Dear colleagues and friends, First I would like to thank the organizers for the invitation to speak here today. I have been a midwife for 25 years and I have a long experience of working in all areas of care during pregnancy and childbirth. My research is also strongly linked to clinical practice.

I will try to mirror women's and sometimes their partner's expectations of and experiences from antenatal, intrapartum and postpartum care and how the expectations are met in relation to midwifery practice. The majority of the research findings I will refer to come from two national and one regional survey in Sweden.

Pregnancy and birth could be viewed from different perspectives. On the one hand as a medical issue and a risky project that needs monitoring. On the other hand, from a family oriented perspective.

The challenge for Midwifery is to balance the bio-medical and the emotional aspects of care. The midwife has the skills to do that.

What is good midwifery practice? Let's look at some theories of midwifery.

Joyce Thomson has described the process of midwifery care with a strong focus on the interaction between the midwife and the woman. Good midwifery practice is medically safe, satisfies women's expectations and needs, promotes health and participation, respects cultural and differences and is family oriented.

Holly Powell Kennedy and her team has described the midwife as being the 'instrument of care' where the midwife-woman relationship is characterized by openness, confirmation and respect. The midwife should advocate the woman's rights, guide and support her and keep normality in focus.

The Swedish model developed by Marie Berg of the genuine caring for women at risk for complications, also emphasizes the relationship as the base for caring and the importance of the woman's integrity, mutual trust, a continuous dialogue and the midwife's presence.

All these theories highlight the importance of the relationship and reflect the core of midwifery derived from the ancient word of midwife-with woman.

Antenatal care

So, first of all, what are women's expectation about the care during pregnancy?

As we all know, considerable changes have occurred in all sectors of health care which also is true for care during pregnancy. Based on results from randomized controlled trials in many countries in the early 1990ies a reduced visiting program was introduced.

The consequences of a reduced antenatal visiting schedule has affected the number of visits as well as the intervals between visits, especially with fewer visits in the first and second trimester. The visiting schedule was only based on a medical perspective.

The importance of continuity of caregiver has been widely discussed and researchers have identified models of care that create continuity of caregiver during all episodes of care, such as one-to-one midwifery, team midwifery, or case load midwifery. Some researchers have argued that in order to have a known midwife at birth women have to meet many more midwives antenatally.
The content of antenatal care has undergone changes in terms of more screening investigations primarily directed to the unborn baby, but also towards detecting mental ill-health and psychosocial issues and in recent years parent education in its present form has been questioned.

Studies from Europe and Australia have shown that women value the clinical and technical competence of the midwife, they want to have sufficient number of ultrasound examinations and check-ups, short waiting times, sufficient information, friendly staff and continuity of caregiver.

From a national Swedish survey of women's expectations about antenatal care we found that 70% of women preferred to follow the standard visiting schedule, 23% wanted more visits and 7% fewer visits.

Two months after birth a follow-up study showed that only 25% actually followed the standard visiting schedule, 57% made more visits, and 17% fewer visits.
There was no association between the actual number of visits made and satisfaction, but women's own opinion that they had too few visits was associated with dissatisfaction with antenatal care.

The results from the fixed questions in the survey was strengthened by women's comments to an open question about antenatal care, where most comments were about the importance of checking the mother's and the baby's health.
The women also made suggestions on how the care could be improved, especially regarding the space between antenatal visits where women wished to have more visits in the beginning

of pregnancy, access to the midwife and enough time to talk during the visits: I would like to show a couple of quotes to give voice to women's expectations.

We also found that continuity of caregiver was important to women as 97% rated it important to meet the same midwife during the antenatal visits.

When the content of antenatal care was rank ordered, the most important issue was to check the baby's health, followed by checking the mother's health. Third in ranking was that the partner should be treated in a way that makes him feel involved in the care. So women are keen about the family perspective as well as the bio-medical perspective.

But are they satisfied? Well, in general the majority of women are satisfied with antenatal care. (88%) were satisfied with antenatal care overall but 18% were dissatisfied with the medical aspects, 23% with the emotional aspects of antenatal care.

The strongest predictors of dissatisfaction were women's opinion that the midwife had not been supportive and had not paid attention to their partners' needs. If women thought that they hadn't enough antenatal visits or had met three or more midwives during pregnancy, they were more likely to be dissatisfied with the care received.

From the women's perspective it is important that the fathers are invited and involved in the care. But what about the fathers themselves?
Well, the literature on fathers' expectations and experiences of antenatal care is sparse.

But we know from a regional survey that that the most important issues in antenatal care from the fathers' perspective were the woman's physical and emotional well-being and the support she received from her midwife. But we also found a large discrepancy between fathers rating of how important certain aspects of care were and how they perceived the reality of these aspects.

On the one hand, fathers were not satisfied with the information they got during the antenatal visits and how they were involved by the midwife. On the other hand, fathers felt that they themselves sometimes got too much attention regarding their own emotional well-being. So to conclude- playing the second fiddle is ok for fathers during antenatal care.

Prospective parents value the information they get from the midwife, but we also know that many pregnant women and their partners get information from sources other than the midwife. The Internet and media plays an important role in creating attitudes about pregnancy and birth. This has been most obvious regarding caesarean section on maternal request, especially in the early years after the millennium.

The concept 'too posh to push' was mirrored in the British press when celebrities such as Victoria Beckham opted for a caesarean. In Sweden we usually talk of the Skugge-effect, due to a well known news paper journalist.

Another expectation that is seen as provocative is women who prefer to give birth at home. These two extremes are however, treated totally different by caregivers.

Women who request a caesarean section were described in the newspapers as being career women in big cities who wanted to schedule their births in a crowded calendar. This group is said to be increasing. They are characterized by not wanting the body to be affected by childbirth, and have a strong need for control or fear of giving birth.

Women who go beyond the norm of giving birth are viewed as suspicious. In Sweden, women who wish to give birth at home are often described as whimsical “back to nature-people” who risk their lives to have it cozy.

They are also considered risk takers who expose themselves and their babies for a really big danger because of unexpected complications that can arise. They could also be far from the hospital.

Nevertheless, women are more likely to have their preferences for a surgical birth fulfilled than a natural birth at home. The number of women who want a caesarean section without any medical reason is unclear. International studies indicate that between 1-18% want a surgical delivery.

In Sweden 7-8% prefer a caesarean section when asked during pregnancy but it seems like the desire increases after birth, both in women and their partners. The main reasons for wanting a caesarean section are childbirth related fear, previous caesarean operations and previous negative birth experiences.

A follow-up study of women's preferences from the national survey showed that 31% of those who preferred a caesarean section in early pregnancy actually had a planned caesarean, and another 15% an emergency. The corresponding figures for those who wanted a vaginal birth was 4% planned and 7% emergency caesareans. Women’s preferences were strongly associated with actually having a cesarean section.

However, caesarean section affects women’s and children’s health. Nearly 7000 women who had caesarean section without medical reason were compared with 16,000 women with full-term pregnancies without this code.

There was a statistically significant greater risk of infection, bleeding complications, anesthetic complications, and breast-feeding complications in women having a caesarean section without medical reason. One woman died after a planned caesarean section.

The caesarean babies who were born this way without medical reason had better Apgar score at 5 minutes, but more frequent breathing problems and hypoglycemia. We do not have any long term data, but research has shown that asthma, allergy and DNA-damage are associated with caesarean births.

We also know from national and regional surveys that during pregnancy between 2-5% of women and 4% of men would like a homebirth. None of the parents included in these surveys actually had a planned homebirth.

If we should follow the parent's wishes about homebirth in Sweden, we would have between 2000 and 5000 homebirths a year. There are about 100. Safety has been the major argument for denying women a homebirth. It is not included in the health care system in Sweden; parents have to find a midwife willing to assist them and usually have to pay for the homebirth themselves.

In the Swedish National Homebirth study we looked at the medical outcome in planned home births, where labor started spontaneously at home, regardless of the actual place of birth and we used a control group of 11,000 women with full-term pregnancies with spontaneous onset of labor. The variables we focused on were acute complications such as uterine rupture, prolapsed cord and placenta abruption, perineal tears, and major bleeding.

No cases of acute complications were found in the home birth group and most results were in favor of women who gave birth at home, with fewer interventions, fewer tears and less bleeding. 12% of the women were transferred to hospital during or shortly after birth. The second most common reason was that the midwife was not available.

There was no difference in Apgar scores, but the babies who were born at home had a higher birth weight. Two babies died in the planned home birth group who started labour at home and so did 9 babies in the hospital group. This is not a statistically significant difference; we would need about 400 years of home births to have power to detect any difference in neonatal mortality.

In order to better study the unusual outcome of perinatal mortality, we have initiated a joint project in the Scandinavian countries where we hope to obtain data from all the home births in the Nordic countries. www.nordichomebirths.com. On this homepage Midwives can register medical data from home births, and parents are given the opportunity to share their birth experiences. So, if you are assisting at a home birth please check this web site and enter the data.

Intrapartum care

Intrapartum care is nowadays characterized by high technology, and interventions and the consequence of a high-technological birth are mirrored in the increasing rates of childbirth

related fear and increasing rates of caesarean section. Changes in the pregnant population such as higher age at childbirth and higher Body Mass Index also challenge the work of midwives. Elevated workload, with more women to take care of, gives midwives less opportunity to be present to support the couple during birth. Alternative models of care, such as homebirth and birth center care are rare and there is a worldwide trend to close down small midwifery-led units.

In general, women are satisfied with the care received during labour and birth, but they do not always have a positive birth experience.

Nearly 40 % of women and 23% of men rated their birth experience as less than positive 2 months after childbirth. The prevalence of women with a negative or very negative birth experience 1 year after birth were 7%, in men the figure was 3%.

One of the main reasons for a negative birth experience was mode of delivery where instrumental vaginal births or emergency cs were associated with a negative birth experience, and so were use of epidural anesthesia and induction of labour. Having met the midwife before reduced the likelihood of a negative birth experience. Looking at normal vaginal births only, those really negative were 3%. These results strengthen the importance to promote normal vaginal births. How can that be done?

One important factor is the presence of a midwife in the delivery room. Continuous presence of a caregiver has substantial advantages for the mother, the father and the baby in terms of reduced needs for analgesia, reduction in instrumental births and caesarean sections, and better Apgar scores. Continuous support does not seem to have any harmful effects. In addition, continuity of caregiver, in terms of having a known midwife assisting at birth, has significant advantages. In a systematic review of studies with more than 12,276 women who received midwifery-led care, where midwives provided antenatal, intrapartum and postpartum care, showed higher levels of satisfaction, stronger feelings of control, and more spontaneous vaginal births. I think we need to develop models of care with increased continuity between episodes of care, where the midwife-parent relationship could be developed.

One challenge for intrapartum care is the increasing prevalence of childbirth related fear, in women, men and caregivers. The increase in childbirth related fear is closely related to the rising caesarean section rates. Women who fear childbirth are more likely to request a caesarean section and also more likely to have their requests fulfilled.

The problem with the increase in caesarean section is obvious. There is evidence that elective cesarean sections are more dangerous to women's health compared to an intended vaginal birth with higher risks of placental complications and uterine rupture in a subsequent pregnancy and increased breathing problems for the baby.

Most of the national and international associations of obstetricians and gynecologists have agreed that Caesarean sections should be undertaken only when the outcome of birth will be improved and mothers and babies' health enhanced. They respect women's preferences and

decisions but state that in order to fulfill a request for CS it must be obvious that women have up-to-date, complete and understandable information about the risks and benefits of the operation

To inform women and their partners about the risks and benefits is one important task for midwives even if we are not in the position to make the final decision. But are we really saying the right things about caesarean section?

Here is a quote from a father who's baby was born by CS: "It is an operation, they are cutting up the body. Nobody talks about as an operation!.

Still, we are facing more and more caesarean section done on maternal request and we know that reasons behind such request are associated with childbirth fear, previous caesarean sections and previous negative birth experiences.

Researchers have argued that the birth experience is more important than the actual mode of delivery. One thing to consider is whether women will have a better birth experience if they have their wishes fulfilled? Theoretically, this would be relevant. But recent research show contradictory results.

When women with and without fear of giving birth were compared regarding their mode of delivery and their birth experience, women without fear and who had a planned CS were not likely to have a negative birth experience compared to women without fear who had a vaginal birth. But women who had reported childbirth fear during pregnancy were twice as likely to have a negative birth experience regardless if they had a vaginal birth or a planned caesarean section and this association grows stronger over time, with a seven-fold risk to have a negative birth experience after one year. One interpretation for this is that caesarean section is not the solution for women suffering from childbirth fear, we need other tools.

Postnatal care

The most pronounced changes have occurred in postnatal care, which provides short length of stay and information intense content. Family-oriented models of postnatal care have in some places closed down, in other places being the only option after a normal birth. Hotel wards, staffed only during daytime, have been introduced mainly for financial reasons.

While intrapartum care in general will be rated as satisfactory by the majority of parents, postpartum care is less valued. New parents all over the world are dissatisfied with the postnatal care. Several studies have pointed out that family oriented models of postnatal care where the father can stay overnight increases parents' satisfaction, but it has also been reported that midwives view fathers as intruders who disturb the mothering process.

From the national Swedish study where women were recruited 10 years ago we studied what factors creates dissatisfaction with postnatal care. The length of hospital stay, both too short and too long was associated with dissatisfaction. The size of the hospital where smaller hospitals were rated more positively, and the partner's options to stay overnight were

important factors. Moreover, lack of hands-on breastfeeding, lack of encouragement and no time for asking questions made women dissatisfied.

Women do not want to be thrown out of hospital as this quote shows.

In many hospitals only women with complications are allowed to stay on the traditional postnatal ward. Other women are supposed to leave hospital within the first 24 hours or use other care options. Family oriented models of care, such as hotel wards will allow the father to stay. Theoretically such a division of care should have open up space and give fathers better options to stay overnight, both in the family oriented wards as well as in the traditional postnatal wards.

Unfortunately, there was very little improvement in fathers' options to stay overnight when a new hotel ward was introduced and although this family oriented model of postnatal care increased satisfaction, fathers continued to be dissatisfied with the content of care, with the strongest association for lack of support from staff. This means that fathers are literally 'Still behind the glass wall'.

It's very depressing with all these studies focusing on dissatisfaction. So, in a recent study we focused on factors associated with being very satisfied with postnatal care. The most important factor, believe it or not, was support from staff, followed by check-ups of the baby and receiving nice treatment from the staff. Model of postnatal care was not associated with satisfaction.

Now I'm about to end this presentation. What lessons have we learned when asking about the parents' views of care?

Regarding antenatal care we can state that there are still issues to consider if we want to listen to and act upon women's expectations.

Midwives working in antenatal care should support pregnant women and their partners in a professional and friendly way in order to increase satisfaction with care. Women would appreciate an individualized visiting schedule.

Continuity of caregiver is important. Organizing teams with no more than two midwives taking care of a woman during a normal pregnancy could make women feel more supported and satisfied.

The health consequences from an operation without medical reason must be clarified for women and support programs must be introduced and evaluated in order to reduce caesarean section without medical reasons

Although preferences for homebirth are rare, healthy women with normal pregnancies should have the opportunity to have access to assisting midwives.

From intrapartum care the lessons learned that women are satisfied with the care but do not always have a positive birth experience.

Women with childbirth related fear do not benefit from having a caesarean section

Continuity of caregiver and continuous presence during labour and birth increases satisfaction, creates a more positive birth experience and lowers the risks for caesarean sections.

From studies on postnatal care we know that

Parents value family oriented models but not the way we deliver the care

Support from staff increases satisfaction

Fathers are still marginalized

The overall message I want you to take home today is that:

Midwifery support, continuity of caregiver and a medically safe family oriented philosophy of care is what parents want.

In conclusion- ‘what is could probably be better’- when midwives and parents collaborate in practice and science.