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ORIGINAL RESEARCH – QUANTITATIVE

Women's birth expectations, are they fulfilled? Findings from a longitudinal Swedish cohort study

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ABSTRACT

Background: The importance of women's expectations on the experience of birth has shown contradictory results regarding fulfilment. The aim of this study was to describe pregnant women's expectations of birth and to investigate if these expectations were fulfilled. An additional aim was to determine if unfulfilled expectations were related to the mode of birth, use of epidural and the birth experience.

Methods: This research investigated a prospective regional cohort study of 1042 Swedish-speaking women who completed a questionnaire about birth expectations in late pregnancy and were followed up with two months after birth. Five areas were under study: support from partner, support from midwife, control, participation in decision making and the midwife's presence during labour and birth. An index combining expectations and experiences was created.

Results: Certain background characteristics were associated with expectations as well as experiences. Statistically significant differences were shown between expectations and experiences in *support from midwife* (mean 3.41 vs 3.32), *support from partner* (mean 3.70 vs 3.77), and *midwife's presence* (mean 3.00 vs 3.39). Experiences 'worse than expected' regarding decision making and control were associated with modes of birth other than vaginal and four out of five areas were associated with a less positive birth experience.

Conclusion: Some women had high birth expectations of which some were fulfilled. An expectation on support from the midwife was less likely to be achieved, while support from partner and the midwives' presence were fulfilled. If the woman's expectations were not fulfilled, e.g. became 'worse than expected' this was associated with a less positive overall birth experience as well as with instrumental or surgical mode of birth.

1. Women's expectations and experiences of birth – a longitudinal cohort study

The importance of women's expectations on the experience of birth has been studied and questioned. Some researchers argue that fulfilled requests increase a more positive overall childbirth experience. This could indicate that positive expectations could contribute to a more satisfying experience.[1] Other researchers have shown the opposite.[2,3] A comparative study of the experience of childbirth between women who preferred and had a caesarean section and women who preferred and had a vaginal birth showed a more satisfying birth experience in the latter group. In addition, women who planned and had a homebirth had a better birth experience compared to women who requested and had a caesarean section, although both groups had their expectations fulfilled.[4] Christiaens and Bracke[5] surveyed 605 women from Belgium and the Netherlands to investigate the influence of childbirth expectations on women's satisfaction with birth. The most important factor contributing to a woman's satisfaction with birth was having her expectations met. Childbirth expectations have changed over time with more women accepting medical interventions in 2000 than in 1987.[6]

Some authors have argued that the birth experience depends mainly on the woman's characteristics. Such characteristics could be perceptions and attitudes towards childbirth. Christiaens and Bracke[5] showed that women with high expectations for a positive birth were more likely to achieve a more satisfying birth

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experience. Research have also shown that women's prenatal attitudes and approaches to childbirth, could predict birth outcome and birth experience.[7,8]

There is strong evidence that expectations are linked to how a person subsequently evaluates the experience.[5,9] A normal vaginal birth[10] has implications for a subsequent pregnancy; women are more likely to go into their next labour with positive expectations for a spontaneous vaginal birth.[9,11]

Not only are the woman's characteristics, attitudes and expectations important when evaluating the birth, but also other aspects are also frequently mentioned in research as being significant. Support and the midwife's presence in the labour room and control and participation in decision making are contributing factors that increase normality in birth and improve the quality of the intrapartum care provided.[12–14] Some of these aspects are closely interrelated, such as the fact that continuous presence enables the midwife to provide emotional support, which may reduce birth interventions and increase women's sense of control and coping abilities.[13] The challenge is being able stay present in the labouring room, when working in a hospital with a medicalised birth environment. In a qualitative interview study Aune and co-workers[15] showed that midwives identified holistic care, which made them work consistently with the ideologies, by being mentally present and developing mutual trust with the women.

Support from the partner during labour and birth is another significant factor in evaluating the birth experience. This support is most likely to be taken for granted in Western societies, because this is an enjoyable occasion, and the father typically wants to participate during birth and provide support to the woman.[16] A recent review, however, reported that men often perceived a lack of ability to provide support.[17]

Women's perceptions of control during birth and its association with the birth experience has been extensively investigated.[18–20] The concept of control is often discussed but could have several meanings. For some women the concept is about having personal control, while for others, it is about managing their own behaviour and cope with labour.[1]

Participation in decision making was also identified by Kennedy and co-workers in a qualitative study.[21] The possibility to make informed decisions, midwives' physical presence, support, and the absence of routine interventions were important for women. The majority of these aspects of care that women were asked to rate, such as receiving adequate support and information and being in control and getting the opportunity to make decisions, were associated with a very positive birth experience. These findings confirm how caregiver's actions and interactions during the labour and birth process can significantly influence a woman's perceptions of her experience.[13]

Women's expectations on mode of birth and pain relief during labour are investigated and planned for during pregnancy and depend on obstetric conditions and the progress of labour. Other important factors in the birth experience, e.g. support, participation in decision making, control and the midwife's presence during labour may not be communicated to the same extent. The aim of this study was to describe pregnant women's expectations about birth and to investigate if their expectations were fulfilled. An additional aim was to determine if unfulfilled expectations were related to mode of birth, use of epidural and the birth experience.

2. Method

2.1. Maternity services in Sweden

Antenatal care in Sweden is situated within the primary care system. It is publicly financed and provided to all residents, on the basis of medical need. Midwives are the primary providers of all maternity care. Virtually all births take place in the hospital and obstetricians work with midwives to provide care when necessary. Midwives work in either community based antenatal care clinics or in hospitals. In some cases, they may rotate between the labour ward and the postnatal ward. Continuity of caregiver through antenatal, intrapartum, and postpartum care is rare in Sweden.

2.2. Design

This study is one part of a prospective regional cohort study where women were recruited in mid-pregnancy and followed up with after birth. Details of the larger project are published elsewhere.[3,4,22]

2.3. Participants and procedure

Recruitment for the survey took place during 2007 in northern Sweden and included all three hospitals in the region. All pregnant women booked for the routine ultra-sound screening offered in gestational weeks 17–19, were sent information about the study two weeks before the examinations. Inclusion criteria were mastery of the Swedish language and a non-malformed foetus. The women consented to participate in the study by signing an agreement form and providing contact details. Those who consented had the opportunity to complete the first of a total of four questionnaires on site and put it in a sealed envelope, or they could choose to complete it at home and return it in a prepaid envelope. Two letters of reminder were sent to non-responders after two and four weeks. The second questionnaire was mailed in late pregnancy (gestational weeks 32–34); the third, two months after birth; and the fourth, one year later. Women who completed the second questionnaire formed the basis of this study with background data merged from the first questionnaire completed in mid-pregnancy, and birth data from the questionnaire distributed two months after birth.

2.4. Background questions

From the first questionnaire completed in mid-pregnancy background questions (age, parity, civil status, country of birth, and level of education) were collected.

From the questionnaire completed in late pregnancy childbirth fear was assessed using the Fear of Birth Scale (FOBS), which is a simple instrument using two 100 mm VAS-scales with the anchors 'calm' and 'worried' vs 'no fear' and 'strong fear'. The scales are summed and averaged to form the FOBS-scale.[22] From the second questionnaire women's preferences for mode of birth (vaginal birth or caesarean section), and their feelings about being pregnant, the approaching birth and the first weeks with a newborn baby (from 'very positive' to 'very negative') were collected.

2.5. Birth expectations

Regarding women's expectations about the upcoming birth, five areas of expectations were focused on: support from midwife, support from partner, participation in decision making, feelings of being in control and midwife's presence in the labour room. Women's expectations in these areas were assessed using a 4-point Likert scale ranging from "of minor or little importance" (=1) to "of very great importance" (=4).

2.6. Fulfilled expectations

Data from the actual birth were collected from the questionnaire two months after birth and included follow up questions