What women emphasise as important aspects of care in childbirth: An online survey study of 8,401 women who have given birth in Norway

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November 23, 2020

Abstract

Objective To explore and describe what women who have given birth in Norway emphasise as important aspects of care during childbirth. Design The study is based on data from the Babies Born Better survey, version 2, a mixed-method online survey. Setting The maternity care system in Norway. Study population Women who gave birth in Norway between 2013 and 2018. Method Descriptive statistics were used to describe sample characteristics and to compare data from the B3 survey with national data from the MBRN, using SPSS® software (version 20). The open-ended questions were analysed with an inductive thematic analysis, using NVIVO 12® software. Main outcome measures Themes developed from two open-ended questions. Results The final sample included 8,401 women. There were no important differences between the sample population and the national population with respect to maternal age, marital status, parity, mode of birth and place of birth, except for the proportion of planned homebirths. Four themes and one overarching theme were identified; Compassionate and Respectful Care, A Family Focus, Continuity and Consistency, and Sense of Security, and the overarching theme Coherence in Childbearing. Conclusions Socio-cultural and psychological aspects of care are significant for women in childbirth, alongside physical and clinical factors. Caring for the woman implies caring for her partner and having a baby is about 'becoming a family or expanding the family'. Childbirth is a continuous experience in women's lives and continuity and consistency are important for women to maintain and promote a coherent experience.

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Short running title: Important aspects of care during childbirth

Abstract

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To explore and describe what women who have given birth in Norway emphasise as important aspects of care during childbirth.

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Setting

The maternity care system in Norway.

Study population

Women who gave birth in Norway between 2013 and 2018.

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Descriptive statistics were used to describe sample characteristics and to compare data from the B3 survey with national data from the MBRN, using SPSS® software (version 20). The open-ended questions were analysed with an inductive thematic analysis, using NVivo 12® software.

Main outcome measures

Themes developed from two open-ended questions.

Results

The final sample included 8,401 women. There were no important differences between the sample population and the national population with respect to maternal age, marital status, parity, mode of birth and place of birth, except for the proportion of planned homebirths. Four themes and one overarching theme were identified; Compassionate and Respectful Care, A Family Focus, Continuity and Consistency, and Sense of Security, and the overarching theme Coherence in Childbearing.

Conclusions

Socio-cultural and psychological aspects of care are significant for women in childbirth, alongside physical and clinical factors. Caring for the woman implies caring for her partner and having a baby is about 'becoming a family or expanding the family'. Childbirth is a continuous experience in women's lives and continuity and consistency are important for women to maintain and promote a coherent experience.

Key words

Midwifery care; Childbirth experience; Intrapartum care; Salutogenesis; Coherence in Childbearing; Thematic analysis

Tweetable abstract

A national survey of more than 8,000 women in Norway showed that childbirth is a life event, not just a clinical procedure, and that continuity and consistency of care are important to maintain and promote a coherent experience.

Introduction

Childbirth is an important existential experience in a woman's life. Childbearing women value a positive birth experience, and WHO recognises a 'positive childbirth experience' as a significant end point for all women who have given birth.[1-3]

Paying attention to service users' views and experiences is a crucial part of improving and developing maternity care.[1,4,5]It is important to develop and provide maternity services that women want and need.[2] The literature on women's negative and traumatic birth experiences is extensive.[6-10] However, there is much less evidence about the nature of positive childbirth experiences and the impact on good health for women and families.

Salutogenic theory focuses on what promotes good health. The theory was first introduced by Antonovsky[11] who suggested that health is movement on a continuum of ease and dis-ease, unlike the dichotomy of healthy or sick. There is good evidence that salutogenesis is a useful theory for maternity care research.[12-14]

To the best of our knowledge, this is the first study with such a large sample of childbearing women, asking for women's views on what worked well in their maternity care experience. The main objective of this study is to explore and describe what women who have given birth in Norway emphasise as important aspects of care during childbirth, with a focus on salutogenic theory.

Methods

Design

This study is based on data from the Babies Born Better survey, version 2, a mixed-method online survey.

Setting

The context of the current paper is the Norwegian maternity care system, which is part of the public health care system. It is tax funded and provided free of charge at the point of use. Midwives and doctors have a fixed salary, and thus have no economic interest in how a labour proceeds. Virtually all women in Norway receive maternity care from the public health care system. Intrapartum care is organised at three levels; 1) specialised obstetric units, 2) smaller obstetric units and 3) alongside and freestanding midwifery units. Midwives attend all births. Apart from a few independent midwives offering antenatal care, homebirths and post-partum care, there are no private birth institutions. There were 45 birth units in Norway in the study period, and approximately 58,000 births per year. The population is widely scattered and is characterised by both centralisation and decentralisation. More than 45% give birth in the five largest hospitals, however there are 19 units with less than 500 births per year, the caesarean section rate in 2019 was 16%, epidural anaesthesia 36%, and vacuum or forceps 10%.[15]

Study population

Women who gave birth in Norway during the period 2013 to 2018 were eligible to participate.

Data collection

The survey was open from March to August 2018. It was launched through social media, mainly through Facebook where the link was widely disseminated to relevant Facebook groups. We also contacted specifically targeted websites and asked them to post the survey on their web forums.

The questionnaire

The survey was an open online survey (SurveyMonkey®), comprising 22 questions (Appendix S1) with sub-questions divided into four sections, including both closed and open-ended response options. The first three sections comprised questions related to demographics and maternal characteristics; age, marital status, migration, self-rated socio-economic status, education, employment status, parity, gestational age, mode of birth and place of birth. The fourth section included two open-ended questions; the first designed to elicit women's views of what worked well during their childbirth experience, and what they think would have improved their experience of care, the second asked for an honest description of the place where they had their baby, and reasons why they would, or would not, recommend it as a birthplace to a close friend or family member.

The Medical Birth Registry of Norway (MBRN)

To assess the representativeness of the study sample, a Norwegian population-based sample with information about maternal age, marital status, parity, place of birth and mode of birth, from the Norwegian birth cohort of all women who gave birth in 2017 was retrieved from MBRN.[15]

Analysis

Descriptive statistics were used to describe sample characteristics and to compare data from the B3survey with the national population-based data sample from the MBRN, using SPSS® software (version 26).

We performed thematic analysis[16] to analyse the two open-ended questions (Q17, Q18). An inductive approach was chosen. Thematic analysis is a method for identifying, analysing and reporting patterns or themes within a data set. The analytical process was data driven, dynamic and continuously discussed in the research group. The stepwise process is illustrated in Figure 1. See Appendix S2 for a more in-depth description of the analytical process. Quality assessment was done using the CHERRIES checklist[17] (Appendix S3).

Ethics

Ethical approval was granted by the Ethics Committee of the University of Central Lancashire, UK (Ethics Committee BuSH 222). The study was approved by the Norwegian Data Inspectorate (ref: 60547/3/HJTIRH), no further ethical clearance was necessary (ref: 2017/1582).

Results

Altogether, 11,135 women who had given birth in Norway responded to the survey. The final sample included 8,401 women (Figure 2).

Demographics of the respondents

Table 1 shows the main characteristics of the included respondents. Whenever national data were available in the MBRN, our sample was compared to the population-based sample in 2017 as a census group. Of the included women, 92.3% were born in Norway. The mean age was 29.9 years (SD 5.0), 45% were nulliparous and 55% multiparous. All 45 birth units in Norway were represented in the sample, the response rates by unit were similar to the rate of births in those units for the population (Figure 3). There were no important differences between our sample and the population-based sample regarding age, marital status, parity, mode of birth, place of birth, except for the number of planned homebirths (1.6% in the study, 0.2% in the population). Missing data varied from 0.04-0.7% across the variables, except for education level which was 2.6%.

Findings from the open-ended questions

The analysis of the open-ended questions resulted in four themes; Compassionate and Respectful Care; Sense of Continuity and Consistency; A Family Focus; Sense of Security, and one overarching theme; Coherence in Childbearing. See Appendix S4 for more quotes.

Compassionate and Respectful Care

To be compassionate implied that the staff were genuinely engaged and concerned about the woman's well-being, through empathy, kindness, attentiveness, love, support, understanding and compassion during labour and birth. If the staff were insensitive or lacked empathy, childbirth was experienced as very difficult and something they would have wanted to change. It was clear that childbirth was perceived as a vulnerable situation that required a sensitive approach. The data implied that simple politeness from the staff was insufficient: the birthing woman needed to feel the care as genuinely intended to be perceived as caring.

'When we changed midwife, we got one that touched my arm looked me in the eyes and said; this is going well. [she said] Do this and that. [she was] Very clear'

Compassionate and respectful care was also connected to the midwife's watchful attendance, perceived as the actual time present and an emotional availability that led to a feeling that the midwife was there for her and saw her. The midwife's emotional presence was perceived as awareness and sensitivity to the woman's signals and needs.

'The first midwife I had was so present and accommodating. Almost didn't have to say anything because she understood what I needed'

To be respected, empowered, seen and listened to as a unique individual led to a sense of partnership when things were to be decided. Having real influence and co-determination in terms of herself and the child was important. If the midwives or doctors were sensitive and acknowledged her wishes, it could lead to a sense of being special and unique and experiencing individual care. If this central aspect was missing, the respondents reported a sense of vulnerability, which was problematic and difficult;

'Midwives don't have enough time, they don't see you as a separate individual, midwives don't have empathy. A feeling that the hospital had a "yes but we see this so often" attitude'

Sense of Continuity and Consistency

Continuity refers to the woman's perception of pregnancy, labour and birth and post-partum as a coherent whole that are not distinguished as different phases. Being allowed to enter the hospital when she felt the need to, in the early stages of labour, was essential;

'The person I spoke to on the phone before I came in seemed brusque and incomprehensible. Asked me to wait to come in because she thought I was not in enough pain. I had to "argue" to get an examination. When I came in, I had 7-8 cm dilatation and frequent contractions'

Another facet of continuity was the midwives' availability throughout the process; the importance of not being left to yourself; and that the midwife had time for the parents and the baby after birth.

Initiation of breastfeeding was also crucial for the sense of continuity, including good breastfeeding support and care throughout the postnatal period.

'Better help with breastfeeding. I felt that the staff was short of time and had completely different opinions about this. This led to a chaotic and stressful situation'

Continuation and consistency of information was also a part of this concept. It seemed crucial that the staff had read the woman's birth plan and medical notes, and that previous pregnancies or births were taken into consideration. This does not merely mean that the woman saw the same person, but that all the staff cooperated on sharing and addressing prior information about her, in a way that optimised her sense of seamless care. The sense of continuity was also connected to receiving the information and explanations needed throughout the birth process and to be offered a post-partum conversation.

A Family Focus

A family focus in care involved not only the partner's inclusion in the birth process, but also that giving birth to a child is primarily about 'becoming a family' or 'expanding the family'.

'The father and I as a unit that did this together'

It was therefore crucial for the women that their partners were involved and felt included and that his/her experiences, feelings and needs were acknowledged.

'That staff listen to both the mother and father of the child. That staff include the father more. The expensive accommodation for partners meant we could not afford to be there together, very difficult and tiring as a new mother all alone without sleep'

The partner's presence and care were crucial to the women, but the midwife's care for the partner was also of great importance. A lack of care for the partner raised difficult emotions for the woman. This was so important that some women noted that it was very positive that their partner was well cared for by staff. Involving and including the partner seemed to be a twofold matter. Firstly, care for their physical condition, including the opportunity for rest, to fetch food and be present throughout the stay. Secondly, the emotional aspects which were about the partner feeling included, that they were treated as a family, and that they could spend time together with the new-born baby.

'Better care of the father both emotionally and physically, he should automatically be able to sleep the first night at the hospital, especially if the baby is born late at night'

Sense of Security

Feeling secure was emphasised as a fundamental part of care by many respondents. While the women linguistically used the same terms, they referred to different meanings regarding what made them feel safe. Feeling secure seemed to encompass both medical, emotional and relational safety. For some women, the aspect of emotional and relational safety seemed most important;

'Then you'll have a sense of peace in a safe and familiar environment, without unnecessary stress and interventions, with a midwife who knows you and your wishes'

For others, the notion of medical safety was most important;

'There's good expertise among employees, and all the facilities you may need in the event of any complications'

The sense of security was also linked to confidence in the staff's competence and a perception that the staff was fundamentally trustworthy and acting in the women's and their babies' best interest. This both referred to medical competence as a competent hospital team of expert midwives and doctors, and trust in their experience and knowledge. It seemed that trusting the staff's competence could lead to a sense of being able to lean on them and "let go" and not worry about whether they knew what they were doing. Doubting whether the staff could offer this sense of security was associated with uncertainty about how safe their birth was, and in their capacity to negotiate it without harm.

'Didn't feel the midwife knew what to do when my pain was at its worst, again, want a more secure and experienced midwife'

Overarching theme: Coherence in childbearing

Coherence in childbearing encompasses all four themes. It refers to the woman's experience of childbearing as a whole and that it is not perceived as a separate event disconnected from both the antenatal and postnatal period or women's lives in general. It implies an understanding of the woman as a unique person with her own history, cultural background, resources, perceptions and personality. Everything she experiences will be

related to this and thus, also, to how she experiences care. The following quotes illustrate what 'good' or 'poor' care felt like;

Good Care

W1: *You will be followed up as if you're the only one, not just one of many on an 'assembly line'. You will get peace and quiet because this is a small hospital, and Dad is recognised as an important part of the birth and maternity experience. You are seen, heard and cared for with warmth and care. A wonderful place to bring new life into the world.*

Poor Care

W2: *They don't have respect for the female body and its ability to give birth. There was no humanity, only medicine. The environment among the staff was poor, they didn't appear to read the medical record, and everyone had to come up with their own solutions. They don't listen to one's objections and it was so poorly staffed that the father basically had to help with everything, yet there was no room for him. I didn't feel safe and didn't get the help I needed.*

Discussion

Main findings

The analysis resulted in a rich and nuanced body of information about what women who have given birth in Norway emphasise as important aspects of care during childbirth. The findings demonstrate that socio-cultural and psychological aspects of care are significant for women in childbirth, alongside physical and clinical factors. Some of the findings reflect earlier research, including the desire for compassionate and respectful care, continuity of care and safety. Women who gave birth in Norway emphasise that respectful maternity care encompasses more than absence of disrespectful care or mistreatment during childbirth,[18-21] they also value empathetic and sensitive clinical staff. [2,22] In our study, continuity of care was highlighted as good care and called for when it was missing. This reflects the desire for and satisfaction with continuity of care, which is a common research finding.[22,23] In our study, the concept of continuity encompasses consistency of information between clinical staff and wards, and continuity of the experience of pregnancy, labour and birth, and even continuity between pregnancies.

The Family Focus theme illustrates new and unique nuances in women's views on the importance of family-oriented care; it is perceived as pivotal that the partner is involved, included and cared for both emotionally and through the provision of good facilities, which is also found in studies on fathers' experiences and expectations of childbirth.[24-29] Furthermore, our results suggest that the value of looking after birth companions is a way of looking after the woman herself. If she does not have to worry about the wellbeing of her partner, she can commit to the labour process.

The theme 'sense of security' goes beyond 'being safe'. The findings demonstrate that the notion of safety and security varies, and that the perception of the concept is individual and complex, which is also found in other studies.[28] This is reflected in the contrasting rationale for feeling safe; some felt safe giving birth in a high-tech hospital ward with monitoring and emergency preparedness, while others felt safe giving birth at home with a midwife they knew well in familiar surroundings.

Strengths and limitations

To our knowledge, this is the largest study of women's childbirth experiences ever conducted in Norway. In 2018, 93% of Norwegian women between 18 and 44 had a profile on Facebook, 98% of these used Facebook weekly.[30] Social media was thus a feasible platform for recruiting participants. The study sample characteristics were very similar to those of the eligible population.

We had limited opportunity to match more demographic characteristics of the study population to the national data such as education, migration and socio-economic inequity. Survey studies have some methodological

limitations such as response and recall bias. Further studies could target specific and more marginalised groups.

Interpretation

Our interpretation of the findings identify new nuances in the care of women during childbirth; the need for an increased family focus in care, sensitivity to the women's individuality regarding the notion of safety and security, to understand childbirth as a continuous experience in the context of women's lives and to maintain and promote a coherent experience.

The women expressed an explicit wish for family-oriented care. This raises the suggestion that women might not be able to enter the 'flow state', neuropsychologically, if they are concerned about the wellbeing of others in attendance who they care about.[31] It also underlines that women view the process of giving birth as a transition towards 'becoming a family' or 'expanding the family'. Shifting roles from woman to mother and man to father or from couple to parents. In light of the theory of 'rite de passage' and liminality, transition refers to a change of status, and ambiguity and vulnerability in connection with this change.[32]

The women's notion of safety and security revealed a complexity that can depend on multiple internal and external factors.[28]One interpretation is to assume that if the woman's ideas and beliefs are shared, or at least respected, by the staff and the organisation where the birth takes place, the associated notion of safety and security can reinforce the woman's sense of security. The sense of freedom that women reported when they felt totally secure was, as for family support, a sense of relief that they could trust the staff to deal with extraneous matters and threats. This meant that they were free to disconnect external vigilance, enabling them to internalise their focus on giving birth.[31]

The women's experience of continuity comprised a sense that each stage of the process, at each level of their experience, was interconnected and this was reinforced if there was no sense of discontinuity even when different staff were involved. The findings coincide with those of others who have suggested that women's experiences during labour and birth does not correspond to physically defined stages, but go beyond this to a life-course concept of continuity, which needs to be recognised by staff when they encounter women in labour.[33-36]

The overarching theme brings these findings of seamlessness together, by incorporating the notion 'Coherence'.[11] In this sense, a coherent labour and birth experience encompasses all the themes, assuming that childbirth can be experienced as meaningful, manageable and comprehensible. A strong sense of coherence (SOC) is associated with positive emotions both regarding birth and the baby, while a weak SOC is expressed through negative emotions and worries relating to labour and birth.[37] It is claimed that women need to organise their childbearing experience into a coherent narrative.[38] However, it may be challenging for women to create and maintain a coherent narrative, as the transition to motherhood is both private and public, social and biological and influenced by their own or others' expectations.[38] Our findings suggest that maternity care that reflects all four themes could help women to create coherent experiential narratives optimising their wellbeing, and that of their baby, partner and family, into the future. Beyond this, it is plausible that women who feel a sense of coherence in childbirth are more able to activate parts of the neocortex required for the neurohormonal processes that facilitate optimal birth physiology and post-birth adjustment.[31]

Conclusion

Socio-cultural and psychological aspects of care are significant for women in childbirth, alongside physical and clinical factors. Compassionate and respectful care encompasses empathetic and sensitive staff, and a sense of the care being genuinely intended. Caring for the woman implies caring for her partner and having a baby is about 'becoming a family or expanding the family'. How maternity services meet both parents' needs are therefore crucial. Women's notion of safety and security is individual and complex. Childbirth is a continuous experience in the context of women's lives and continuity and consistency are important for women to maintain and promote a coherent experience, which refers to the woman's experience of childbearing as a

whole.

Disclosure of interest

The authors report no conflict of interest.

Contribution of authorship

The conception and design of the work: CV, ABVN, EB, SD, TSE. Acquisition of data: CV, ABVN, EB, SD, TSE. Analysis and interpretation of data: CV, ABVN, EB, SD, TSE. Drafting the work and revising it critically for important intellectual content: CV, ABVN, EB, SD, TSE.

Details of ethics approval

Ethical approval was granted by the Ethics Committee of the University of Central Lancashire, UK (Ethics Committee BuSH 222). The study was approved by the Norwegian Data Inspectorate (ref: 60547/3/HJTIRH), no further ethical clearance was necessary (ref: 2017/1582).

Funding

CV was funded by a PhD scholarship from Oslo Metropolitan University.

Acknowledgement

This study was derived from the Babies Born Better project, developed as a part of two EU COST Actions supported by the Cost (European Cooperation in Science and Technology Programme as a part of European Horizon 2020): 1) COST-Action IS0907 "Childbirth Cultures, Concerns, and Consequences: Creating a dynamic European Union framework for optimal maternity care"; and 2) COST-Action IS1405: Building Intrapartum Research Through Health—an interdisciplinary whole system approach to understanding and contextualizing physiological labour and birth (BIRTH).

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Table/Figure Caption List

Figure 1. The stepwise analytical process as described by Braun and Clarke[16]

Figure 2. Flowchart illustrating inclusion in the study

Figure 3. Proportion and distribution of place of birth in study sample (n=8,401) and MBRN 2017 (n=56,553)

Table 1. Sociodemographic and obstetric characteristics of included respondents (n=8,401), compared to a national Norwegian sample (n=56,553) from year 2017

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Sociodemographic	**Study sample**	**Study sample**	**MBRN 2017***	**MBRN 2017***
	n=8,401	(%)	n= 56,553	(%)
Maternal age				

Sociodemographic	**Study sample**	**Study sample**	**MBRN 2017***	**MBRN 2017***
Mean (SD)	29.9	5.0	30.9	4.9
<19	60	0.7	500	0.8
20-24	940	11.3	5,872	10.4
25-29	2,904	34.8	18,672	33.0
30-34	2,944	35.3	19,943	35.3
35-39	1,257	15.1	9,429	16.7
>40	233	2.8	2,137	3.8
Education				
No higher education	1,805	22.1		
Higher education [?] 4 years	3,653	44.6		
Higher education > 4 years	2,727	33.3		
Employment				
Employed	6,701	79.9		
Student	674	8.0		
Unemployed	410	4.9		
Other	601	7.2		
Socio-economic status**				
1 (Much worse)	276	3.3		
2	351	4.2		
3 (Average)	5,787	69.0		
4	1,313	15.6		
5 (Much better)	667	7.9		
Marital Status				
Married or in a relationship, cohabiting	7,863	93.7	52,984	93.7
Other	533	6.3	3,568	6.3
Obstetric characteristics	**Study sample** n=8,401	**Study sample** (%)	**MBRN 2017*** n=56,553	**MBRN 2017*** (%)
Place of birth				
Obstetric unit***	7,673	91.3	52,693	93.2
Alongside midwifery unit****	485	5.8	3,000	5.3
Freestanding midwifery unit	69	0.8	387	0.7
Planned homebirth	132	1.6	126	0.2
Born before arrival	38	0.5	347	0.6
Parity				
Nulliparous	3,772	45.0	23,841	42.2
Multiparous	4,606	55.0	32,712	57.8
Mode of birth***				
Spontaneous vaginal delivery	6,240	74.4	42,075	73.7
Instrumental vaginal delivery*****	907	10.8	5,968	10.3
Caesarean section (emergency)	828	9.9	5,870	10.4
Caesarean section (planned)	407	4.9	3,159	5.6

*The Norwegian birth cohort Medical Birth Registry of Norway (MBRN) data from year 2017

** My living standard compared to the people in the country I am currently living in. Likert scale 1-5

*** Includes specialised obstetric units and smaller obstetric units

****Not registered in MBRN, all alongside units were contacted to obtain number of births.

***** In MBRN, this refers to number of babies born and not births

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Figure 1.pdf available at https://authorea.com/users/378017/articles/494613-what-women-emphasise-as-important-aspects-of-care-in-childbirth-an-online-survey-study-of-8-401-women-who-have-given-birth-in-norway