qualitative researchers to build a more comprehensive picture of the studied phenomenon, revealing the participants' varied perspectives and experiences (Sands, 2006; Tobin & Begley 2004). The implication is that, rather than for confirmation purposes, triangulation allows for completeness by depiction of the contextual elements surrounding the phenomenon, thus adding to the scope and depth of understanding by the researcher (Knafl & Breitmayer, 1991).

Interviews are commonly utilised for data collection in qualitative grounded theory studies (Birks & Mills, 2015; Charmaz, 2014). FGDs are used as the primary data collection method or as an adjunct with other qualitative methods in grounded theory research (Birks & Mills, 2015). Despite Glaser's dictum that 'All is data' (Glaser 1998, p. 8), the suitability of FGD data in theory development is debated in the literature. One criticism is that FGDs produce only fragmented data that fails to provide an in-depth narrative of participants'

experiences (Morse, 2001). Another criticism is that the strategy of collecting rich data through the interaction of FGD participants is incompatible with the grounded theory aim to generate theory that is validated through the systematic process of concurrent data collection and analysis, and constant comparison of data obtained via methods including interviews, observation and documents (Jayasekara, 2012; Webb & Kevern, 2001). Yet other researchers have supported FGD use in grounded theory research, arguing that FGDs, in addition to being a suitable method for understanding participant viewpoints, allow researchers to develop sensitivity from that understanding (Basch, 1987). Sensitising concepts may guide researchers to areas for further enquiry in the process of developing ideas and constructing theory (Charmaz, 2014). There are no rules governing data collection methods in constructivist grounded theory studies and the order in which they should be conducted. In grounded theory, researchers 'take successively more analytical control over their data collection and emerging theoretical ideas' (Charmaz, 2014, p. 85). FGDs can be used successfully with interviews for data collection when the tenets of grounded theory are respected and the methodological foundation of the methods is fully discussed (Webb & Kevern, 2001). Individual interviews and FGDs provide researchers opportunities to collect raw data with the explicit aim to limit preconceived ideas or predetermined theories. Researchers can then use the inductive process to assign data to codes, categories and concepts using the constant comparative method (Denscombe, 2014). This approach enables researchers to more fully understand the phenomenon of study and build theory directly from the perspectives and experiences of study participants.

Conclusion

Few articles reporting the use of interviews and FGDs in constructivist grounded theory health care studies were retrieved in the CINAHL literature search for the 2011–2015 period. While the use of FGDs in grounded theory research is debated, the findings from this

review indicated researchers combined FGDs and interview methods to better explore the range and depth of participant experiences of the studied phenomenon. Researchers predominantly conducted FGDs prior to interviewing participants, yet few authors reported using FGDs to inform interviews. Most studies did not provide a rationale for using FGDs and interviews for data collection and their sequencing. This lack of rationale has implications for research design and quality. To improve methodological understanding of methods in constructivist grounded theory studies, authors need to state the rationale for the choice of particular data collection methods to meet the research aims. Addressing reporting standards is one means by which researchers can better explicate the decision-making process regarding use of FGDs and interviews for data collection.

Authors' contributions

KC and KT conceived the study and participated in the study design. KC took the lead role in database search, literature review and data extraction and analysis and drafted the paper. All authors edited and revised the draft paper and approved the final manuscript.

Funding

KC is the recipient of an Australian Postgraduate Award. The Far North Queensland Hospital Foundation, National Tertiary Education Union and the School of Arts, Education and Social Science, James Cook University provided financial support for this research.

References

- Basch, C. E. (1987). Focus group interview: An underutilized research technique for improving theory and practice in health education. *Health Education Quarterly*, *14*(4), 411–448.
- Birks, M., & Mills, J. (2015). *Grounded theory: A practical guide* (2nd ed.). Thousand Oaks, CA: Sage.

- Bloor, M. (2001). *Focus groups in social research*. Thousand Oaks, CA: Sage.
- Brinkmann, S., & Kvale, S. (2015). *InterViews: Learning the craft of qualitative research interviewing* (3rd ed.). Thousand Oaks, CA: Sage.
- Carter, S. M., & Little, M. (2007). Justifying knowledge, justifying method, taking action: Epistemologies, methodologies, and methods in qualitative research. *Qualitative Health Research, 17*(10), 1316–1328.
- Charmaz, K. (2006). *Constructing grounded theory: A practical guide through qualitative analysis*. London, United Kingdom: Sage.
- Charmaz, K. (2011). Grounded theory methods in social justice research. In N. K. Denzin & Y. S. Lincoln (Eds.), *The SAGE handbook of qualitative research* (4th ed., pp. 359–380). Thousand Oaks, CA: Sage.
- Charmaz, K. (2014). *Constructing grounded theory* (2nd ed.). Thousand Oaks, CA: Sage.
- Cheer, K., MacLaren, D., & Tsey, K. (2016). The use of grounded theory in studies of nurses and midwives' coping processes: A systematic literature search. *Contemporary Nurse, 51*(2–3), 200–219.
- Denscombe, M. (2014). *The good research guide: For small-scale social research projects* (5th ed.). Maidenhead, United Kingdom: McGraw-Hill Education.
- Flick, U. (1992). Triangulation revisited: Strategy of validation or alternative? *Journal for the Theory of Social Behaviour, 22*(2), 175–197.
- Glaser, B. G. (1998). *Doing grounded theory: Issues and discussions*. Mill Valley, CA: Sociology Press.
- Glaser, B. G., & Strauss, A. L. (1967). *The discovery of grounded theory: Strategies for qualitative research*. Chicago, IL: Aldine.

Horne, G., Seymour, J., & Payne, S. (2012). Maintaining integrity in the face of death: A grounded theory to explain the perspectives of people affected by lung cancer about the expression of wishes for end of life care. *International Journal of Nursing Studies*, 49(6), 718–726.

Hutchison, A. J., Johnston, L., & Breckon, J. (2011). Grounded theory-based research within exercise psychology: A critical review. *Qualitative Research in Psychology*, 8(3), 247–272.

Jayasekara, R. S. (2012). Focus groups in nursing research: Methodological perspectives. *Nursing Outlook*, 60(6), 411–416.

Johnston, J. L., Lundy, G., McCullough, M., & Gormley, G. J. (2013). The view from over there: Reframing the OSCE through the experience of standardised patient raters. *Medical Education*, 47(9), 899–909.

Khan, M., & Manderson, L. (1992). Focus groups in tropical diseases research. *Health Policy and Planning*, 7(1), 56–66.

Kirsh, B., Slack, T., & King, C. A. (2012). The nature and impact of stigma towards injured workers. *Journal of Occupational Rehabilitation*, 22(2), 143–154.

Kitzinger, J. (1995). Qualitative research. Introducing focus groups. *BMJ*, 311(7000), 299–302.

Knafl, K. A., Breitmayer, B. J. (1991). Triangulation in qualitative research: Issues of conceptual clarity and purpose. In J. M. Morse (Ed), *Qualitative nursing research: A contemporary dialogue* (pp. 226–239). Thousand Oaks, CA: Sage.

Kuper, A., Lingard, L., & Levinson, W. (2008). Critically appraising qualitative research. *BMJ*, 337(7671), 687–689.

Liamputtong, P. (2011). *Focus group methodology: Principles and practice*. London, United Kingdom: Sage.

- MacKay, C., Sale, J., Badley, E. M., Jaglal, S. B., & Davis, A. M. (2016). Qualitative study exploring the meaning of knee symptoms to adults ages 35-65 years. *Arthritis Care & Research, 68*(3), 341–347.
- Martinez-Marcos, M., & De la Cuesta-Benjumea, C. (2015). Women's self-management of chronic illnesses in the context of caregiving: A grounded theory study. *Journal of Clinical Nursing, 24*(11–12), 1557–1566.
- Mills, J., & Birks, M. (Eds.). (2014). *Qualitative methodology: A practical guide*. London, United Kingdom: Sage.
- Moher, D., Liberati, A., Tetzlaff, J., & Altman, D. G. (2009). Preferred reporting items for systematic reviews and meta-analyses: The PRISMA statement. *BMJ, 339*, b2535.
- Morgan, D. L. (1996). Focus groups. *Annual Review of Sociology, 22*, 129–152.
- Morgan, D. L. (1997). *Focus groups as qualitative research*. Thousand Oaks, CA: Sage.
- Morgan, D. L., & Spanish, M. T. (1984). Focus groups: A new tool for qualitative research. *Qualitative Sociology, 7*(3), 253–270.
- Morse, J. M. (2001). Situating grounded theory within qualitative inquiry. In R. S. Schreiber & P. N. Stern (Eds.), *Using grounded theory in nursing* (pp. 1–15). New York, NY: Springer.
- O'Brien, B. C., Harris, I. B., Beckman, T. J., Reed, D. A., & Cook, D. A. (2014). Standards for reporting qualitative research: A synthesis of recommendations. *Academic Medicine, 89*(9), 1245–1251.
- Peek, L., & Fothergill, A. (2009). Using focus groups: Lessons from studying daycare centers, 9/11, and Hurricane Katrina. *Qualitative Research, 9*(1), 31–59.
- Peters, K., & Halcomb, E. (2015). Interviews in qualitative research. *Nurse Researcher, 22*(4), 6–7.

- Pham, M. T., Rajic, A., Greig, J. D., Sargeant, J. M., Papadopoulos, A., McEwen, S. A. (2014). A scoping review of scoping reviews: Advancing the approach and enhancing the consistency. *Research Synthesis Methods*, 5(4), 371–385.
- Rice, P. L., & Ezzy, D. (1999). *Qualitative research methods: A health focus*. Melbourne, Australia: Oxford University Press.
- Rosenthal, M. (2016). Qualitative research methods: Why, when, and how to conduct interviews and focus groups in pharmacy research. *Currents in Pharmacy Teaching and Learning*, 8(4), 509–516.
- Sands, R. G. (2006). Using data triangulation of mother and daughter interviews to enhance research about families. *Qualitative Social Work*, 5(2), 237–260.
- Tobin, G. A., & Begley, C. M. (2004). Methodological rigour within a qualitative framework. *Journal of Advanced Nursing*, 48(4), 388–396.
- Tong, A., Sainsbury, P., & Craig, J. (2007). Consolidated criteria for reporting qualitative research (COREQ): A 32-item checklist for interviews and focus groups. *International Journal for Quality in Health Care*, 19(6), 349–357.
- Tracy, S. J. (2012). *Qualitative research methods: Collecting evidence, crafting analysis, communicating impact*. Chichester, United Kingdom: Wiley.
- Watling, C., Driessen, E., van der Vleuten, C. P., Vanstone, M., Lingard, L. (2013a). Beyond individualism: Professional culture and its influence on feedback. *Medical Education*, 47(6), 585–594.
- Watling, C., Driessen, E., van der Vleuten, C. P., Vanstone, M., Lingard, L. (2013b). Music lessons: Revealing medicine's learning culture through a comparison with that of music. *Medical Education*, 47(8), 842–850.
- Webb, C., & Kevern, J. (2001). Focus groups as a research method: A critique of some aspects of their use in nursing research. *Journal of Advanced Nursing*, 33(6), 798–805.

White, C., Woodfield, K., & Ritchie, J. (2003). Reporting and presenting qualitative data. In J. Ritchie & J. Lewis (Eds.), *Qualitative research practice: A guide for social science students and researchers* (pp. 287–320). London, United Kingdom: Sage.

Wilkinson, S. (1998). Focus groups in feminist research: Power, interaction, and the co-construction of meaning. *Women's Studies International Forum*, 21(1), 111–125.

Wilson, M. G., Lavis, J. N., Guta, A. (2012). Community-based organizations in the health sector: A scoping review. *Health Research Policy and Systems*, 10(36), 1–9.

Appendix D: Coding examples

Examples of early initial codes

Adhering to nursing ethics
Advocating
Appeasing men
Assigning task of pregnancy to women
Baby is precious
Being cautious in providing information
Being compassionate
Being culturally sensitive
Being relied upon
Being powerless as a woman
Belonging
Blaming
Charging for services
Childbearing for a purpose
Comforting the mother
Continuing the family name
Coping strategies
Counselling the mother
Defining customary roles
Difficulties in convincing families about causes
Encouraging the mother
Ensuring wellbeing
Experiencing stillbirth for the first time
Families responding
Feelings
Following clinical procedures
Following mother's wishes
Getting along with people
Getting men involved in maternal health care
Having authority as a man
Having confidence to inform the mother
Having the right to make decisions
Hiding emotions
Informing about the stillbirth
Keeping feelings inside
Knowing about stillbirth as a health professional
Lacking compassion
Leading by example
Learning from past experiences

Examples of early focused codes

Working as a professional

Valuing specialist midwifery skills
Upskilling
Using skills and knowledge to provide care
Learning from experience
Gaining confidence
Holistically caring with the four aspects of care

Acting as an agent of change

Being an advocate for antenatal care, supervised delivery, family planning
Promoting men's involvement in maternal health care
Educating to affect change

Belonging and believing

Cultural beliefs
Medical knowledge
Religious learning
Switching

Balancing

Rejecting cultural beliefs
Respecting cultural beliefs
Drawing on cultural beliefs
Being a male midwifery student

Performing socially

Valuing men and devaluing women
Having authority
Living with restrictions

Living as a Christian

The importance of prayer for solace and guidance
Seeking solace and guidance in the Bible
Missionary role

Traversing the tension field

Delivering bad news
Spirits (Masalai)
Blaming the midwife
God's will
Social issues
Medical causes

Dealing with feelings

Emotional responses; e.g., guilt, distress, sadness, excitement
Coping strategies; e.g., sharing, activity, prayer and God