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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 to 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.

**Keywords**

Qualitative, descriptive analysis, woman-focused, relational, maternity care
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 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, are often based on a pre-prescribed list of issues with the inability to capture opinion or nuance.

There are evident differences in women’s experiences of maternity care for multiparas and primiparas. One study found first-time mothers experienced birth as novices, however, their reactions were influenced by levels of support. Other studies have identified that multiparous women have different expectations because they have previous experience of giving birth. Parity is also likely to affect how women express their experiences; primiparous women may be less likely to express opinions about services if they don’t know or haven’t experienced the alternatives. Research to date has identified satisfaction at single stages of pregnancy – antepartum, birth and postpartum. Furthermore, previous research has tended to ascertain women’s views within rather than across a variety of geographical settings including urban, regional, rural and remote. 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.

**Methods**

*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 twelve month period February 2011 to 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. 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 was achieved at each site.

A midwife (MJ) conducted all interviews, which took 30-45 minutes 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. 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.

**Data analysis**

Data were analysed, consistent with Green’s understanding of a descriptive study based on dominant categories. 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. First twelve 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. 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. All transcripts were coded to the list of categories by two of the authors (MJ, JF) to promote reliability.

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
coded to the overall coding framework (developed across the entire interviews) by
two of the authors (MJ, JF).

Subsequent papers will explore responses to other questions and recurrent categories
throughout the whole of the women’s interviews.

**Results**

Fifty-three semi-structured interviews were conducted among women experiencing
maternity care and a diversity of primiparous and multiparous women,
antepartum/intrapartum and postpartum women, mode of birth at time of interview.
Twenty-seven women had given birth and 26 women were still pregnant (Table 1).

Analysis of the complete interviews identified five overarching categories. These
were: woman-focused care, systems and facilities, staff qualities, continuity of
care/information, and family-focused care. Each of these categories were included
among the three important aspects of care spoken about by women.

Fifty-one (of fifty-three) women nominated 3 aspects of care they considered as most
important. Two women did not specify important issues due to multiple interruptions
by staff and family members resulting in termination of the interview before the
question was asked. Responses identified 5 broad domains:
Table 1. Characteristics of women in the study (n=53)

<table>
<thead>
<tr>
<th>Characteristics of women (n=53)</th>
<th>No.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean Age (years)</td>
<td>28</td>
</tr>
<tr>
<td>Geographic location</td>
<td></td>
</tr>
<tr>
<td>Urban</td>
<td>9</td>
</tr>
<tr>
<td>Regional</td>
<td>15</td>
</tr>
<tr>
<td>Rural</td>
<td>21</td>
</tr>
<tr>
<td>Remote</td>
<td>8</td>
</tr>
<tr>
<td>Parity</td>
<td></td>
</tr>
<tr>
<td>Primiparous</td>
<td>26</td>
</tr>
<tr>
<td>Multiparous</td>
<td>27</td>
</tr>
<tr>
<td>Plurality</td>
<td></td>
</tr>
<tr>
<td>Singleton</td>
<td>47</td>
</tr>
<tr>
<td>Twins</td>
<td>6</td>
</tr>
<tr>
<td>Model of care</td>
<td></td>
</tr>
<tr>
<td>Private obstetrician</td>
<td>8</td>
</tr>
<tr>
<td>Hospital based medical</td>
<td>27</td>
</tr>
<tr>
<td>Hospital based midwifery</td>
<td>6</td>
</tr>
<tr>
<td>GP shared/medical/midwife</td>
<td>12</td>
</tr>
<tr>
<td>Interview timing</td>
<td></td>
</tr>
<tr>
<td>Antepartum</td>
<td>22</td>
</tr>
<tr>
<td>Intrapartum</td>
<td>4</td>
</tr>
<tr>
<td>Postpartum</td>
<td>27</td>
</tr>
<tr>
<td>Type of birth at time of interview</td>
<td></td>
</tr>
<tr>
<td>Spontaneous vaginal birth</td>
<td>20</td>
</tr>
<tr>
<td>Operative vaginal birth (vacuum or forceps)</td>
<td>1</td>
</tr>
<tr>
<td>Pre-labour Caesarean section</td>
<td>2</td>
</tr>
<tr>
<td>Intrapartum Caesarean section</td>
<td>4</td>
</tr>
<tr>
<td>Undelivered</td>
<td>26</td>
</tr>
<tr>
<td>Transfers</td>
<td></td>
</tr>
<tr>
<td>Antepartum</td>
<td>8</td>
</tr>
<tr>
<td>Intrapartum</td>
<td>2</td>
</tr>
<tr>
<td>Postpartum</td>
<td>3</td>
</tr>
</tbody>
</table>

Staff qualities

Women referred to the importance of personal characteristics as well as competency of obstetric and midwifery staff. Personal characteristics included a non-judgemental attitude, as described by one women:

“having a nice midwife…one that’s understanding and doesn’t, like, judge”

W34 multiparous postnatal regional
For many women a caring attitude by staff was important and involved more than just competency in completing tasks:

“I would say the care factor. Like they actually care. They don’t pass it off as their day-to-day duty that they have to do it” W8 nulliparous antenatal urban

However, having competent staff was also listed as important by women:

“a competent doctor of course to look after me” W51 multiparous postnatal rural

**Woman-focused care**

This type of care covered women’s desire to be kept informed and involved in decision-making. Some women expressed the importance of receiving tailored care that addressed their particular concerns:

“I’ve told every single person I’ve seen every time that I want help with breast feeding” W3 nulliparous antenatal urban

For other women, having someone that understood their circumstances and communicated what was happening with their care was important:

“Just understanding and compassion. Yeah, just general care…just to be informed and just to know what’s going on and in a nice manner” W32 multiparous postnatal remote

This was important, not only in the context of their own care, but also the care and health of their babies:

“I mean, just feeling comfortable, the baby’s health, my health – and just a general knowledge of what’s going on, to me, that’s very important at the time, there’s nothing worse than being somewhere and not being aware of what’s happening” W35 nulliparous antenatal regional
To be involved in decision-making, women felt they needed to understand the process of how care was provided in their setting.

“I think particularly with your first pregnancy it’s probably having that clear picture of what the process is… like particularly booking in appointments and stuff like that because I think with the first pregnancy I was a bit confused but I sort of just went along with the process, or what I thought was the process”

W33 multiparous antenatal regional

*Systems and facilities*

Systems and facilities including available resources, type of care and environment were also highlighted as important aspects of care.

Facilities were important to women, but were not listed as key features of maternity care by the majority of women. When facilities were mentioned, it was the overall environment rather than specific features that were highlighted:

“You want to be in a home-like environment. You don’t – so this feels a little less institutionalised” W4 multiparous antenatal urban

A more frequently mentioned aspect was the organisation of care to optimise time spent with patients. This was expressed in a range of ways including professionalism, efficiency of care and availability:

“I mean everyone basically expects to be looked after and to be looked after properly by professionals. That is their job, it’s what they were trained to do”

W51 multiparous postnatal rural
“Probably the first thing, just the efficiency and a high level of care, like with the transfer and the ambulance being there within moments and getting brought here and rushed straight up there (to birthing suite) and everyone – everyone knew what was happening” W1 multiparous antenatal urban

Lack of available time was particularly noted in the non-urban settings:

“Being able to know who you can go to, know when, that they’re going to be checking on you as much as you are chasing them” W17 multiparous postnatal remote

“They’re very busy, and mightn’t be able to spend the time with the patients that they would like to because they are so busy” W24 primiparous postnatal remote

Continuity of care

Continuity of care or information reflected women’s desire to experience a relationship with one person or team, familiarity with staff and receive consistent information.

Some women described the importance of rapport with staff, whether this involved one or many staff involved in their care:

“I think a rapport and, well with staff that are going to be looking after you and caring, that continuity of care” W17 multiparous postnatal remote

When a number of staff were involved in care, conflicting opinions, information and practices sometimes resulted in a negative perception of care:

“Consistency is very, very hard when you have no idea what you are doing and you’ve got someone coming and telling you one thing and then you’ve got
someone coming and telling you something else because that’s what they believe” W14 primiparous postnatal remote

This was sometimes expressed in terms of ‘discontinuity’ of information:

“I just want to be listened to, receive the same information because there was a little bit of conflicting stuff out there and basically just make sure that whatever is happening to me and my child is just – that we’re all looked after properly. That’s all I want” W47 multiparous antenatal regional

A number of women were keen to have not only a rapport with their midwives, but also have the same midwives care for them throughout their pregnancy:

“Continuity, I think is a good one. To know – I think it would have been really nice to have my midwives that I had during my pregnancy to be there when my baby was born” W24 primiparous postnatal remote

Family-focused care

Family focused care was an important aspect of care, particularly to multiparous women living in non-urban settings. Comments representing this theme included opportunities for access by family members and acknowledgement of wider family by staff.

For some women the location where they gave birth made it difficult for friends and family to visit:

“I think having a baby in town is the most important, because you’ve got your support network there, friends and family” W25 multiparous postnatal remote

“I actually think that’s pretty important, to, once you’re happy to have those really close to you able to come and see you” W5 multiparous antenatal rural
For other women, this involved giving birth at a facility that made access easy or possible:

“I suppose if I wanted to I could have a visitor in during non-visiting hours”

W34 multiparous postnatal regional

Another important aspect of well-received care was when particular family circumstances were taken into account by caregivers and this involved taking into account family in decision-making and making physical access for family members possible:

“it’s not sort of just about me, like there’s family home as well” W36 multiparous antenatal regional

“Basically they (the staff) were trying to get me closer to home so family can come and visit, because my husband has only been able to come down twice a week and having the option if he wanted to stay overnight” W6 nulliparous antenatal regional

_Differing responses by birth experience_

Overall, staff and woman-focused care were the dominant categories most often mentioned by women among their most important 3 aspects of maternity care.

Important aspects of care differed based on women’s birth experience (by parity, geographical location and stage of pregnancy when the interview occurred). First-time mothers more frequently specified staff, woman-focused care and continuity as among the 3 most important aspects of maternity care, whereas, multiparous women were more likely to mention systems/facilities and family-focused care as important.
Overall, women who were interviewed after their baby was born were more likely to identify woman-focused care and continuity as important features. Antenatal nulliparous women highlighted women-focused care and postnatal primiparous women considered continuity an important aspect. Urban women did not mention family focused care among the 3 most important aspects of maternity care, women in regional locations frequently did. Urban mothers nominated staff qualities among important aspects of care while rural and particularly remote women specified systems and facilities as important.

Categories identified in response to the question asking women to identify the most important aspects of care did not necessarily reflect the spectrum of categories identified throughout entire interviews. For example, two-thirds of women mentioned aspects of continuity in the entire interview, but only one-third of women identified continuity among the three most important aspects of care. Some women also identified multiple aspects of the same categories in their responses to the question “What 3 aspects would you see as most important for delivery of maternity care?

Discussion

This study has described the aspects of care women identified as most important when receiving maternity care. To our knowledge, this is the first paper that has used in-depth semi-structured interviews to explore women’s views of the issues of most importance to their experience of maternity care throughout the pregnancy continuum in a range of urban, regional, rural and remote locations. Overall, women were more likely to focus on relational aspects of care, such as woman-focused care and staff qualities, than systems of care as important to their maternity experience. These are consistent with the categories of personal expectations, interactions with caregivers...
and involvement in decision-making identified in systematic reviews\(^1\) and surveys.\(^9\)

The issues highlighted by women in our study varied according to their circumstances such as parity, geographical locations and stage of pregnancy.

**Differences between urban and rural**

Urban mothers in our study nominated staff qualities among important aspects of care while rural and particularly remote women specified systems and facilities as important. This is not to say that staff qualities are not important to women in these settings; it likely indicates the importance of access to nearby care for these women. Similar to a Canadian study of rural parturients,\(^31\) close access was particularly important for rural multiparous women for whom there is stress incurred by the challenges of arranging care for other children, either in their own or referral communities and the stress of separation for those who had to leave their children behind. The mention of lack of available time among non-urban women in our study possibly reflects the staffing issues and particularly the inability to attract and retain staff in rural and remote obstetric services\(^22\). Our findings suggest that convenience of care and location are a key consideration for those women. Staff qualities were important for urban and regional women and it may be that in the absence of difficulties accessing local facilities, staff issues become paramount.

**Influence of parity**

Important aspects of care differed based on women’s birth experiences by parity. In our study, first time mothers more frequently specified relational issues such as staff, woman-focused care and continuity than systems and facilities. Women expressed a desire to be kept informed and be involved in decision-making. For example, one of
the nulliparous women expressed a desire to understand what was happening to them and their baby, whereas for one of the multiparous women an important part of woman-focused care was understanding the overall process of care. Many women wanted to be informed about choices in maternity care with enough information to assist in decision-making. Others have reported similar sentiments in terms of a need to feel in control, with multiparas more likely to report feeling in control than primiparas. Multiparous women were more likely than primiparous women to nominate issues related to systems and facilities and family-focused care as important. These issues include features of maternity units that contributed to a positive experience, such as wanting to be in a home-like environment, but also expecting efficiency, continuity and a high level of care. With previous experience to compare to, multiparous women may be more attuned to processes and systems of care. Catling-Paull et al found multiparous women choosing publicly-funded homebirth display strong confidence in their belief in the health system’s ability to cope with any complications that may arise. Others have suggested that women are less likely to express opinions about services if they don’t know or haven’t experienced the alternatives.

**Stage of pregnancy**

Overall, women who were interviewed after their baby was born were more likely to identify woman-focused care and continuity of care as important features of maternity care. Antenatal women having their first baby tended to highlight woman-focused care whereas postnatal primiparous women considered continuity an important aspect of maternity care. While expressed as different concepts, there is clearly some overlap in woman-focused care and continuity of care in terms of the development of a
relationship with a staff member or team in which a woman feels her views and experiences are being taken into account. Given the importance of continuity of care to women in our study and in other recent maternity research, further in-depth analysis of this concept will be presented in a separate paper. The importance of woman-focused care is reinforced when women undertake antenatal classes, where they receive information about pregnancy, labour and birth and make plans about birth. The importance of continuity of care to women interviewed postnatally is not surprising; it is at this stage of the childbearing experience, when learning to care for a new baby and undergoing a major life change that having consistent care and information is most likely to be highlighted by women. Other studies have reported that while women were largely positive about their care during pregnancy, labour and birth and afterwards, the lowest rates of dissatisfaction related to postnatal care and primiparous women were less satisfied with postnatal care than multiparous women.

To date research differentiating the influence of pregnancy history, stage of pregnancy and geographical location on maternity care experience has focused on differences between primiparous and multiparous women. Few studies have incorporated simultaneously the views of women at each stage of pregnancy and across the diverse range of geographical locations. Our research demonstrated that women interviewed antenatally were more likely to focus on woman-centred care and understanding processes, whereas for women interviewed postnatally it was an overall continuity of care that was emphasised. While the views of urban and rural women have been elicited separately, comparing the perspectives of these women within our study revealed that rural women were more likely to stress the importance of systems and
facilities as services are removed from their local hospitals whereas urban women more often focused on staff issues.

The strength of this study is the large sample of women represented in a range of geographic localities, comprising nulliparous, primiparous and multiparous women and at various stages of pregnancy enabling capture of a large range of views. This diversity of women interviewed allowed differentiation of important issues according to women’s characteristics. This can be seen as both a strength and a weakness; just as there are differences arising from pregnancy history, stage of pregnancy and geographical location, women’s views are also likely to have been affected by a range of factors including personal preferences, values and expectations that have not been captured in this study. In most cases, women were asked about the most important aspects of maternity care at the end of their interviews. It is possible that previous question prompts (for example about health facilities and health professionals) may have influenced the issues highlighted by women at this stage of their interviews. However, if they had strong feelings about their care this is likely to have been elicited. Given that interviews were mostly undertaken in a hospital setting, women interviewed antenatally were likely to represent a relatively high-risk maternity population and this potentially influenced the relative importance of different aspects of care nominated by these women. Women giving birth at home were not interviewed. Whilst acknowledging this study relates mainly to a sample of predominantly Australian born and English-speaking women, future research could target Indigenous, non-Australian born and non-English speaking participants.

Conclusion
Our study showed that women from a range of settings are more concerned with staff and relational issues than facilities, even at a time when maternity services have been stretched in the context of a baby boom in Australia. 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.

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