Integrating Women’s Views into Maternity Care Research and Practice

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ABSTRACT: The purpose of this paper is to consider the role of women’s views in maternity care research and practice: what we mean by that, how and when women’s views are sought (or not), and what we should do next. It is argued that women’s views are not a stand-alone extra, but integral at every stage, including having an impact on clinical outcomes. Attending to “women’s views” should not only mean a post hoc assessment of experiences but also needs to consider expectations and values. Importantly, this approach needs to apply not only to the care of individual women but also to the shaping of research and policy agendas. Recommendations are made for ways in which women’s views can have a more central role in research and practice in the future. (BIRTH 2012)

Key words: childbearing women, patient involvement, research agenda, women’s experiences, women’s view

The woman’s position in maternity care is paradoxical. On one hand, she is central; no maternity scenario would exist without her. On the other hand, most of what actually happens to her is determined by agendas other than her own. She may be given some choices, for example, to give birth in this hospital rather than that one, but, as Martin Richards pointed out in this journal 30 years ago (1), this is not much of a choice if neither option is what you want.

This paper is about the importance of women’s views in maternity care and practice. Few of the points that I will make are new. Iain Chalmers, for example, at the Ninth Birth Conference in 1990, presented an excellent analysis demonstrating the influences on the perinatal research agenda and the ways in which women’s voices were failing to be heard (2). However, it appears that the recognition that women’s voices should be heard is not enough to make it happen. I will therefore focus on what is meant by ‘women’s views’ and why they matter, how we determine what it is that is important to women, and how their views should influence policy and practice.

What Is Meant by “Women’s Views” and Why Does It Matter?

I am using the terms women’s voices, women’s views, and what is important to women interchangeably as a shorthand for a woman’s beliefs, thoughts, and emotions before, during, and after her childbearing experience. As a psychologist, I naturally believe that these aspects are important in their own right and that caregivers and researchers need to understand them to optimize care. Researchers have long known that prenatal stress, anxiety, and depression have an impact on perinatal and child outcomes, and now understand much more about the possible mechanisms (3). In addition, women’s views are important because they lead the woman to certain decisions and behaviors, for example, attendance for prenatal care, avoidance of pharmaceutical pain relief, and breastfeeding, which, potentially, have clinical and health consequences. Thus, what women believe and how they think and feel matter not only for the psychosocial outcomes of themselves and others, but also for the outcomes of their children.
their families but also for clinical and health outcomes too. For example, a woman who sees all her peers formula feeding, and was perhaps formula fed herself, is likely to believe that that is the right way to feed a baby and is thus less likely to breastfeed. This link between attitudes/behavior and clinical outcomes has now been demonstrated at numerous levels from the link between antenatal attitudes to intervention and mode of birth (4) through to the ability of women’s groups in Nepal to reduce perinatal mortality (5). Women’s views should therefore not be thought of as stand-alone extras to “hard” clinical outcomes, but as a key part of the process.

Different women want different things, and any individual woman will probably want different things at different times. What women (think they) want will be heavily influenced by what they are told—by their caregivers, by their family and friends, and by the media—and will change over time and settings. It will also change as the woman’s own experience changes. This motility should not be seen as invalidating women’s views, but as an essential part of being human. It has several implications. First, it means that we should not be thinking only about individual maternity encounters, but about the context in which they sit: for example, the information that women are given, their sociocultural background, the priorities of the policies that determine their care, the way that health professionals are trained, and the research agenda that generates the evidence that (we hope) determines the policy. All these factors need to be informed by women’s voices. Second, as I shall argue below, this motility needs to be recognized in how we go about determining what is important to women.

How Do We Determine
What Is Important to Women?

How we determine what is important to women is a key consideration, bearing in mind the points made above. Porter and Macintyre in 1984 drew attention to the reluctance of childbearing women to be critical of their care or to be able to see the possible value of a type of care that they have not experienced (6). This response means that women who have experienced something will generally be more positive about it than women who have not. A danger of drawing the wrong conclusions exists if we solicit the views of only one or the other. An example of this pitfall can be seen in the United Kingdom in 1993, when a key indicator of success set out in the maternity agenda Changing Childbirth (7) was that women should be cared for in labor by someone they already knew. The evidence to support this indicator was that women who had experienced such continuity said that they liked it. However, this evidence was only part of the story, and a subsequent literature review showed that being cared for in labor by a known caregiver was not, in fact, generally highly valued by women who had not experienced it (8), even if antenatally they had thought that it was important, and that other definitions of continuity of caregiver mattered far more. Policy based on women’s views needs the same high-quality research and standards of scientific rigor in its evaluation as would be applied to any other evidence used to determine policy.

Direct evidence from care providers about women’s views often comes from patient satisfaction questionnaires. These tools can be a very useful way for practitioners to know if women are dissatisfied, but they have some limitations, for example, women are strongly disposed to express satisfaction when they have just given birth to a healthy baby; they are reluctant to seem to criticize their caregivers; they are not clear what aspects of care are being judged (6, 9–12).

Another concern about the focus on patient satisfaction questionnaires is that they are generally administered at the end of the episode of care. This “exit poll” approach sees women’s views only as an outcome and fails to recognize that women have “views” throughout their maternity experience. Although responses to such questionnaires may (possibly) result in changes to a woman’s care in a future pregnancy or to care for other women, for this birth, it is too late. Yet, a woman comes to the maternity scenario with wants and expectations and, underpinning these factors, her values. Her expectations and what she (thinks she) wants are liable to change with changing information and experience, but values are likely to be more deep-rooted and less liable to change.

I would therefore argue that the priority is not only to hear her views at the beginning of her maternity care but also the important conversation to have with her is not so much about what she wants as about what she values. In a prenatal testing scenario, for example, the important conversation would not start and end with “do you want this test?” but would discuss the values that should underpin that decision. Practitioners who fail to use this approach are in danger of making erroneous assumptions about why women behave as they do, leading to inappropriate action by the practitioner. An example is the failure to offer tests to Muslim parents because of assumptions about their attitudes to termination of pregnancy, whereas several studies have now demonstrated a much more nuanced picture (13–15). Caregivers should try to avoid stereotyping and not second guess the reasons for women’s wants—they may be wrong.
A focus on why women hold the views that they do should lead us to questions, such as “why does this woman intend to formula feed?” Is it to do with the perceived benefits of formula feeding or the perceived lack of benefits of breastfeeding? Does it relate to her beliefs about the true benefits of breastfeeding—especially if she herself was formula fed (outcome beliefs), to what she sees her peer group doing (social norms), or to her belief in herself to be able to overcome the problems of breastfeeding (perceived behavioral control)? This is a situation where theoretical models from health psychology can help guide health care practitioners toward a greater understanding of “women’s views,” which will help them address barriers to breastfeeding (16). In other words, caregivers need to know, not just “what do women (say that they) want?” but “why do they want it?” This concept brings us back to the importance of understanding what a woman values, and particularly understanding that in a social context.

Health caregivers and health policy makers do not only need research specifically about women’s views and experiences but also need the inclusion of women’s views as the norm in any large-scale study that may be used as a basis for changing policies and practices of care. Studies need to be large enough to be able to compare subgroups, and they need to be able to explore why people hold the views that they do. This approach may use either qualitative or quantitative methods, but whatever methods are used, they need to recognize the complexity of women’s views and allow them to be expressed, which satisfaction rating scales generally fail to do. This challenge may mean that researchers need to devise new approaches. Examples in maternity research include adjective checklists, which allow women to express both positive and negative feelings simultaneously (17); the Cambridge Worry Scale (18), which goes beyond standard anxiety measures in identifying what women are worried about; and the Mother-Generated Index (19), which allows the woman to define her own parameters for assessing her postnatal quality of life. These measures are all in keeping with the trend elsewhere in health care toward identifying outcomes that matter to patients (20).

Health policy makers should also be thinking about how women’s voices are to be heard in service and research planning. Service users and their representatives need to be represented on all relevant decision-making bodies, and practices put in place to ensure that their voices are heard. This approach should improve the quality and impact of research (21). In addition, health policy makers and caregivers should be using the impressive body of research on women’s views and experiences of maternity care that has been accumulating over the past 40 years. Recognition of how contextualized women’s views necessarily are suggests the need to focus less on specifics and more on the values underlying them.

Viewing the research literature at this level points to clear evidence of aspects of care that are highly valued by most women in many different countries and contexts. Specifically, we know that women value positive interactions with their caregivers (22). Indeed, this factor is a more important determinant of a woman’s appraisal of her birth experience than anything else, including pain (23). As a result, the evidence-based guidance for the care of healthy women and their babies during childbirth issued by the National Institute for Health and Clinical Excellence in the United Kingdom states as its first recommendation (24):

All women in labour should be treated with respect and should be in control of and involved in what is happening to them, and the way in which care is given is key to this. To facilitate this, health care professionals and other caregivers should establish a rapport with the labouring woman, asking her about her wants and expectations for labour, being aware of the importance of tone and demeanour, and of the actual words they use. This information should be used to support and guide her through her labour.

Thus, this recommendation provides a very important starting point. We could—and should—be using this knowledge to prioritize, for example, how maternity budgets are spent, the educational curricula of health care professionals, and which research questions to address.

How Should This Approach Influence Policy and Practice?

At the level of individual care:

1. Implement what we know is important to women: to be treated as an individual and with respect, to have her concerns taken seriously, and to be given clear advice that she can understand and for which she can understand the rationale.

2. Establish what else matters to this individual woman, what she values.

3. Give the woman evidence-based information appropriate to her needs and preferences that will allow her to be an active participant in her care, if that is what she wants. Recognize that for some women, a sense of control comes from handing over decision making to trusted caregivers (25).

At the local systems level:

4. Ensure that mechanisms exist that allow childbearing women (users of services) to influence the services
on offer and the way they are made available. In the United Kingdom, every National Health Service Trust offering maternity care has a statutory Maternity Service Liaison Committee, which has the obligation to ensure that at least one third of its members are service-users. If the committee can have a relationship with maternity care researchers (as exists in York), relevant research can quickly be fed back to the committee and, conversely, important issues for the research agenda can be brought to researchers’ attention. In many countries where individual maternity care practitioners are largely autonomous, the challenge to find ways for women to influence the services available is much greater; however, different ways of organizing care will give different opportunities for influence.

At the level of policy:

5. Ensure that policy is based on high-quality research, both qualitative and quantitative, which reflects what matters to childbearing women.
6. Ensure that mechanisms exist that allow service users and organizations representing their views to influence policy.

At the level of the research agenda:

7. Ensure that the research agenda is based on high-quality research, both qualitative and quantitative, which identifies gaps in the evidence concerning issues that are potentially important to childbearing women.
8. Ensure that mechanisms exist that allow service users and organizations representing their views to influence the agenda of research funding bodies.
9. Ensure that women’s views are seen as fundamental part of all research, integrated with other outcomes, and fund appropriately, then follow through to ensure that women’s voices are heard.

I have argued that women’s views are not a stand-alone extra for maternity care, but integral at every stage of service planning and delivery. They need to be the concern not only of maternity caregivers but also of those who set research and policy agendas.

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References

