Midwifery 39 (2016) 71–77

Contents lists available at ScienceDirect

Midwifery

journal homepage: www.elsevier.com/midw

Content of antenatal care: Does it prepare women for birth?

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ARTICLE INFO

Article history:
Received 2 February 2016
Received in revised form
27 March 2016
Accepted 2 May 2016

Keywords:
Antenatal care
Women's views
Content of care
Information
Birth
Guidelines

ABSTRACT

Objective: clinical guidelines for antenatal care recommend informing women about birth. The aim of this study was to explore the content of antenatal care from women's perspective and to establish whether they consider information on birth to be sufficient.
Method: the data was gathered in a longitudinal, cross-sectional cohort study known as The Childbirth and Health Study in Iceland. The study group consisted of 765 women attending antenatal care at 26 urban and rural health care centres in Iceland, during the year 2009–2010. They participated by replying to two questionnaires, at 16 gestational weeks and six months after birth. The questions covered objective and subjective aspects of antenatal care, pregnancy, birth, and the postpartum period.
Results: the majority (87%) of the women want to be informed about birth in the antenatal phase of care, and 41% reported 5–6 months post partum that too little time had been spent on this issue, by health care professionals. Post partum, mode of delivery affected women's estimated time spent on information in pregnancy, with women who had planned caesarean section being most satisfied with the time spent on antenatal information about birth. Women who experienced their birth as difficult or very difficult were more likely to report that insufficient time had been spent on information than women who had experienced their birth as easy or very easy.
Conclusions: antenatal care can play an important role in preparing women for birth. This study shows that information about birth provided during pregnancy is insufficient from women's perspective, although some groups of women do report being more satisfied with this information. The way that this segment of antenatal care is provided leaves room for improvement.

Introduction

Antenatal care aims at promoting the physical and psychological well-being of women and prepares them for birth and first steps in parenting. Studies exploring the link between women's expectations of the content of antenatal care in early pregnancy and actual experience after birth are still scarce. Several studies have been published on women's expectations regarding antenatal care, the majority of which relate to the organisation of care—that is, the number of visits and care providers (Hildingsson et al., 2002; Ayoola, 2011; Hofmeyr and Hodnett, 2013). In a previous Icelandic study we found a compliance with women´s satisfaction and number of antenatal visits where women living in rural areas were more likely than women in the capital area to reach the set standards of number of visits and report on more satisfaction with their physical health control (Kristjánsdóttir et al., 2014).

Adapted and translated from the 2008 National Institute for Health and Care Excellence (NICE), guidelines for care in uncomplicated pregnancy were implemented on a national basis in Iceland in 2008 (Kristjánsdóttir et al., 2014). The guidelines highlight that women should be approached with information about birth preferably before the 36th week of pregnancy and that this information should emphasise such aspects of the birth experience as the onset of labour, preparation for birth, information about pain relief, and the use of a birth plan. Research on how and

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http://dx.doi.org/10.1016/j.midw.2016.05.002
0266-6138/

if this has clinical relevance are scarce (Dowswell et al., 2015), but there are indications that limited information during pregnancy increases women's anxiety and dissatisfaction (Kirkham, 1993). Similarly, a feeling of confidence is elevated through knowledge and information provided in antenatal care (Luyben and Fleming, 2005).

Hildingsson and Rådestad (2005) studied women's satisfaction with the emotional and medical aspects of the content of antenatal care and found that dissatisfaction was associated with inappropriate time spent on antenatal information. The way in which antenatal care is organised may affect women's experience, especially where continuity of carer as a mode of service delivery increases women's willingness to discuss their personal preferences regarding the upcoming birth (Homer et al., 2002; McCourt, 2006).

Factors like age, parity, educational level, marital status, ethnicity, and health care policy can explain some significant differences in women's experience of care (Rowe and Garcia, 2003; de Jonge et al., 2009; Chiavarini et al., 2014). To ensure adequate care for all women, the importance of tailoring interventions has been emphasised. In general, women value regular antenatal visits because as evidence indicates, a higher incidence of antenatal visits lowers levels of maternal anxiety and dissatisfaction (Khan-Neelofur et al., 1998; Hildingsson et al., 2002). In relation to breast feeding, information provided during antenatal visits has been reported to be positively associated with encouraging breast feeding intention and prolonged breast feeding (Meedya et al., 2014). In many parts of the world, structured antenatal education and preparation for birth has been provided to women and yet the effects remain largely unknown and doubt exists about its value (Gagnon and Sandall, 2007). The evidence on the effect of structured antenatal education on mode of birth seems to be contradictory, especially regarding labour and birth interventions such as the use of epidural (Fabian et al., 2005; Paz-Pascual et al., 2008) and induction rates (Escott et al., 2009; Phipps et al., 2009). However, antenatal education may decrease false labour admissions (Maimburg et al., 2010; Lumluk and Kovavisarach, 2011).

From women's perspective, antenatal care is seen as a source of information that supports their confidence and autonomy (Gibbins and Thomson, 2001; Luyben and Fleming, 2005). In a recent review it was suggested that antenatal care guidelines would be better able to deliver a positive pregnancy experience if they incorporated the provision of relevant, appropriate and timely information as one of three important domains (Downe et al., 2015). This study explores women's views in early pregnancy, before they are exposed to the influence of the maternity services, and again after birth. It aims to describe whether women found the time spent on information they were given during pregnancy about childbirth sufficient and whether this information affected their experience of birth.

Methods

Design

The data was gathered in a longitudinal, cross-sectional cohort study, The Childbirth and Health Study, that was conducted in primary health care settings in Iceland and that focused on women's expectations and experience of pregnancy, birth, and the postpartum period. The overall study has been described in detail elsewhere (Kristjánsdóttir et al., 2012; Erlingsdottir et al., 2014).

Participants and settings

The overall study consists of three self-reported structured questionnaires, but the results reported in this study are from the first and second only. From February 2009 to March 2010, all women with antenatal booking appointments at 26 health care centres distributed around Iceland were invited to participate in the study. The inclusion criteria were that participants needed to be 18 or older and have adequate knowledge in Icelandic to be able to complete the questionnaires.

A total of 1765 women who consented to take part were mailed the first questionnaire at around 16 gestational weeks; 1111 (63%) of these answered. This figure equates to approximately 23% of all pregnant women in Iceland in 2009. The second questionnaire, to which 765 (69%) women responded, was sent out 5–6 months after childbirth.

Measures

The questionnaires were translated and adapted from the KUB study (Hildingsson et al., 2002) by the steering group of the Childbirth and Health study (Erlingsdottir et al., 2014). The first questionnaire included questions on socio-demographic information. Education was measured by four predefined parts and coded into three categories: primary school, secondary school, and college or university education. Obstetric history and parity were derived from asking women about the number of earlier pregnancies and births. Questions about physical and emotional well-being were also included in the questionnaire, with questions about self-reported health in general and one question about self-reported mental health; both question groups with the following response alternatives: very good, good, neither good or bad, bad, and very bad. These alternatives were collapsed into three groups for analysis: very good or good, neither good or bad, and bad or very bad. Women were also asked about expectations of their birth in early pregnancy, with the following response alternatives: very positive, rather positive, mixed feelings, rather negative, and very negative. For analysis, the alternatives were collapsed into three groups: very positive or rather positive, mixed feelings, and rather negative or very negative.

The second questionnaire referred to women's experience and satisfaction with their antenatal care as well as to other important aspects regarding their birth experience and pregnancy. Mode of delivery was coded into vaginal, instrumental (vacuum extraction or forceps), planned caesarean section (CS), and emergency CS. Women's birth experiences were measured by a direct question with the following response alternatives: very difficult, difficult, average, easy, and very easy. For analysis, the responses were consolidated into three categories: difficult or very difficult, average, and easy or very easy. The women were asked about the pain that they experienced during birth compared to their expectations, with the following response alternatives: much worse than expected, worse than expected, similar to what was expected, less than expected, and much less than expected. For analysis, the responses were consolidated into three categories: much more or more, similar, and less or much less. The women were also asked if they had attended birth classes and if the antenatal care visits were too few, sufficient, or too many. In analysis, the last two categories were put together.

The outcome variable was 'if the women thought that sufficient time was used on information about childbirth in antenatal care'. The women were asked to evaluate the contents of their antenatal care by assessing the amount of time spent on several issues during the visits. The response alternatives were too little time, enough time, and too much time. In this analysis women who thought too little time was spent on information about birth are compared to those who estimated the time spent on the subject to be sufficient (enough or too much time).