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Women's expectations and experiences of maternity care in NSW – What women highlight as most important

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ABSTRACT

Background: Although surveys have identified that women are generally highly satisfied with maternity care provision, those aspects of care that women highlight as most important for achieving satisfaction and a satisfactory maternity care experience have not been reported. The aim of this study was to investigate how women understand and experience their maternity care and to report which aspects of care women highlight as most important.

Methods: This large qualitative study explored women's expectations and experiences of maternity care provision. In-depth semi-structured interviews were conducted with 53 women experiencing maternity care in a range of tertiary, regional, rural, remote hospitals and midwife-led practices in the state of New South Wales, Australia during 2011–2012. Included in the interview schedule was the question 'What 3 aspects would you see as most important for delivery of maternity care?' Descriptive analyses of entire transcripts and responses to the question on most important aspects of care were undertaken.

Results: Descriptive analyses of women's responses identified 5 important aspects of care: woman-focused care, staff qualities, systems and facilities, family-focused care and continuity of care/information. First-time mothers were more likely to identify woman-focused care, staff qualities and continuity of care/information as important aspects than multiparous mothers. Urban and regional mothers highlighted staff qualities as having greater importance for satisfaction with their care while rural and particularly remote women nominated systems and facilities as important.

Conclusions: Our study showed that women from a range of settings are more concerned with staff and relational issues than facilities. Differences in perceptions among primiparous versus multiparous women, at different stages of pregnancy and among women from rural and remote compared to urban settings highlight the need to include women with a diversity of experience when trying to understand the aspects of maternity care most important to women.

1. Background

Women's expectations and experiences of maternity services are increasingly important to healthcare professionals, administrators and health policy makers, and can inform decisions about the organisation and provision of services.[1] In New South Wales, as in the case across Australia, 60% of women give birth as patients in public hospitals, and 99% of women give birth in hospitals or co-located birth centres.[2] There has been extensive investigation of women's satisfaction, expectations and experiences internationally.[3–8] Generally women report high levels of satisfaction in relation to care received during pregnancy and birth.[3,8] However, *levels* of women's satisfaction with maternity care in NSW have not been systematically explored.

Although studies have used a variety of methods to measure satisfaction, elements associated with satisfaction are remarkably consistent. A systematic review of factors influencing women's evaluations of their childbirth experiences including descriptive studies and randomised control trials identified four factors: personal expectations, the amount of support from caregivers, the quality of the caregiver–patient relationship and involvement in decision-making as important when women evaluate their

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childbirth experiences.[1] Conversely, factors most strongly associated with dissatisfaction included a lack of sensitivity of caregivers, how rushed caregivers appeared, the helpfulness of advice and support, and whether help and advice were offered at all.[9] Satisfaction studies do not reveal how important an issue is in relation to other aspects of care and therefore provide limited guidance to policymakers and managers about how resources should be allocated.[10] Few studies have explored the impact of geographical location and ease of access on satisfaction. Finally, satisfaction studies have varied greatly in the time-points at which satisfaction has been measured,[11] are often based on a pre-prescribed list of issues[12] with the inability to capture opinion or nuance.[13]

There are evident differences in women's experiences of maternity care for multiparas and primiparas.[14] One study found first-time mothers experienced birth as novices, however, their reactions were influenced by levels of support.[15] Other studies have identified that multiparous women have different expectations because they have previous experience of giving birth.[16] Parity is also likely to affect how women express their experiences; primiparous women may be less likely to express opinions about services if they do not know or have not experienced the alternatives.[10] Research to date has identified satisfaction at single stages of pregnancy – antepartum,[17,18] birth[15,16] and postpartum.[9,19] Furthermore, previous research has tended to ascertain women's views within rather than across a variety of geographical settings including urban,[20] regional,[21] rural[22] and remote.[23] To address this gap we conducted semi-structured interviews among women at different stages of pregnancy and from urban regional, rural and remote settings to identify the aspects of maternity care most important to them.

The overall aim of this study was to investigate how women understand and experience their maternity care and in particular, issues they highlighted as most important for maternity care.

2. Methods

2.1. Interviews with women

Semi-structured interviews were conducted to explore women's expectations and experiences of maternity care across a range of care models and settings in the state of New South Wales, Australia. Facilities were selected to include a range of urban and rural, tertiary and non-tertiary, small and large hospitals and associated clinics. Participants were recruited over a 12 month period February 2011–February 2012. Participants were eligible if they were receiving public maternity care in New South Wales, at least 18 years of age, and able to understand and read English. Women deemed too unwell to participate or in advanced stages of labour were not approached. Purposive variation sampling was used to select women with a range of pregnancy and birth experiences (antepartum and postpartum, uncomplicated and complicated pregnancies, transferred to another hospital and not) who would provide a broad range of perspectives regarding maternity care received.[24] Variation was sought in care models, maternal age, parity, obstetric risk status, socioeconomic status, and urban versus rural residence. Fifty-three women were invited (either in person or by phone) to participate in the study (obstetricians and midwives facilitated our approach to women for interview). No participants declined involvement.

Women took part in a one-on-one interview in the antenatal period during the second or third trimester of pregnancy or in the postpartum period. Interviews were conducted in one large tertiary hospital, a regional hospital and two large rural hospitals, one with 6 outreach clinics in remote communities. These hospitals provided care in a range of settings attended by GPs, obstetricians and midwives. For private patients, care was provided by the women's chosen obstetrician in private rooms and delivery at a public hospital. For a small number of women, care was provided by midwifery models of care in either caseload or team midwifery, with support from the hospital obstetric staff when required. Sites were chosen to represent diversity in size of geographic boundaries, varying distances to birthing hospitals, and diversity of cultural sub populations within communities based on co-authors' (JM, CR) knowledge of statewide obstetric services. The Head of Obstetrics Services and the Maternity Unit Managers at each health facility facilitated access to the hospital and identified a group of patients suitable to approach for recruitment. Interviews were conducted until saturation of data[25] was achieved at each site.

A midwife (MJ) conducted all interviews, which took 30–45 min to complete. All were conducted in rooms in the hospitals, health centres and women's homes and tape-recorded. The interviews were guided by the following key probes:

(1) Can you tell me how you came to be here today?
(2) Can you tell me about your relationship with health professionals over the course of your pregnancy?
(3) Can you tell me about your experience of attending health facilities?
(4) How have your expectations been met or changed as a result of the care you have received?
(5) What 3 aspects would you see as most important for delivery of maternity care?

Audio-recorded interviews were transcribed verbatim in Microsoft Word. Transcripts were then checked against interview playback for errors or omissions and imported into QSR-NVivo v9.2 for analysis.[26] Interviews were de-identified with names of women and care providers removed.

Ethical approval for the study was from the Northern Sydney Central Coast Area Health Service Human Research Ethics Committee (Approval No. 1102-075M), and written consent was obtained from all women prior to interviewing and audio-recording.

2.2. Data analysis

Data were analysed, consistent with Green's understanding of a descriptive study based on dominant categories.[27] Initially, codes were developed based on entire interviews; codes consisted of single words, phrases, or whole paragraphs that contained information relating to each particular point being made.[28] First 12 entire transcripts were individually coded by three members of the research team to independently develop descriptive codes. Open coding was employed to develop a category list.[25] Two researchers independently developed category lists and, following a process of comparison and review of codes, a consensus on categories was reached that formed the final coding framework.

Summaries of the interviews (written immediately after the interview) and field notes were read and reread to obtain a sense of the content. In conjunction with the interviews MJ kept a diary of daily reflections which was reviewed after each day's interviews to form an iterative process of interview/analysis to identify consistent categories. The process of carefully listening, questioning and verifying the data was cyclic and an important part of both data collection and analysis.[29] All transcripts were coded to the list of categories by two of the authors (MJ, JF) to promote reliability.[30]

This paper presents analysis of the question "What 3 aspects would you see as most important for delivery of maternity care?" (question 5, see above). Women were given the opportunity to nominate up to three aspects of care. The responses were then