Continuity in Antenatal Care: Exploring Perceptions of Care and Emotional Experiences

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Abstract

Perspectives and value systems inform views of antenatal care and childbirth, influencing how they are understood and organised. Professional, academic, institutional and cultural views all influence what maternity care is considered to be, how it should be delivered, and how the experiences and outcomes associated with it are measured. The objective of this study was to analyse women's lived experiences of antenatal care in the NHS. In particular, I sought to understand how the continuity of the care women received influenced women's experiences, with the aim of identifying areas for improvement with respect to well-being and satisfaction with care. I conducted semi-structured interviews with 6 women who were within 24 months of childbirth. I analysed transcribed texts using a reflexive thematic approach, undertaken through a social constructionist lens. I developed three themes in the analysis. These were: the impacts of poor communication, the impacts of not being heard, and fear of the unknown. Participants emphasised the need for a person-centred care model, and more specifically a midwife-led continuity of care model. Early antenatal care and late antenatal care were identified as two critical periods of care when women require the greatest levels of advocacy and support. Based on this analysis, the NHS maternity framework could make improvements to information organisation and sharing, the encouragement of active patient participation in care, and the promotion of shared decision-making. Greater attention to how holistic perspectives and medical perspectives could be blended to broaden understandings of what successful birth experiences could be, is required to validate women's antenatal needs and subsequently improve maternity care outcomes.

Chapter 1 - Literature Review

Introduction

This research intends to explore the perceptions of women's antenatal care experiences within the British National Health System (NHS). Health models, health systems and professionals influence women's experiences and outcomes. However, person-centred care models that highlight the importance of continuity of care and empowerment in health care decision-making are often rejected in favour of biomedical models. This research aims to contribute to a more holistic understanding of what antenatal health could look like, to better suit women's needs. In this chapter, I will be exploring the literature on women's perceptions and experiences of antenatal care with respect to the continuity of midwifery care received.

Maternity Care: Defining the Terms

In the United Kingdom (UK) the term 'maternity care' is used interchangeably with the term 'perinatal care'. The term encompasses the specialty care received by women[1] and their babies throughout pregnancy, labour, delivery, birth and after the birth of the baby (Figure 1). Care throughout pregnancy is referred to as antenatal or prenatal care. Care during labour, delivery and birth is referred to as parturition care. Care for mother and baby after birth is referred to as postnatal, or postpartum care. My research focuses on the antenatal (or prenatal) stage of maternity care. This stage of care is critical in that it is pivotal in promoting improved outcomes for subsequent stages of maternity care, and overall maternity care outcomes (Webb et al, 2021; O'Brien, Casey & Butler, 2018; Dahlberg & Aune, 2013).

[1] In this thesis, I use the term 'women' to include all people identifying as women. People of different genders are able to become pregnant; however, the participants in my study

identified as women. Additionally, women's experiences are the focus of the literature presented in this chapter.

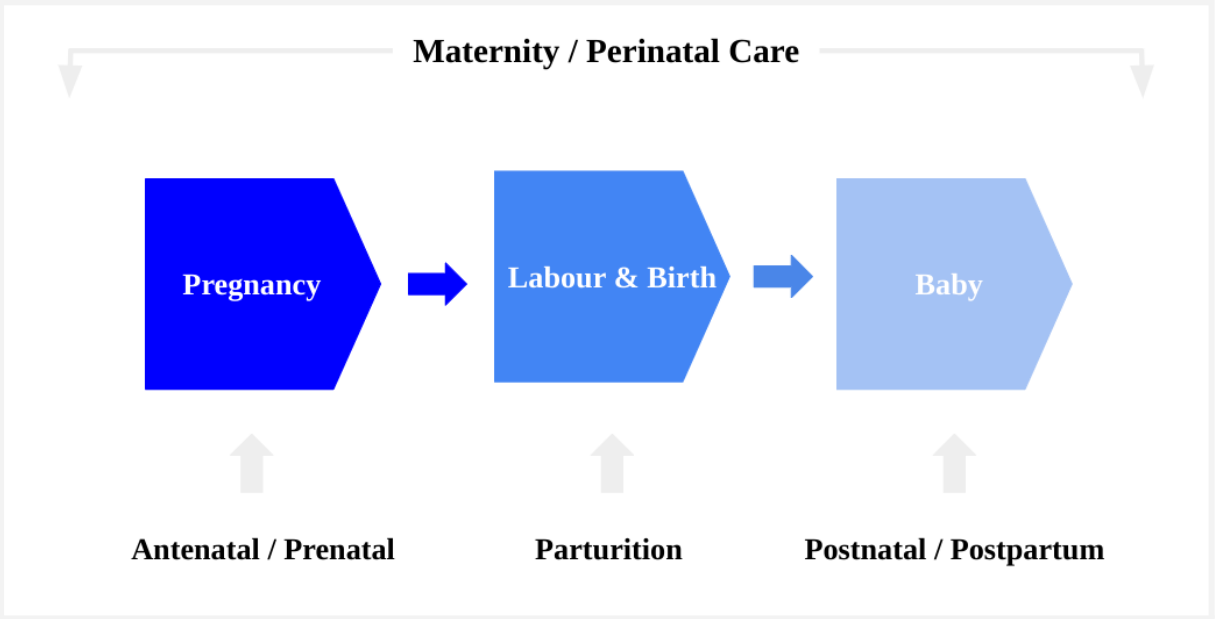

Figure 1: Own Image

Experiences and Outcomes

Pregnancy, childbirth and parenthood can be significant events in women's lives that can produce both negative and positive outcomes (Webb et al, 2021). In positive maternity experiences, women can benefit from improved physical, psychological and emotional outcomes, including a stronger 'sense of self' (Webb et al, 2021; O'Brien et al, 2018; Parratt, 2002). Positive birth experiences can improve reported feelings of elation, satisfaction and empowerment (Aune et al, 2015). Negative birth experiences, however, are associated with poorer physical, psychological and emotional outcomes, including feelings of disappointment, the onset of depression or Post-Traumatic Stress Disorder (PTSD) and delays in future pregnancies (Webb et al 2021; Gottvall & Waldenstrom, 2003; Thompson & Downe, 2016; Bai et al, 2019).

Poor outcomes for mothers, such as the increased likelihood of divorce that can impact child custody, and loneliness (Engqvist & Nilsson, 2011) are also associated with poorer outcomes for the baby, both developmentally and psychologically (Webb et al, 2021). Furthermore, poor experiences in antenatal care are known to have cascading impacts upon the outcomes of subsequent parturition and postnatal care experiences (Dahlberg et al, 2013). In the World Health Organisation (WHO) report *Recommendations on Antenatal Care for a Positive Pregnancy Experience* (WHO, 2016) antenatal care systems are described as necessary not only to save lives, but also to improve them through the avoidance of negative outcomes, and the promotion of positive ones. Three factors are regularly cited in the literature as being critical in influencing how antenatal care is experienced: relationships, continuity of care, and expectations of care (Dahlberg et al, 2013; Freeman & Hughes, 2010; Galle et al, 2015; Sandall et al, 2015).

Relationships

Women's relationships with their maternity care providers are of vital importance. These experiences are not only "the vehicle for essential lifesaving health services, but women's experiences with caregivers can empower and comfort or inflict lasting damage and emotional trauma" (Respectful Maternity Charter, 2019, p. 1). These individual experiences stay with women for a lifetime and are often shared between women - which influences broader social perspectives on healthcare systems (Respectful Maternity Charter, 2019). These experiences may reflect high levels of trust and satisfaction, or they may cast doubt and lower the confidence in others yet to experience healthcare services firsthand.

O'Brien et al (2021) found that the relationships women build with their midwives in particular influence their levels of trust in hospital policies, in the midwives' abilities, and in their own abilities to prepare for birth. The relationship between woman and midwife can be

powerful in influencing maternity care experiences to be considered as either positive or negative. It is particularly interesting that the strength of this relationship holds the potential to influence women's own self-efficacy in giving birth. Over 21% of women have reported wanting more contact with their midwife during the antenatal stage of their care, compared to only 4% reporting that less contact was desired, when surveyed after their birth experience (CQC, 2013). With over 700,000 births every year in the UK, the number of women wanting increased contact exceeds more than 147,000 women annually (CQC, 2013). This would indicate that significant numbers of women could benefit from empowering antenatal relationships annually.

Beyond the UK, the central role of relationships within healthcare is becoming more recognised globally, with some countries integrating relationship-first strategies into their maternity policies to maximise the benefits of relationship continuity (Sandall et al, 2015). In New Zealand, Australia, The Netherlands and Canada maternity policies prioritise positive relationships between women and their midwives by applying a model of care continuity (Gray et al, 2016). The WHO promotes a person-centred antenatal care model that centralises trusting relationships with care providers and responds to the emotional support needs of women (WHO, 2018). This establishment of trust is critical in building positive relationships that in turn promote positive outcomes for women and their babies in maternity care (Sandall et al, 2015).

Continuity of Care

Continuity of care includes the continuity of care staff (relational continuity) and the predictability and expectations of care (communication continuity). Relational continuity in maternity care has been shown to be a key factor in positive birth experiences (Dahlberg et al, 2013). Relational continuity also makes communication continuity much more likely

(Tuominen et al, 2014). When antenatal care staff are consistent for women (i.e. women interact with the same professionals for their maternity care experience), it is more likely that a transparent care plan is in place that both care providers and women are familiar with (Tuominen et al, 2014; Sandall et al, 2015). This sets clear and honest expectations for women as to what to expect from their care experience, increases the predictability of their course of care, and promotes a sense of trust in their care relationships (Tuominen et al, 2014).

In the latest comprehensive maternity care survey conducted by the Care Quality Commission (CQC, 2013), only 34% of women reported experiencing continuity of care in their antenatal midwife appointments. Only 1% of women surveyed did not want to see the same midwife for their antenatal appointments, likely attributed to a mutual relationship between the care provider and woman being difficult (CQC, 2013). Compared to earlier CQC reports, the number of first-time mothers participating in the survey had increased from 10% to 15%. In addition to this shift, the number of women seeking antenatal care from General Practitioners (GPs) had decreased from 71% in previous years to 63% in 2013, and women who sought midwives as their primary contact increased by 8% (CQC, 2013). This data indicates that women had a diminished preference for GP-led antenatal care, compared to an increased preference for midwife-led antenatal care. This seemed especially so for first-time mothers.

The National Maternity Review of England reiterated the central role of continuity in antenatal care from a health services perspective (National Maternity Review, 2016). In line with national commitments, the role of the midwife in strengthening public health and the compelling evidence base for continuity of care highlights the importance of commissioners and planners building continuity of care models into maternity service requirements (Sandall et al, 2015). Of the key priorities to drive improvements in antenatal care, continuity of care

including personalised care have been cited as critical (National Maternity Review, 2016). In addition, the NHS England 'Five Year Forward View' (2014) encourages the implementation of more innovative models of care that challenge biomedical models in favour of different, more holistic approaches (NHS, 2014). This creates opportunities "to really address continuity at a population and system-level" within the antenatal care sector (Sandall et al, 2015, p. 5). Planning, implementation and monitoring of continuity of antenatal care within the NHS have been drafted and are currently under review. This approach to improving antenatal systems aims to enrich current care systems with more holistic alternatives for women (NHS, 2021).

Expectations of Care

Missed expectations in the antenatal care stage have been linked to poorer parturition and postnatal outcomes (Webb et al, 2021). Mismatches between expectations and experiences occur when a woman's expectations of care are not met. Unsatisfactory maternity experiences as a result of such mismatches are associated with increased likelihoods of women developing psychological disorders, such as Post-Traumatic Stress Disorder (Webb et al, 2021). Lack of choice and control are major contributing factors to these negative outcomes commonly described by women (Better Start, 2021). Being uninformed about the process, and a lack of discussion around expectations, or the consideration of the potential for alternative outcomes, are regularly cited by women as areas within maternity communication that are least satisfying (Beake et al, 2010). Key themes in women's experiences of antenatal care are staying informed, respect in their treatment (privacy and dignity in particular), relationship quality, the strength of communication, rapport with care staff and continuity of care (Redshaw et al, 2019).

One approach to improving women's antenatal experiences and subsequent parturition and postnatal outcomes focuses on a proactive approach to managing women's expectations of the process. This approach prioritises the sharing of information between women and care providers, to ensure that women are informed, aiding in the managing of expectations and the building of trust in these vital care relationships. A recently published maternity care guide outlines the processes health systems should adopt in order to implement a communication-based practice that avoids unnecessary perinatal trauma in women (Better Start, 2021). It centralises communication as a means for care providers to provide environments for women to establish and maintain a sense of control and choice in their antenatal care, as well as to share information to set and meet antenatal care expectations. This care guide provides some hope for improvements to postnatal outcomes as a result of experiencing mismatches of antenatal care in the near future. Much of the current and historic research in maternity and antenatal care is quantitative in nature and based on observations and outcomes of pregnancy and birth (Savage, 2006). There is value in ensuring women's voices and lived experiences become more prominent in influencing maternity care systems, for instance through qualitative research (Savage, 2006).

Fear Culture

Fear of pregnancy and childbirth is a widespread norm in Western society (Preis et al, 2018). Women are socialised from a young age to approach the process of childbearing with much preparation, and to employ all the resources they can afford to the process (Preis et al, 2018). In fact, fear of childbirth is one of the leading causes of women requesting caesarean births (Nilsson et al, 2018). Media portrayals normalise highly medicalised views on pregnancy and childbirth (Luce et al, 2016). The media is also hugely influential in its portrayal of birth as “risky, dramatic and painful” and is heavily responsible for the effects that this portrayal has

on society (Luce et al, 2016, p. 40). By extension, this media climate of fear is a contributor to the poorer outcomes associated with medical interventions such as unnecessary caesarean births.

In reality, however, the perception of risk is often far greater than the actual risk of pregnancy (Lee et al, 2019). Social pressures associated with media exposure are also increasing risks in pregnancy for women in other ways. Social media enables women to compare themselves to others and can be detrimental to women by affecting their eating patterns (linked to the avoidance of "excessive" weight gain in pregnancy) as well as depression (Ross & Hess, 2019). The impact of fear on the attitudes and beliefs of women around childbirth increases the likelihood of a negative birth experience (Haines et al, 2012).

Birth stories, in addition to media portrayals, are another significant influence on women's beliefs and attitudes toward childbirth (Kay et al, 2017). Birth stories were traditionally shared between close social contacts, although now with the age of the Internet can be shared and accessed by much larger audiences (Kay et al, 2017). Information seeking in the form of birth stories from online sources has been associated with increased levels of anxiety in pregnant women (Coglianese et al, 2020). This exposure increases the likelihood of potentially negative outcomes (Coglianese et al, 2020). Pregnancy experiences and representations of pregnancy, birth and motherhood on social media also negatively impact women, contributing to feelings of inadequacy and impairing self-efficacy (Smith et al, 2020).

Strong relationships between midwives and women that are bolstered by continuity within the midwife care act as a buffer to these negative effects (Baptie et al, 2020). Continuity in midwife care increases women's perceptions of support throughout their maternity care experiences (Baptie et al, 2020). Perceived support from midwives can also

mediate the effects of birth trauma, making the midwife- expectant-mother relationship a vital one for optimising antenatal, parturition and postnatal outcomes (Baptie et al, 2020).

Roles in Antenatal Care

There are five roles within antenatal care in the UK that are part of most pregnancies within the NHS. These include general practitioners (GPs), obstetricians, midwives, sonographers and doulas (NHS, 2017). In addition to these professional roles (Figure 2), expectant mothers and their chosen birth partner(s) must also be considered as equally valid and influential roles within their own antenatal experiences. Due to the high number of both professional and non-professional roles within standard NHS antenatal care, the delivery of consistently high levels of care suitable to women's needs becomes complex. Whose opinion counts the most when opinions differ? Power imbalances within this healthcare system are rife (Hunter et al, 2017). Antenatal care professionals operate under a hierarchical system where obstetricians hold the most validity in their opinions over other professional roles (Hunter et al, 2017). All too often women are seen and treated as a singular, homogenous category of patients, whose pregnancy experience becomes one of being intervened upon (Hunter et al, 2017).

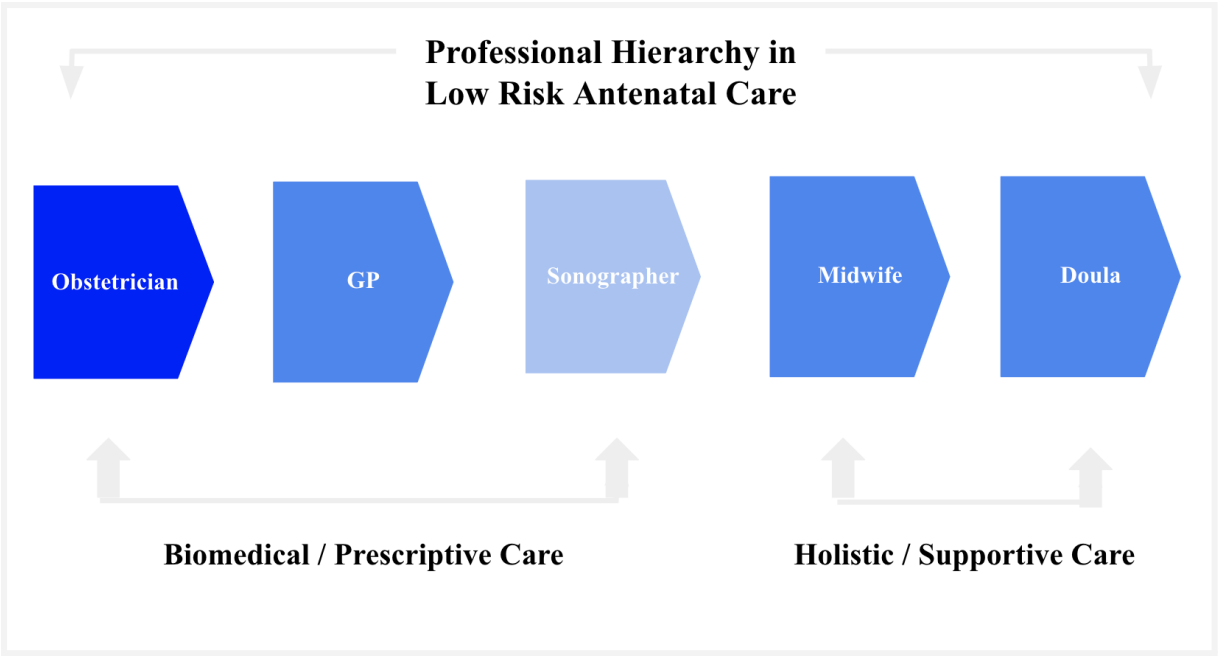

Figure 2: Own Image

These views are often underpinned by a belief in a biomedical view of health and fed by social norms that reinforce the fear of childbirth and a safety-first approach (Hunter et al, 2017). The biomedical viewpoint considers health to be solely the absence of illness (Humphrey, 2006). As much as safety is important and infant mortality rates have declined as a result of medical advancements, interventions have progressed from being used only when necessary, to being commonplace, to finally being routine procedure (Jansen et al, 2013). Research would indicate that for women in low-risk pregnancies, this unnecessary medical intervention increases the risk of both physical and emotional trauma to both mother and baby (Webb et al 2021; Gottvall et al, 2003). When applied appropriately, interventions can be life-saving. However, routine use of interventions without valid reasoning "can transform childbirth from a normal physiologic process and family life event into a medical or surgical procedure" (Jansen et al, 2013, p. 83). In the NHS, any woman in a low-risk pregnancy will be encouraged to accept an intervention to induce birth from 40 weeks gestation (Madeley, 2021). But, once a medical route to birth is initiated, this often leads to what is known as a

‘cascade of intervention’, where one action produces side effects requiring further, often riskier intervention measures (National Partnership for Women and Families, 2022).

Obstetricians

Obstetrics was originally the practice of the extraction of a baby during labour, in order to save a mother's life (Drife, 2002). Over the centuries, this practice has evolved to accommodate advancing techniques such as the introduction of forceps in the 17th century, by male midwives; the development of anaesthesia and caesarean section surgeries; and antibiotics and monitoring systems, such as ultrasound (Drife, 2002). Today, as trained medical doctors, obstetricians specialise in delivering babies and providing antenatal, parturition and postnatal medical treatment to women (Health Direct, 2022). Obstetricians have the skills to manage complex or high-risk pregnancies and births and can perform interventions and caesareans (Health Direct, 2022). This risk focus in obstetricians can make them more likely to apply high-risk interventions to low-risk pregnancies (Fox, Callander & Topp, 2019). The higher the socio-economic status of a woman, the more likely she is to experience an unnecessary medical intervention, increasing the likelihood of poor health outcomes for mother and baby (Fox et al, 2019). In recent years, caesarean sections have been increasing, and as of 2002 already accounted for over 20% of births in the UK (Drife, 2002).

This highly medicalised perspective of maternity care in obstetrics differs from more holistic views held by midwives and doulas. Resultantly, relationships between obstetricians and other antenatal care providers - midwives in particular - can be less about collaboration and more about conflict (Baldwin et al, 1992). The clinical disconnect between medicalised and holistic viewpoints on pregnancy and the birth process sees more medically aligned, hospital-trained nurse midwives favoured over more holistic midwives (Baldwin et al, 1992).

Holistic midwives are encouraged to forge better relationships with obstetricians through more hospital-based training, despite this being one-directional, and opposed to many women's preferences or needs (Baldwin et al, 1992).

Obstetrics is also a unique specialism within medical surgery. Where most surgical patients are usually unconscious for their medical procedures, women under the care of obstetricians are most often awake and able to recall their experiences of the procedure (Ennen & Satin, 2010). Obstetricians may lack an understanding of the distress caused to women as a result of caesarean section surgeries (Fenwick et al, 2002). Common causes of this distress include not feeling supported, having expectations violated, loss of control, the use of medical language, attitudes and care practices used by obstetricians, the cascade of interventions, and surgical birth separation of the baby from the mother (Fenwick et al, 2002).

The very nature of obstetrics monitoring and interventions can also impose upon women an unnatural and uncomfortable supine birth posture (Miller, 2019). Finally, in the UK (and many other Western countries) men dominate the obstetrics profession (Conrad et al, 2003). For women in their maternity care journey, this can represent a man as the ultimate power holder and decision-maker in their professional care hierarchy. This can be a source of discomfort, upset, frustration and resignation for women (Shabot, 2020). The embodied experience of pregnancy cannot be expected to be fully understood by cisgender men, regardless of their professional rank. Yet historically, women were considered intellectually inferior to men, excluding them from the practices of science and medicine that presumed to understand and support this feminine state (Davison, 2020). These feminised states of pregnancy and childbirth are central to prevailing societal beliefs about what it means to be a woman (Tavris, 1992). Despite this, biomedical constructions of women's bodies and

processes are pathologising, “particularly in its reproductive capacities” (Chadwick, 2006, p. 223).

GPs

The main role of the GP in low-risk antenatal care within the NHS is to coordinate the administration of routine procedures such as blood tests, vaccinations and monitoring, and to provide referrals to more specialised care if required (NHS, 2017). In the NHS healthcare system, however, GPs are not well integrated into overall antenatal care (Raine et al, 2010). GP interactions in antenatal care that are considered to be constructive for women include an empathetic conversation style, openness to answering questions, allowing time to sufficiently talk through concerns, and a proactive approach to communication, such as text message reminders for upcoming antenatal appointments (Raine et al, 2010). Unfortunately, most women do not experience this level of GP care within NHS antenatal care (Raine et al, 2010). As a result, some women become proactive in their own pursuit of antenatal care needs, while some withdraw and receive inadequate levels of support (Raine et al, 2010).

GP contact in low-risk antenatal care is often secondary to the community midwife (NHS, 2017). It is not uncommon for women to have only a single interaction with their GP throughout the course of their pregnancy (Smith et al, 2010). For women who may have access to increased GP support during pregnancy, there is no guarantee that they will have access to the same GP throughout their antenatal care programme (Jeffers & Baker, 2016). This lack of continuity in GP care increases the likelihood of unsatisfactory experiences and outcomes (Jeffers et al, 2016).

Sonographers

Sonographers are medically trained healthcare professionals, who use ultrasound technology to monitor health and diagnose conditions during pregnancy (Sholapurkar et al, 2021). At least two ultrasound scans are offered to women in the NHS antenatal care system during pregnancy (NHS, 2017). These scans are a key tool in determining risk levels in pregnancy (NHS, 2017). Women's interactions with sonographers are mixed. Ultrasound appointments can be reassuring for some and worrying for others (Bashour et al, 2005). For many women, sonographers provide comfort in the knowledge that their pregnancy is progressing healthily (Bashour et al, 2005). For others, the perception of excessive technology use can be a cause for concern (Bashour et al, 2005). There are also instances where health concerns may come to light through ultrasound scans and delivered to women directly by the sonographer. In such cases, it is important that sonographers have an awareness of the sensitive and emotional nature of this critical period with women when sharing information with them.

Midwives

In NHS antenatal care, midwives fall into two main categories: community midwives and hospital midwives (National Childbirthing Trust, 2022). Midwives are responsible for the care of women and their babies throughout the antenatal, parturition and postnatal periods in normal pregnancies (National Childbirthing Trust, 2022). The role of the community midwife is intended to provide a degree of continuity of care throughout antenatal and postnatal checkups, although they do not attend hospital births (National Childbirthing Trust, 2022). Hospital midwives are based in labour wards or consultant-led hospital units and provide parturition care for women (National Childbirthing Trust, 2022).

Despite the admirable goal of a multidisciplinary, collaborative team working together to provide women with the best antenatal care experience, the reality is that this is seldom achieved (Behruzi et al, 2017). Specific boundaries of responsibility between community and

hospital midwives, and indeed between other antenatal care professionals, represent barriers that limit the facilitation of continuous care plans for women (Behruzi et al, 2017). Not only is continuity in midwifery care the most desired antenatal care model requested by women, but it also provides the most convincing evidence for promoting improved outcomes for mothers and babies (O'Donohue, 2021). Beyond the mediating effects of the midwife-expectant mother relationship against poor birth outcomes, the advocacy for more natural birth positions in labour and birth is central to the holistic birth methods adopted by midwives (Miller, 2019). These positions advocate for women to adopt upright, forward and open stances to encourage gravity and mobility to aid in natural birth preparation and delivery (Miller, 2019). This positioning is in direct contrast to the medicalised positions for women in antenatal and parturition care adopted by obstetricians, GPs and sonographers (Miller, 2019). Although these two approaches to maternity care could be complementary, midwives are often marginalised within the professional division and encouraged to medicalise their approach to fit in with biomedical perspectives (Najmabadi et al, 2020).

The relationships between midwives and women are also more important for women compared to other professional care relationships (Griffith University, 2022). These relationships extend beyond the usual health professional-patient relationships, to include more private aspects such as physical, emotional and social understandings (Griffith University, 2022). In fact, women who receive continuity in their midwife care (the same midwife provides both their community antenatal appointments as well as hospital and aftercare) are 24% less likely to experience preterm birth, 19% less likely to miscarry the baby, 16% less likely to lose their baby at any stage of the maternity care process, and are less likely to receive medical intervention compared to women receiving medical-led or shared (part medical, part midwife) care (Sandall et al, 2015).

Doulas

A doula is a trained maternity care companion for women (Doula UK, 2022). In the UK, doulas are not particularly common, as they are not provided as part of NHS antenatal routine care. In the UK, doulas are predominantly privately employed or contracted by women to give them continuity in their maternity care journey (Doula UK, 2022). Doulas attend antenatal appointments with women, attend the labour and birth to advocate for women, and even provide support after the birth of the baby for as long as the mother feels is necessary. Although not required to be medically trained, doulas provide women with the supportive personalised care that is lacking when continuity in routine NHS antenatal care is lacking. Within the UK, doulas are becoming increasingly sought after by women, to bolster their NHS antenatal care with a private, familiar and trusted presence (Fearn, 2015).

Power Dynamics

Power imbalances in maternity care manifest themselves when shared decision-making is not prioritised (O'Brien et al, 2021). Women typically value remaining informed and being given a choice when it comes to their own maternity care (O'Brien et al, 2021). Equally important, however, is the continuity of the relationship that women have with their midwife (O'Brien et al, 2021). When one or both of these elements are lacking, women can lose trust, confidence and a sense of autonomy in their pregnancy experience (O'Brien et al, 2021). Powerlessness for women in their maternity care has been described as tantamount to abuse, for which both short and long-term consequences are likely (Van der Pijl et al, 2020). This specific type of abuse is referred to as obstetric violence (Pickles, 2017). Obstetric violence includes disrespectful and coercive treatment of pregnant women and impacts upon their "autonomy, human rights and sexual and reproductive health" (Pickles, 2017, p1). Chadwick (2017)

refers to obstetric violence as a relational, disciplinary, and productive process that impacts negatively on women's subjective experiences and self-efficacy during childbirth.

The impacts of power dynamics between professionals and women can be minimised or even averted when differing professional opinions and expertise are respected (Diorgu & George, 2021). This can include repositioning women as equal to and central within their own care. This stance adopts a more balanced status quo by informing information sharing through collaboration and empowering a more shared approach to decision-making. Unfortunately, imbalances of power are still rife in professional environments where obstetricians reign supreme (Hunter et al, 2017). When women's preferences and individual needs are subjugated to professional opinion, their voice and sense of control may be removed (Diorgu et al, 2021). A balance must be struck between safe medical practice and the control, voice, empowerment, and psychological safety of women. The vulnerability inherent to antenatal, parturition, and postnatal care renders the inappropriate handling of such care as gendered violence (Shabot, 2020). The historic dominance of the study and practice of medicine, and obstetrics specifically, over women indicates structural inequalities affecting women in their maternity care (Shabot, 2020).

Context: Historical, Cultural, Social

The gendered dominance of men in this highly vulnerable area of women's health is both historic and current. Prevailing care models are based upon popular medical opinion, which is still heavily influenced by men (Johanson et al, 2002). This continues to be so within Western obstetrics-led maternity care. What women view as trusted sources of information and as being most competent in providing their care is very much influenced by social, cultural, economic, historic, and familial influences (Bhugra, 2014). In this way, women have been, and continue to be, dictated to in their maternity care (Johanson et al, 2002). Those in

positions of greatest power are most often of a medical mindset and background and are most likely to be men (Shabot, 2020). A leading male obstetrician in the UK, Michel Odent, addressed the Royal College of Midwives to explain his position that birth partners should not attend childbirth (The Guardian, 2009). As a childbirth specialist, his position directly negates the findings of studies that suggest the role of the birth partner is important in providing emotional support through labour and birth (Simkin, 2010). Socially, however, men as birth partners have only become the norm in the past 100 years (The Guardian, 2009; Simkin, 2010). Odent goes on to say that

> "The ideal birth environment involves no men in general. Having been involved for more than 50 years in childbirths in homes and hospitals in France, England and Africa, the best environment I know for an easy birth is when there is nobody around the woman in labour apart from a silent, low-profile and experienced midwife – and no doctor and no husband, nobody else" (The Guardian, 2009, p. 1).

The contradictory nature of the information landscape can become complex. How can women know what to believe, who to trust, or which sources are valid when it comes to preparing for the best maternity care and outcomes possible? This is particularly relevant in the current era of digital and social media, antenatal groups, pregnancy forums and public health campaigns, where much of the advice shared is contradictory. Much of the problem stems from the dominant Western models of antenatal care being based upon normative values and standardised assumptions of what pregnancy should look like (Mayoh, 2018). Resistance to dominant discourses of what constitutes the perfect pregnancy, the need for change in how women embody these discourses (such as neoliberalism, medicine, and

hegemonic masculinity) and using the likes of social media to reshape these ideals, are suggestions for rebalancing the maternity care context for women in future (Mayoh, 2018).

Weight gain in pregnancy is an example of a contentious maternity care issue. Advice for how much weight gain is 'good' versus 'bad' can be contradictory. Social media can paint one picture of what healthy pregnancy weight gain looks like, while medical advice can paint another (Parker, 2017). Women are caught in the middle between conflicting sources of information and advice. Eating disorders during pregnancy are on the rise, a rise that is often attributed to striving for the perfect pregnancy body (Cardwell, 2013). At the heart of this issue is the assumption that there is a standard amount of weight that all women should aim for - not too little and not too much - beyond the recommendation (Parker, 2017). This assumption and the application of this one-size-fits-all model of normative and standardised values in maternity care is both unhelpful and unrealistic (Luce et al, 2016). This is not to say that all medical or standardised care structures must be discarded or completely discredited. It is to suggest that a more complex and integrated model of maternity care can help to balance and stabilise differing perspectives and levels of input (Implementing Better Births, 2017). Different medical backgrounds, cultural needs, individual risks, emotional support, and familial expectations of women could be better represented and catered to by moving away from such rigid care models.

Models of Care

All models of care are based on underlying values and attitudes that ultimately dictate the practice of care, but also how care systems are organised (Eri et al, 2020). The lack of an explicit epistemological stance serves as a less than desirable basis for maternity care knowledge sharing (Eri et al, 2020). Three key models that are based on an explicit epistemological stance are the scientific birth, person-centred care, and midwife-led

continuity of care models. Each represents a model that is practised in various parts of the world, and that represents different views on pregnancy, birth and healthcare (Eri et al, 2020).

The Scientific Birth

The scientific view of birth is based on the beliefs of the biomedical view of health and illness. This perspective views pregnancy and birth as illnesses requiring medical intervention (Neiterman, 2013). The human body and human health are essentially viewed as mechanical in nature (Neiterman, 2013). Successful pregnancy under this model of care is defined as the survival of the mother and baby (Neiterman, 2013). As a result of this mechanical and one-dimensional view of health, emotional influences on health are often ignored. Treatments and interventions fail to adequately consider the impacts of relationships and emotions on outcomes and experiences of care (Neiterman, 2013). This model of care is adopted by the scientific-leaning professionals within the NHS maternity system. Obstetricians, GP's and sonographers are the most common roles that women in need of maternity care come across in the UK that adopt this scientific perspective (Baldwin et al, 1992). Although they do not constitute the entirety of the maternity care professionals, other roles tend to have more holistic views of maternity health care, especially midwives and doulas (Baldwin et al, 1992).

Person-Centred Care

Person-centred care is focused on improving health in body and mind, as well as satisfaction with the care received (WHO, 2007). The person-centred care model centres the individual within the broader context of physical, social, economic, cultural and environmental factors that influence their health and wellness outcomes (WHO, 2007). Ultimately, it is about giving the patient's own perspective greater attention. Although person-centred care is applicable to all areas of medicine, health and well-being, within maternity care it advocates for giving

women a greater voice in determining their own needs. In practice, the person-centred care model aims to disrupt structural inequalities that favour scientific views over holistic views (WHO, 2007). Uniting professional standards bodies (such as The Royal College of Obstetricians & Gynaecologists with The Nursing and Midwifery Council) can aid in building professional rapport and respect. This is an exciting possibility for disruption that offers the possibility of improved maternity care services that empower women to determine their own care needs and experiences (WHO, 2007).

Midwife-Led Continuity of Care

The midwife-led continuity of care model is a person-centred care approach that goes a step further in also explicitly advocating for continuity of midwife care. This model is underpinned by a view of pregnancy and childbirth as natural processes, though appreciating there are some circumstances under which medical intervention is necessary. When used alongside adequate risk assessment criteria, the midwife-led continuity of care model is the most effective maternity care model - providing women with the best physical and emotional outcomes for both mother and baby (National Maternity Review, 2016).

Compared to other, more wholly medicalised roles within maternity care, midwives tend to hold a more holistic view of health that encompasses physical and emotional well-being. From this perspective, a successful pregnancy is defined as achieving positive outcomes for both mother and baby, both mentally and physically (Baptie et al, 2020). As a result of this view, an understanding and emphasis on building trusting relationships that go beyond the usual 'professional-patient' support, is central to this belief. Continuity of the primary maternity carer then becomes central in achieving this in practice. Not only do women want continuity in their antenatal midwife care (and person-centred models of care support this need), but midwives too would typically prefer to work alongside women in

providing them with continuous care (Evans et al, 2020). This model is already providing women with care continuity, within a person-centred model, in countries including New Zealand, Canada, and Australia (Sandall et al, 2015). As a model of maternity care, it is supported by the most evidence for success in physical and emotional outcomes in both mothers and babies, with the minimum of unnecessary, risky medical interventions (Sandall et al, 2015). Building up the workforce capability within the NHS to scale this solution over time then becomes the next logical step for putting this plan into action within the UK (Sandall et al, 2015).

Risk Levels in Pregnancy

The NHS has developed a structured system of assessment for determining risk categories in pregnancies. Three categories are used to identify high risk in pregnant women (NHS, 2016). These are current pregnancy risks, risk assessments from previous pregnancies (if applicable) and risks associated with certain (if applicable) long-term health conditions (Figure 3). The following attributes are used to determine if a woman is considered to be at high risk within the NHS maternity care service within her current pregnancy: multiple (e.g. twin) pregnancy, gestational diabetes, high blood pressure, low-lying placenta, raised body mass index (BMI), growth-restricted baby, breech baby, anaemia, infection, fluid retention or lack, early (pre-37 weeks) or late (post-40 weeks) onset of labour (NHS, 2016).

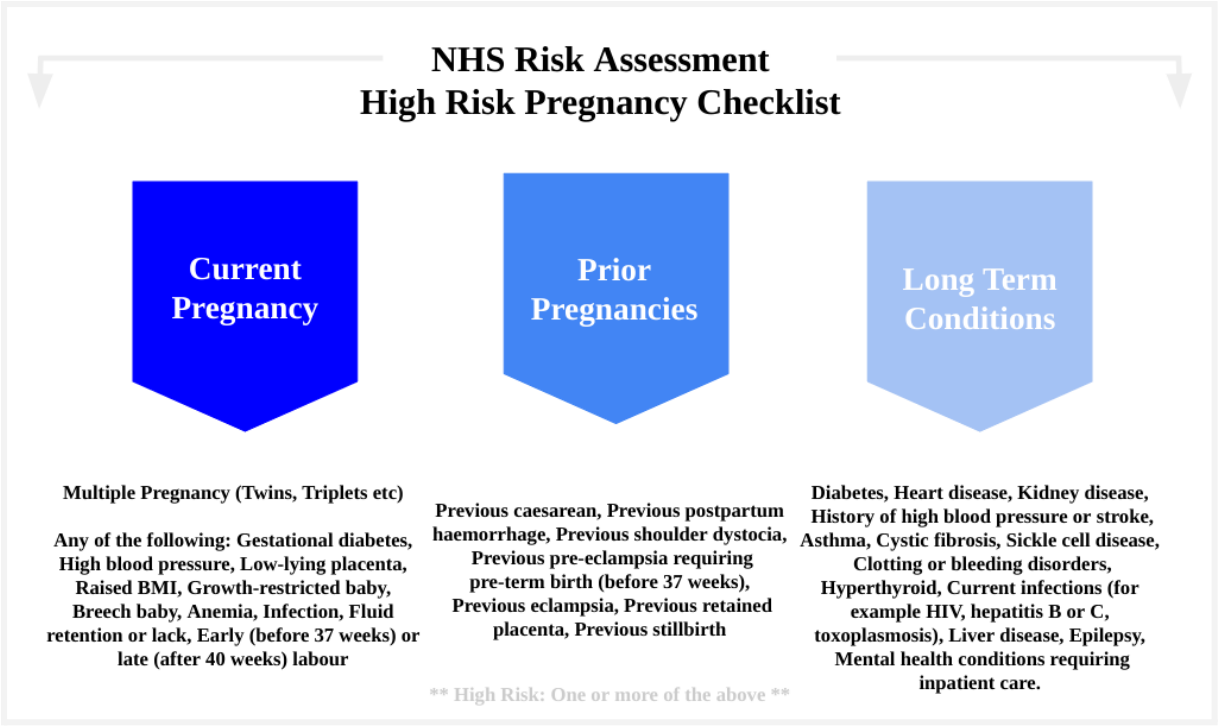

Figure 3: Own Image

Low risk is similarly defined. For women deemed as low-risk pregnancies, labour and birth are considered to be "generally very safe" for both mother and baby (NHS, 2016, p2). Low-risk categorisation not only involves the lack of any and all symptoms associated with high-risk pregnancies, but also the addition of several more criteria. These include being healthy and well throughout the pregnancy (antenatal checkups), with no known medical or obstetric conditions, no complications in prior births or pregnancies (if applicable), being pregnant with only one baby that is growing normally and is in a 'head down' position, the absence of developing new problems - such as waters being breaking for longer than 24 hours before labour, or being more than two weeks over your due date (NHS, 2016; Figure 4).

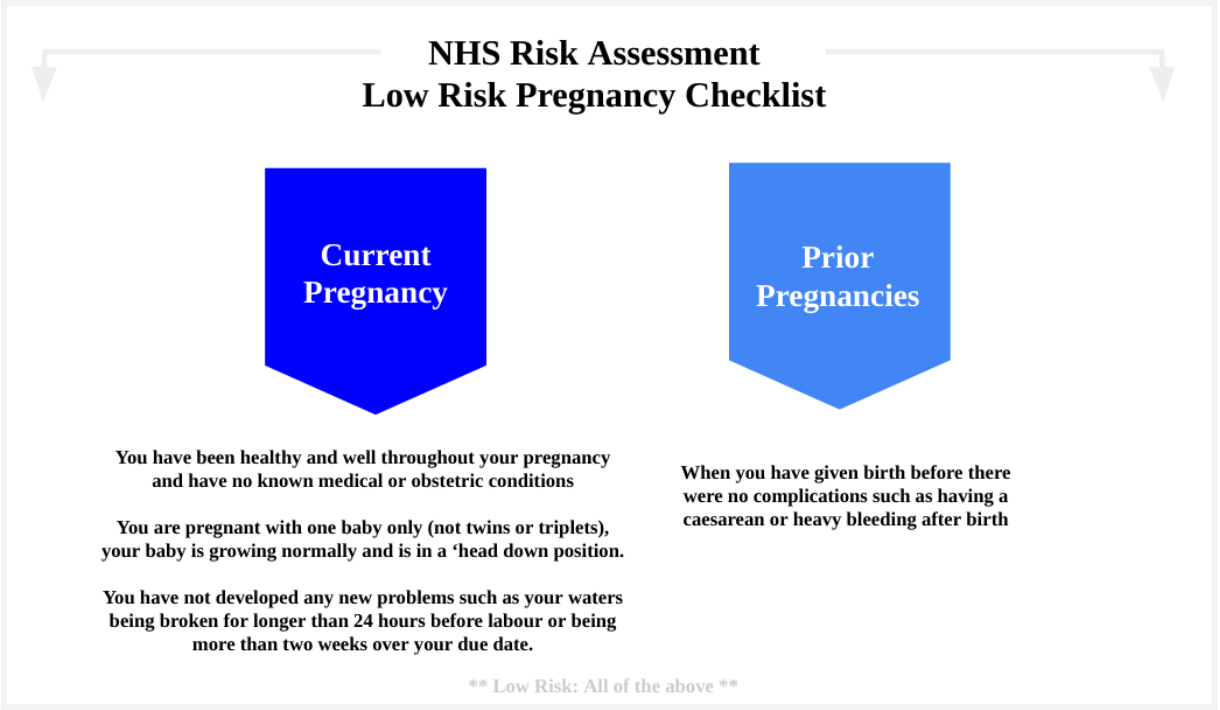

Figure 4: Own Image

Contextual Considerations

A variety of factors can influence women's expectations of care, which in turn influences their perceptions of how that care was provided, and their ultimate satisfaction levels as a result.

COVID-19

Governmental restrictions imposed highly controlled measures on how care within the NHS (and private care) was delivered during the COVID-19 pandemic. The impacts of the COVID-19 pandemic on maternity care were not just limited to pregnant women. Restrictions on birth partners prevented the majority of doulas and other birth partners from attending antenatal appointments, labour, and in some cases the birth itself, and imposing strict time restrictions on visitations after the birth (Black et al, 2020). Denying women this support network may even have a lasting negative impact on affected women (Black et al,

2020). Fear, resentment and a diminished sense of safety from the loss of birth partners were exacerbated further by the uncertainty and anxiety caused by the COVID-19 virus directly (Black et al, 2020). Despite the WHO insisting that women should have the continued right to a birth partner of their choice throughout the pandemic, within the NHS this advice was not heeded and this support was denied to most (Black et al, 2020).

Another impact of COVID-19 on women's experiences of maternity care was the ultra medicalisation of maternity care during this time. This was further exacerbated by the strains of low care staff levels, long shifts for care workers on shift and severe limitations on many medical supplies resources (Coxon et al, 2020). In many parts of the UK, homebirths were removed as an option for women due to low staff levels (Romanis & Nelson, 2020). Women were required to give birth in more medicalised settings, or risk a homebirth without professional assistance or the guarantee of an emergency ambulance transfer if required (Coxon et al, 2020). COVID-19 restrictions also prevented women from familiarisation tours of their hospital labour ward or birth centre prior to birth (Coxon et al, 2020). As a result of these restrictions on birth partners, place of birth, and physical restrictions (e.g. mask-wearing, social distancing, time limitations to visits) many women attempted to delay their transfer to the hospital as far into labour as possible (Aydin et al, 2022). Restrictions during COVID-19 diminished the already limited freedoms of choice for women in this unique period of care (Romanis et al, 2020). What was already an imbalance of power between medical professionals and women resulted in an even greater divide. Policies implemented quickly for the purposes of safeguarding care professionals and women alike often left women feeling intimidated, isolated and poorly communicated with (Black et al, 2020).

Prior Pregnancy

Women receiving maternity care have a multitude of backgrounds and experiences relating to pregnancy. For some, it might be their first experience of pregnancy and maternity care. For others, they may have had successful pregnancies and births in the past, and are adding to their family. For other women, the process can be much more complex. The impacts of prior failed pregnancies, miscarriages, chemical pregnancies, stillbirths or even the loss of a child can all affect anticipations, expectations and perceptions of care (Lamb, 2002). Other women may have had fertility issues leading to pregnancy and have endured medicalised procedures such as IVF to even get to the point of receiving maternity care. So for some, antenatal care is a new beginning. For others, it is a more familiar path. Past experiences influence our perspectives, and impressions and expectations around what to expect from care providers can be impacted as a result. It is also worth considering if care providers perceive subsequent pregnancies for women as requiring less attention or special handling.

Poor Care Relationships

Midwives represent the primary professional carer in 98% of cases, for women experiencing antenatal care in the UK (Quality Care Commission, 2013). Research suggests that midwives take a more holistic approach to maternity care compared to the more medicalised approaches of other maternity care professionals, such as obstetricians (Miller, 2019; Fox et al, 2019). Midwives are seen as more nurturing and are the preferred option for most women (O'Donohue, 2021). Continuity of this midwifery care provides additional benefits to women by buffering against poor health outcomes for both mother and baby, through strengthened relationships (O'Donohue, 2021). These relationships establish trust in the care team for pregnant women, as well as help to build a sense of trust and advocacy between women and midwives (O'Brien et al, 2021). In some cases, however, women and their allocated midwives may not (for whatever reason) be able to form a positive relationship. In these

instances, persevering with an unsuited relationship can be damaging - causing women to engage less with their care (Rayment-Jones et al, 2020). It is important that in advocating for person-centred care within maternity care in the NHS, support for continuity in midwife care is balanced with clear systems and procedures for both care professionals and women to follow, should this situation arise. Women should be able to request a change in midwife easily and without fear of retaliation or offence.

Summary

Antenatal care systems of the future must not only save lives, but also improve them through the avoidance of negative outcomes, and the promotion of positive ones (WHO, 2016). Three factors are regularly cited in the literature as being critical in influencing how antenatal care is experienced. These factors are relationships, continuity of care and expectations of care (Dahlberg et al, 2013; Freeman et al, 2010; Galle et al, 2015; Sandall et al, 2015). The ultimate maternity care framework within the NHS would be a midwife-led continuity of care model. This supports a person-centred focus on care, ensuring women are given the validity, control, respect and voice they deserve in their care experiences. Power balances within maternity care must also be considered and addressed when determining who dictates a path of care, especially when professional opinions are conflicted. Risk in pregnancy must also be factored in alongside considerations of maternity care, and how the balance of control may shift to support necessary paths of care in high-risk categories. Women's experiences of the current maternity care system in the NHS must be understood and acknowledged as the starting point of this journey, in order to gauge the effects of the experiences that current systems are imposing upon childbearing women. The current research aims to explore further how the perceptions of continuity of antenatal care can influence women's experiences of pregnancy within the NHS system of care.

Chapter Two - Methodology

Reflexivity Statement

As a first-time mother to a new baby boy, I have recent lived experience of maternity care within the NHS. Having grown up in New Zealand, my knowledge of maternity care was based on the Plunket continuity of care model in New Zealand. In this maternity care system, there is a high level of midwife continuity across antenatal, parturition and postnatal care components (Clemons et al, 2021). Living in the UK throughout my pregnancy and subsequent childbirth, my expectations of the NHS were based upon this familiar knowledge of the Plunket system. I presumed that the NHS would provide me with continuity of midwife care throughout my maternity journey, but I was to be disappointed. I had two community midwives in my antenatal appointments and during induction, labour and birth I saw over 20 different professionals, including midwives, nurses and consultant obstetricians. I found this lack of consistency in care incredibly distressing. Building a relationship with my community midwife was in many senses pointless, as I knew she would not be there with me for the labour. I believe this expectation set me up for disappointment in my maternity care with the NHS and it is the reason behind my interest in this research.

I wanted to explore other women's perceptions of antenatal care within the NHS and understand what their expectations and emotional experiences were from these interactions. As a researcher with this recent lived experience on this topic, I am both a member of this group, as well as a commentator. This gave me a deep understanding of the subject matter when talking to participants as well as an empathy that can only be understood through lived experience. It also creates the potential for me to interpret participants' maternity experiences and narratives through my own experiential lens. I was conscious of my own position as a researcher as an influence on participants and was careful in my research not to presume participants' experiences were the same as my own. I was also aware of the potential for

these to be sensitive and emotional experiences for participants in what is still a very male-dominated care model. It was important for me to provide participants with the comfort of familiar surroundings by conducting interviews online, in an environment of their own choosing. It also aided in building trust and credibility in the participant-researcher relationship. Every participant's maternity journey is unique. It is the product of a specific set of past and present experiences, beliefs, expectations and assumptions. The subsequent data collection and analysis are my own reflection of these subjective reports from participants. I have attempted to mitigate and minimise my influence on this research throughout the data collection and analysis, which is detailed further on in this chapter. I opted for a qualitative approach to the research using semi-structured interviews and feminist theory to accommodate deeper depth and meaning of women's antenatal experiences. It was essential to provide scope for participants to incorporate their own beliefs and feelings into their responses and not to limit them with a more rigid quantitative approach. Overall, the aim of the research was to explore the perceptions of continuity in antenatal care amongst low-risk women and how this care influences women's experiences of pregnancy in the NHS.

Procedure

As the primary researcher, it was my responsibility to ensure that participants were able to share what they wanted in ways that worked for them. As I was involved in every stage of the research process, it was vital to ensure that ethical guidelines were adhered to, ensuring the well-being of participants, and myself, to minimise any potential harm. My observations and interpretations become pivotal to the findings and implications of the research. In accordance with the ethics protocols expected by Massey University, I conducted my research under the close and constant supervision of my supervisor Dr Andrea LaMarre. I was conscious of my responsibilities to be ethical in how I conducted my research procedures, how these ethical

guidelines translated into practice, and also how I conducted myself personally in my interactions and communications with participants.

Procedurally, Massey University's ethics protocols dictated a comprehensive set of requirements for gaining ethical approval. This involved the justification for conducting my research, as well as for the selection of recruitment channels and participants. It also included the detailing and approval of communications to participants such as informed consent, transcript releases and interview guides. Benefits and risks to participants and researchers, as well as support requirements and cultural sensitivities, were also recognised, considered and documented. Ethical approval was granted by the Massey University Ethics Committee (protocol NOR22/11) prior to the research commencing.

Practically, I aimed to deliver on my responsibilities by adhering to the ethical requirements aforementioned when conducting this research. This included treating all participant data confidentially. This included the treatment of all data throughout the research process - from transcriptions to the encrypted storage of information. Informed consent was required from each participant at the outset of the research, which involved reading and signing the information sheet. I provided the opportunity to review transcripts to all participants, and the expectation of confidentiality was also provided to all participants involved in the research. I conducted interviews via Zoom, manually transcribed them, anonymising identifying information as I went along and stored these securely on a password-protected computer. Understanding my influence as a researcher on the collection and analysis of data was also an ethical responsibility. It was a conscious decision to ensure that my understanding of qualitative procedures (conducting semi-structured interviews and reflexive thematic analysis) was well-researched and understood in advance of engaging in any data collection or analysis.

Personally, I strived for my interactions with participants to be respectful, empathetic, and timely. To minimise my own influence on participants' responses to the interview questions, I made sure to give each participant the space to answer each question fully, before either moving to the next question, commenting or asking for clarification. I remained flexible to fit around participants' needs, particularly work commitments and childcare. I also provided assistance whenever technical difficulties arose in conducting the interviews themselves. Whenever in doubt, I would ensure my decisions were reviewed by my research supervisor, Dr Andrea La Marre.

Sampling & Selection

The National Childbirthing Trust (NCT), a charitable organisation for pregnancy, childbirth and antenatal education in the UK was the recruitment channel I used for selecting participants for this research. As the NCT is available to all women throughout the UK regardless of geographical location, age and residency status, it offered a large and diverse pool from which to recruit participants. Recruitment flyers were provided to prospective women through an NCT staff member, who ran antenatal courses for women. This flyer detailed the inclusion criteria for participants. These included identifying as a woman and being an adult (18+). Participants also had to have experienced a low-risk pregnancy within 24 months of participating in the research. My contact details as a lead researcher, my research supervisor's contact details and the ethics committee approval reference number and contact details were also provided on this information sheet.

Six women were recruited from the National Childbirthing Trust. Though each participant in the sample met the inclusion criteria, it was not intended to be representative of the wider British population. The participants in this sample were all from the East and South East of England. The sample size of the study was guided by the concept of ‘information

power', whereby the more rich and more detailed the data collection, the fewer participants are required (Malterud et al, 2015). Through a semi-structured interview style, I was able to provide participants the space to discuss the topics that were most important and relevant to them, whilst also ensuring the conversation centred around the overall theme of antenatal care. Participants were provided with an information sheet, informed consent, and transcript release sheets to read. I checked their understanding and invited questions, after which participants were required to sign and return to me as the lead researcher. Two women who did not meet all of the inclusion criteria were excluded from the sample and study at the outset (from an initial participant pool of eight). I discussed their interest in participating in the study with them individually and detailed the requirements for participants and the reasoning behind it. They were both understanding about why the study was not a good fit.

Method

Interviews were scheduled via email with each participant, for a time and date that suited them. These were confirmed via an electronic calendar invite, containing the Zoom link for the online interview. An email reminder was sent out in the week prior to each interview.

Interviews were conducted using the online conference software Zoom, which also allowed for each interview to be recorded. Using semi-structured interviews, I asked each participant 24 questions relating to their antenatal care experiences. Each interview followed the same order of questioning, in accordance with the interview guide (see Appendix 3). These began with introductory questions to help familiarise participants with the process and to ensure they were comfortable with the exercise. Participants were each reminded of their ability and right to stop the interview at any time without consequence. Each of the six participants completed the interview in its entirety.

Each call began as an unrecorded video call, where we warmed up the conversation with an introductory exchange, reiterating the background of the research, the participants' rights to stop the interview at any time, and that the interview would be recorded. Once agreement was reached, the recording was started and the interview guide was used to navigate each interview in the same order and covering the same questions for each participant. I was sure to allow space for participants to answer each question fully before commenting, or moving on to the next question. I wanted to ensure that participants' answers were not guided by my own commentary, nor cut short by assumptions on my part that the question had been fully answered. When in doubt, I would check with the participant first if they had anything else further to add, before moving on to the next question. Throughout the interviews, I would provide participants with an update on progress, such as 'we are now on the second-to-last section of the interview, with five questions to go' in order to maintain focus and motivation toward the end of the interview.

There were occasions when participants became upset recalling a traumatic event or memory. In these instances, I made the participant aware that I was understanding, supportive, able to stop the recording and the interview, and would be happy to take their lead on whatever they needed. In all cases, participants were happy to proceed after being given a moment to gather themselves, and often explained why they were emotionally triggered. All participants mentioned the emotional nature of pregnancy and birth, especially as each participant had been a first-time mother with the pregnancy discussed in these interviews. In many cases, it had been the most that they had discussed their pregnancy experiences with anyone outside their marriage or immediate family circle. Once all of the questions were concluded for each interview, the recording ended. The conversation was ended by answering any further questions the participants might have had, thanking each participant for their time

and honesty in sharing such a personal experience, and that as a ‘thank you’ they would receive a £20 Amazon gift card via email.

Data

All the data was collected between June 2022 and July 2022. Minor technical challenges arose for the majority of participants. There were also a number of occasions where participants were required to reschedule or, forgot to attend the scheduled meeting altogether. I maintained contact with participants in these instances to reschedule the meetings at the next available opportunity.

Each interview took approximately one hour per participant to complete. Individual digital files were also stored securely within privacy-protected and encrypted folders. Participants were all given the option to review their transcripts prior to analysis, although none elected to do this. At the completion of the interviews, the honorarium gift cards were sent to participants by email.

Data Analysis

I analysed the data using reflexive thematic analysis. This method is consistent with the research questions, as well as my constructionist and feminist underpinnings of the research. As a framework for conducting the analysis, I was guided by Braun & Clarke (2006). This process began with manually transcribing each interview. Listening back to interview recordings allowed me to ensure that participants' accounts were captured accurately in each transcription. Where necessary, I noted non-verbal responses such as crying, to ensure that the intensity of the response was remembered. Several coding stages followed the transcription of the interviews. For each stage of analysis, I used a separate document, so that I could always refer back to earlier iterations. The first stage involved active reading and

re-reading of each interview transcription and constant note-taking throughout the process, to ensure that I was deeply familiar and focused on each account. I also used a colour coding system for each of the participants when it came to collating the information from the interviews.

After transcription and familiarisation, I then began with the first level of coding, which aimed to generate initial codes for each data item. This involved writing descriptive codes for each sentence of each interview, systematically throughout each participant account. This first stage of coding was less about the reduction in volume and more about ensuring all key dialogue was retained to allow for the best comparison of trends across participants. These initial and highly descriptive codes were then used to group together codes that related to others. For example, codes that related closely to another would form one category, and codes that did not relate would form a separate category. It became obvious very quickly that high levels of description were required at this level of coding to retain the content in which each participant was relating to a topic. For example, 'COVID-19' would be insufficient as a descriptive code, because it would not explain once the data was collated from several sources what the perspective on COVID-19 was - or if it was positive or negative. I thus needed to be far more descriptive - such as coding 'COVID-19 preventing birth partner to ultrasound scans'. Where participant accounts would contradict themselves, I would leave in both accounts and count them equally in the coding process, so as to ensure I was not unconsciously favouring one view unfairly over another. The colour coding was also extremely helpful at this stage, and throughout the course of the analysis, in identifying where each code or theme had come from. Being aware of my own perspectives on the research subject, I was very particular in coding each interview and segment equally, to the best of my ability. I did not consciously omit details from any interview under the assumption that they lacked importance or relevance. Over 24 pages of codes were recorded.

The second level of analysis involved consideration of how to retain the diversity of the first coding, whilst condensing the dialogue content down into higher-level sub-themes. The research question informed this process. In this coding stage, I started to condense the volume of the dialogue down to gain a level of specificity, whilst also retaining individual distinction. Searching for the initial themes from these descriptive codes involved collating all of the descriptive codes from each data item into a data set, the combined body of data from all participant interviews. Of the 24 pages of descriptive codes, I created 45 initial themes. Each descriptive code fit into one of these initial themes (no miscellaneous category was used). On occasion, I was in doubt as to where best to put a descriptive code if there were two or more potential possibilities in the initial themes. In these instances, I would put the code under both themes, so as to keep the analysis as broad as possible and not omit any possibilities. I then took these into consideration further on in the analysis. This is where the colour coding became particularly useful, in identifying patterns across participants. It became straightforward to measure the overall prevalence of a particular theme by assessing the colour scheme of each theme. Due to the volume of descriptive codes, this coding system helped a great deal in organising large quantities of data into more manageable themes. I began by initially sorting descriptive codes into columns of similarity. I then began to look at how these columns might be named, and how these related to other columns. From here it was useful to engage a visual aid. I used hand-drawn mind maps to visualise how themes related to one another or overlapped. I used these sketches to create digital mind maps where I could easily drag and drop codes and themes.

Once these initial themes were identified, I conducted a review of the themes in several stages. I found it useful to dedicate large periods of time to the analysis in order to retain focus and understanding of the data at hand. When this was not possible, I re-read the

transcriptions, descriptive coding, initial themes and mind maps over again, to refamiliarise myself if a particular session of analysis ended before I had completed a full data item. I used the colour coding for each participant to calculate prevalence for each code and each theme. This allowed me to pragmatically manage themes and retain the context of important information in relation to the research question, such as particularly emotional responses, in order to more clearly conceptualise my thoughts. I also considered the importance of particularly emotional responses, such as changes to patterns of conversation (e.g. greater detail given in answers, visible upset or emotion). As a researcher, it ultimately came down to my own interpretation and discretion of this weighting as to which key themes were represented as the most important. I aimed to ensure that data themes were not directly linked to the interview questions, to ensure that the analysis was as open-minded with respect to the research agenda as possible.

While prevalence was not the only determining factor in creating themes, key themes were identified where prevalence was relatively high when compared to other themes. Negative sentiments around induction, for example, was mentioned by five out of six participants, compared to 'not wanting to be a bother', which was referenced by one out of six participants. I used these rates to rank each theme in order of importance, which was straightforward for the most part. Some themes were discarded as there was not enough data to support them, or they were too diverse to be a key theme (e.g. COVID-19). Some eventually converged as analysis progressed. I found it useful to keep sub-themes underneath the key themes, particularly on the mind map as a visual aid to retain context and meaning for the key themes identified. A difficulty I had was some of the sub-themes overlapping between key themes. They did not all fit neatly under one single column in every instance. After much back and forth, I decided to keep them under both theme columns, because I

believe that they tell the full story in this way, and to restrict them to a single column for the purposes of a simpler end report would be a misrepresentation of the data.

Defining each theme and naming it accurately was the next step in the process. Theme interpretation was not just achieved at the explicit level - i.e. participants relating the descriptive code to the theme. It involved reading between the lines, particularly with respect to underlying causes. It involved a description of the data and an interpretation of the underlying cause behind the themes. Themes were also referred to in different ways by different participants. A particularly passionate response for example was noted in the analysis.

Initially, I defined each theme too broadly - the titles were too long-winded and descriptive. Under the recommendations of my research supervisor, I shortened these to be much more concise. However, I went too far the other way and made them too short. ‘Communication’, ‘induction’ and ‘consistent midwife’ do not really give enough detail or context to a reader that has not had access to the raw data in the way that I have as the researcher. Defining and naming the themes to a point where I was satisfied they reflected the data fairly required a little bit of back and forth to strike a balance between description and brevity. Each definition clearly summarised what the theme itself was about. I reviewed these themes prior to defining and naming them. I applied my own judgement to the identification and naming of themes in relation to the research. For example, all six participants referenced COVID-19 in their interviews, each at several stages, but COVID-19 was not considered to be a key theme relating to antenatal experiences more broadly, but a through-thread that holds relevance within all of the other key themes. I made sure to compare the finalised theme map back to the data set and descriptive codes to ensure that they reflected accurately. I re-read the original transcriptions to ensure that nothing was inadvertently missed. Once these themes

were finalized, as well as reviewed by my research supervisor, I began the final write-up of the findings.

Three key themes developed relating to women's antenatal care experiences. These included the impacts of poor communication; the impacts of not being heard; and fear of the unknown. Together these themes explore women's experiences of how pregnancy care factors can influence perspectives and experiences of pregnancy and birth.

Research Positioning

My ontological positioning was aligned with a social constructionist perspective, similar to the work of Parratt & Fahy (2011), by also focusing on the importance of individualised accounts of pregnancy and childbirth, compared to more commonly referenced normative models. As a researcher, my stance is one that understands people's perceptions, attitudes and beliefs to be influenced and shaped by social norms. Who and what we are exposed to, as where and when we are situated alter and influence what we know to be true. In the context of this research, I expect participants' experiences of antenatal care to be influenced by their perceptions of that care. Participants perceiving care to be superior would more likely report a positive experience in their care. But, I would argue that these perceptions and experiences were influenced by the participants' pre-conceived notions and expectations of that care based on a variety of subjective factors (personal history of care, peer influence on expectations etc). In this way, another researcher from a different ontological viewpoint could potentially (even likely) view the results in a different way.

This social framing of the research recognises the role of community as a contributor to knowledge (Kusch, 2022). This social constructionist position would suggest that women's knowledge of pregnancy and childbirth is defined in part by society. I believe the influence of

family, friends, peers and topical and social media play a part in establishing expectations of these experiences for women in advance of them 'knowing' it for themselves.

Within the broader frame of social constructionism, I also took a feminist theoretical lens on the work. Feminist theory also aims to understand gender inequality and this focuses on gender politics, power relations, and sexuality (Crossman, 2020). It provides a critical perspective of social and political influences on women, whilst promoting the rights and interests of women (Crossman, 2020). Feminist theory provided the opportunity to challenge dominant medical discourses within antenatal care by giving women the opportunity to detail and share their perspectives and personal experiences of care. Maternity care in the UK and much of the current literature on the topic of maternity care represent and promote a medicalised viewpoint. Feminist theory also challenges the gendered dominance of men within the medical profession, including within obstetrics (Risberg et al, 2009). By adopting a feminist viewpoint, I aimed to provide an alternative insight into the topic of maternity care experiences of women in the UK. Because the experiences are voiced by women directly, the research aims to empower to women by adopting a feminist approach. By putting women at the centre of their own care conversations, power is put back into their hands. The subjective experiences of women are captured in this research in their own words and collated into key themes after a process of deep analysis.

Budget

This project was not funded externally. The Postgraduate Research Fund contributed to the honoraria gift cards (£20 per participant).

Summary

I have recent lived experience of NHS antenatal care, and knowledge of arguably more

successful comparable antenatal systems in other countries. I was drawn to the research topic from this position of personal interest, and as such identified as both a member and commentator of this group. I recruited six participants from the NCT and conducted semi-structured interviews with participants online, via recorded Zoom calls. The recordings allowed me to transcribe participants' interviews, and these transcriptions were the basis for the coding of my reflexive thematic analysis of the data. I identified three key themes in the analysis - the impacts of not being heard; the impacts of poor communication; and fear of the unknown. I approached the research and analysis from a social constructionist perspective, and applied a feminist theoretical framework.

Chapter Three - Results

3.1 Overview

3.2 Summary of Findings

3.3 Impacts of Not Being Heard

3.4 Impacts of Poor Communication

3.5 Fear of the Unknown

3.6 Results Summary

Overview

Participants were all first-time mothers aged between 37 and 39 years old. Geographically, they were located in the South and East of England. They were all members of the NCT and had completed their antenatal educational classes delivered by the Trust. Women all identified as British. Participants all spoke very positively about their overall experiences of pregnancy. They all expressed how their body confidence had grown, and how, with morning sickness and fatigue aside, pregnancy had been an enjoyable experience. Despite experiencing their own unique challenges within their antenatal journeys, there were some commonalities in their shared accounts.

Participant Pseudonym	Age	Ethnicity	# Children	Location
"Abbie"	38	British	1	London
"Amelia"	37	British	1	London
"Brooke"	37	British	1	Margate
"Denise"	39	British	1	Hinchingbrooke
"Naomi"	38	British	1	Ashford
"Rose"	39	British	1	Margate

Table 1. Summary of Participants

Of the interviews I shared with the participants and throughout the process of analysis, three key themes stood out to me as I interpreted the data. These included not being listened to, followed by issues with communication, and fear of the unknown in pregnancy, antenatal care and around the topic of miscarriage. There were also a number of aspects of

that were part of the overall key themes. I have provided an overview of the key themes and key aspects in a thematic map (Figure 5).

Summary of Findings

Figure 5. Key Themes and Theme Aspects

Impacts of Not Being Heard

Most of the participants reflected a sense of not being heard during their antenatal care. This was reflected in their lack of choice in the direction their care was taking, their birth choices not being honoured, and feeling pressured into accepting interventions that they were not comfortable with - most notably the induction of labour. Most women shared that information about their birth options, particularly about inductions, was not provided early enough in the antenatal journey. In most cases, the conversation around induction only occurred in the lead-up to labour itself, causing participants stress, a sense of urgency in having to make an uninformed and quick decision, and unnecessary added pressure in an already pressurised

situation. Participants had not been given the time to familiarise themselves with information about inductions, nor given the space to make informed decisions based on their own preferences. Most participants also shared that information on inductions was not presented to them as a clear choice but as an instruction. This highlighted to me the importance for the 'cascade of interventions' to be explained and made clearer so that women can fully understand their choices and the consequences of these choices. The negative sentiment felt by women around inductions was mentioned by five out of six participants. I also sensed a great deal of emotion in participants' discussions of this topic. It roused responses that were more charged than many other talking points in the interviews. Responses were more passionate and more detailed compared to responses to other aspects of the interview. Some of the participants explained their anger and frustrations, and others their upset and stress. For instance, Abbie shared:

> "Towards the end, when I didn't want the induction, that was pretty difficult. I had to like, negotiate with them not to have an induction. And they were not, just not very positive. They have to say what the research says. I did a lot of research on it myself. And it's quite old research that they have, but I know what they're trying to do. They're just trying to keep everyone safe. And so they have to kind of say that, but it was quite difficult too. And it was a little bit upsetting because they were like, you know, you're gonna put your baby in danger if you don't do this induction. And I was like, I don't want it. And I've read other research, which says that that's not the case. So yeah, that was a bit stressful. And I didn't particularly feel heard at that point." *Abbie.*

This quote from Abbie illustrates the extent to which she needed to take the lead in knowing her options and advocating for herself, which was emotionally exhausting for her. She shared how she did not feel heard within a situation where risk was the primary topic of conversation, illustrating how power dynamics can serve to minimise the voices of women in these kinds of healthcare interactions. While she is sympathetic to the health care providers' reasons ("I know what they're trying to do") she still described the situation as difficult and conflicting with her research. Although within the NHS, the final induction decision rests with the mother (except in the case of emergencies), if women are not made aware of this fact, they can be easily pressured into accepting interventions without adequate explanation or justification. Abbie also describes the difficult balancing act for her between respecting the experience and knowledge of the medical professionals and advocating for herself and her own personal needs and choices.

Birth plans can be a useful tool for women to ensure that their preferences are understood and they are heard in their care experience. Of the participants who mentioned birth plans for their labour and in the lead-up to birth, none of them had been advised or recommended to make a birth plan by their antenatal care team. Participants recalled that pre-knowledge of the benefits of a birth plan and of induction preparation was usually provided by a friend, family member or external training provider such as the NCT. Encouraging the use of a birth plan could be an introduction to this conversation between midwives and women during their first trimester within the NHS. Planning for birth and understanding the options for birth can be a very important aspect of preparing for labour and delivery for women and to ensure that their needs are heard. In encouraging women to prepare a birth plan, an awareness of this planning phase is created, as well as a natural lead into the conversation around induction of labour. Birth plans can provide an opportunity for a more balanced approach to power-sharing, by enabling women to feel a sense of

preparedness and control over their own care. It gives an opportunity for both women and care professionals alike to feel confident that care decisions are made that respect women's choices, and make them feel heard. Pregnancy, labour and birth can be very emotional and personal experiences for women, but for care providers who have seen it all before, there is the potential for women's individual needs with respect to birth plans to be overlooked.

> "It wasn't until, you know, I spoke to my sister that I found out I could have a second sweep. So obviously, that was more appealing than having a pessary which, you know, that in itself is a kind of chemical thing that is kind of, you know, one step away from the natural birth that, you know, it's against the kind of, yeah, the natural way of birthing. And that moment is the most crucial part of the whole experience. I think had I not had that external advice, which should have come from the NHS, but it came from, you know, a sibling, I would have possibly not had the birth that I wanted. If the person I saw towards the end of my care had been more aware of the type of birth I was having, then maybe they would have been more cognizant about, you know, my reluctance for inductions. That probably comes down to like, a sort of continuity of care. Maybe they would have sort of explained other options to me a bit better if there had been more continuity in those kind of final stages, then that probably would have improved things." *Amelia.*

This quote from Amelia illustrates the importance of feeling heard about her birth choices and for her preference for a natural birth. Seeking induction advice from a sibling over her NHS care provider demonstrates the importance that she placed on trusting the information provided to her in order to feel comfortable making her own informed decisions on care. Many of the participants referenced the importance they placed on their care

provider understanding their histories and stories. In a system with little to no continuity in the care provided to women, the impact on relationship development may lessen the ability for trust and rapport to flourish between women and care providers. Amelia also explicitly described the impact that this lack of continuity caused her in having to defend her reluctance to induce birth. Had she been supported by a familiar and trusted midwife who understood her history and story, there could have been a greater understanding and respect for her care choices. This is one example of how a person-centred care model can benefit women in their antenatal care, by understanding and respecting women's personal needs and desire for involvement in their own care.

Induction also dictates the location of labour and birth. Five out of six participants had discussed wanting a natural birth in a birth centre, and all five were very distressed when this option was taken away from them. Because inducing labour requires medicating women with synthetic hormones, close monitoring of both mother and baby is required. The birth location then becomes not a choice but a directive - one of giving birth in a hospital labour ward with a high level of medical observation and intervention.

> "I sort of felt like when it came to inductions, it was like, right, you know, you've hit this time, and so this is the procedure now, rather than you have a choice" *Amelia.*

Amelia describes the lack of choice in her situation of feeling pressured into an induction. This demonstrates the negative impact of the unbalanced power dynamic within the care system. The medicalised and masculine view of birth, often dictating high levels of intervention and monitoring, can feel dominant and imposing for women. She describes her lack of involvement in her own care by having this decision dictated to her, rather than explained, adequately justified or reached by her own decision-making. The scientific model

of birth applied by the care team in this scenario provided an unsatisfactory emotional experience for Amelia in this case. A shared complaint of participants across the interviews was the sense of not being listened to by their care providers.

Impacts of Poor Communication

All six participants referenced their frustrations with poor communication. Poor communication was described in several ways, including poor communication of care plans from the outset of early antenatal care (e.g. a lack of visibility for women on what to expect throughout the process), little or no communication within care teams (e.g. deficient handovers between departments or individual members of staff), insufficient communication around upcoming appointments (e.g. inadequate notice given to attend appointments; letters to attend an appointment being lost in the post) and an absence of tailored communication (e.g. feeling they were being treated as a number and not as an individual in tick-box exercises).

Participants discussed the need to regularly repeat themselves to care providers, despite their case notes being made available to these providers. Despite the challenges they identified around communication, participants also all recognised the scale of the job faced by the NHS in delivering maternity care to women across the UK. Participants were all very grateful and thankful for the NHS and understood that resources were limited; their frustrations could thus be interpreted as related to systemic constraints, rather than individual care providers. What care providers *could* do, though, according to participants, was communicate more clearly about why decisions about their individual care plans were made in the context of resource shortages. They commonly mentioned that they would have understood and been accommodating to shortcomings in care if an appropriate level of communication and explanation were provided to them.

> “Communication could have been improved on - within the care team and to me. If you’re new to the case - read the notes. I don’t want to have to explain to four people within four hours - they should know that. It could all be computerised. They’re understaffed. The handoff between departments was shockingly bad. You could do more with the midwife and less at the central hospitals. That would be better. Because she knows you, she knows your story. You’re not in a random room and someone else is telling you something. It’s a disjointed story” *Naomi.*

Naomi explained that she needed to self-advocate to compensate for what she feels is poor communication from her care team. She also demonstrates a strong desire and preference for greater continuity in her care and the frustrations in having to repeat herself ("I don't want to have to explain to four people within four hours"). Systemic constraints are highlighted with respect to communication, in particular how resource limitations have negatively impacted upon communication outcomes for women, as a result of underfunded communications systems. She further references resourcing issues within the NHS system (“They’re understaffed. The handoff between staff was shockingly bad”) which have impacted on the level of communication that her care team were able to offer. She also makes suggestions for how these communication issues could be mitigated, whilst also demonstrating an understanding of the wider systems inefficiencies. Naomi explains how greater continuity in her midwife care would have improved her communication experiences (“You could do more with the midwives and less at the hospitals. That would be better. Because she knows you, she knows your story.”).

Information overload was also commonly referenced in the interviews, for example, care professionals providing charts or updates without fully explaining what it meant. Several participants also disclosed their experiences of not being believed by medical professionals about being in active labour. Typically the onset of labour is slow and builds to a more active phase of labour. Particularly for first-time mothers, this process can be lengthy and women are often advised to stay at home until the onset of active labour - usually defined as three contractions lasting at least 60 seconds each, within a ten-minute period, and sustained for at least one hour (NCT, 2022). Several participants recalled their experiences of not being listened to or believed and actually being dismissed over the phone by the care team. This really impacted these women's confidence and led to them questioning themselves, their belief in their own bodies, and their own pain thresholds. Some participants explained how they had received conflicting advice from different care professionals in their antenatal journey. This caused some of the participants great distress - in both their antenatal experiences and in recalling their memories. In several cases, participants explained that they had opted to ignore the professional advice, feeling that it did not cater to their specific needs, or was irrelevant to them personally.

> “His head was growing at quite a rapid pace, which was concerning and no one ever really explained it to you. So you've got a chart with his head up there, his legs down there, his body somewhere in the middle. I'm like, my baby's head is going off the charts and his legs are at the bottom, like what's going on? And no one really explained it. I got upset, I cried at one point. So I got myself all worked up. Because they send you off with this chart. And I'm like, what does it mean like, you know, and so it's almost like you're better not knowing that information. It's almost like you're better not to see it. But you're seeing it and you don't know what it means you don't

know what the repercussions are. You don't know what's normal and what's not and so yeah" *Brooke.*

This quote from Brooke illustrates the frustrations, confusion and upset at the insufficient explanations she received from her care team about the borderline 'abnormal' results in her NHS antenatal growth charts. She explains the impacts that providing only partial visibility to a patient about their own care can cause ("...it's almost like you're better not knowing that information. It's almost like you're better not to see it. But you're seeing it and you don't know what it means you don't know what the repercussions are"). The imbalance of power dynamics with medical professionals controlling access to information and information sharing of patients' data underlies this issue. Providing patients with transparency in their care could help to reset this status quo, as well as aid in building a greater sense of trust within the medical-patient relationship. Unmet expectations for how her care was communicated was likely further impacted by 'fear culture' influences and the accompanying tendency to 'think the worst'. This combined with a lack of explanation on her baby's unusual growth patterns led to severe anxiety and distrust.

As a protective buffer against the confusion that 'information overload' can cause, birth partners could prove particularly helpful for women. Each participant referenced the impacts that COVID-19 had on their pregnancy experiences, as well as their birth experiences and the involvement of their chosen birth partner. Several participants also highlighted that they had experienced the phenomenon commonly referred to as 'baby brain' during their antenatal care. This phenomenon involves poor concentration, absentmindedness and poor memory during pregnancy (Deakin University, 2018). Birth partners provide support to women in a number of ways and observing antenatal, parturition and postnatal communication with care providers is a very important part of this role.

> “I don't think I'd have coped as well without him. Because they were telling me so much information, having him there to take in other information just made a massive difference. Because when you're being told certain things when you're pregnant, you're just like, how do you take all in? So having that birth partner there made a huge difference, because it meant that I can actually rely on him to take that information in. And we would talk about it afterwards, once I'd had a chance to sort of process everything else that was happening, because they tend to talk to you while you're being scanned. Yes, like, okay, well hold on a minute. Like, what do I do, like, pay attention to you? Or do I watch the scan? What do I actually focus on? So yeah, having him there taking in the extra information was a big help” *Denise*.

Denise highlighted the importance of having a trusted advocate with her during her care (“having that birth partner there made a huge difference, because it meant that I can actually rely on him to take that information in”). This suggests that a more collaborative approach to her care, and care communication overall, is important to her. In Denise’s case, and in most cases in antenatal care in the NHS, the medical professionals responsible for providing her care were in a more dominant, powerful and influential position. They have the medical knowledge, the access to resources, and the authority to influence the course of her care plan. The communication she received about her care is central to this power balance playing out. Withholding or confusing communication is an uncollaborative and scientific model for delivering care, compared to the more balanced and person-centred approach that supportive and personalised communication can provide.

Poor organisation of key contact information was also a common complaint of participants. In early pregnancy and at the beginning of antenatal care within the NHS

system, women are provided with a physical folder of charts, notes, key contacts and general information to reference throughout their pregnancy and antenatal appointment (Thomas, 2021). Women are often referred to these notes, known as the 'purple folder' if they have any questions or concerns. But confusion as a result of the poor presentation of key information was a common complaint among participants. For example, key phone number contacts being in different areas within the folder makes them difficult to find, or confusion over which phone numbers to call for minor queries or major concerns.

> "One phone number, for example. That would be, yeah, a better organization of contacts. It doesn't need to be a one-person contact, but a one-number-catch-all number that you can then link to the early pregnancy unit, the lactation consultants, you know, the labour ward, or your midwife, a gestational diabetes team, you know, all of those things under one roof would be great." *Rose*.

Here, Rose expressed her desire for a clearer organisation of care contact information. Multiple participants recalled their difficulties in making contact with their care team as a result of the poor presentation of contact information, or contacting the wrong team as a result, and subsequently missing out on the care that they required. All of the women interviewed expressed their appreciation for having access to 24/7 helplines, but many did refer to the difficulty they had in making use of this resource as a result of the poor presentation of key information. This provides an opportunity for a simple, yet effective improvement to women's experiences of antenatal care, and how supported they feel throughout pregnancy and early labour in particular, by reformatting this contact information into a more straightforward and accessible format.

Fear of the Unknown

A common response across all participants was their sense of anxiety and fear of the unknown in their antenatal journey. For all of the women, it was their first healthy, full-term pregnancy. The disparities between care expectations and care realities were exacerbated by immature relationship development between participants and their care teams. This further exacerbated participants' sense of anxiety and fear of the unknown.

Participants commonly described concerns with respect to poor continuity of midwife care. For instance, women felt rushed in their antenatal appointments and had to repeat themselves often; they described being provided with conflicting information, having age and experience concerns with their midwife, all leading to increased anxiety of the unknown. The impacts of poor care relationships, particularly between women and their midwives is known to produce more negative outcomes for mother and baby than positive and consistent ones (Dahlberg & Aune, 2013). There was also an expectation for many women that they would be provided with greater continuity in their midwifery team. Several women expressed their surprise in not seeing the same person twice. These experiences exacerbated fears and anxieties of the unknown by adding a layer of inconsistency to participant's antenatal care.

> "The early antenatal care was very inconsistent in terms of staff. I never saw the same midwife more than once. It was a different person every single time and that's no discredit to them personally because they were all amazing. But I think having continuity even to see the same two or three people. It seemed crazy to me that every time I went back, I had to say clearly they have my notes and the purple folder etc. But I found myself having to say the same thing at every appointment again and again and again and there was no build-up of rapport, no build-up of a relationship because

it was always somebody different. That was a big, big negative for me. I think it was an assumption that I had when I first got pregnant that I would be assigned a midwife and she would be with me till, almost till the birth." *Rose.*

Rose, and most participants, made clear that they felt the midwives had done the best that they could for them, but that they understood that they were stretched within an overburdened system. The sentiments of the participants toward their midwives in our interviews were mostly very positive, with an understanding that they had a job to do, and were doing the best that they could with the little time and resources available to them. There are also contextual influences on how women build up their expectations of care. Social influences such as friends and family members sharing their experiences of antenatal care with women can impact a woman's expectations of pregnancy and of maternity care. Cultural influences such as representations in popular and social media, and historical influences such as their own prior experiences of pregnancy and birth can also impact how a woman expects her care to be delivered and subsequently, her level of satisfaction in that standard being met.

"They're always lovely, but it was very rushed, and tick-boxy. But I mean, I didn't have a bad experience. It was just kind of indifferent. I felt like I needed to hurry up. And just be like, I'm sorry, I'm taking up your time. But that's just like me, I guess. I'm sure other people would have sat there for ages and asked all the questions." *Abbie.*

In this quote by Abbie, she explained that she felt apologetic in her antenatal appointments ("I'm sorry, I'm taking up your time"). This sense of inferiority she experienced in her position reflects an imbalance of power when compared to the more 'important' medical professional.

Most of the participants painted a similar picture of the perfect midwife in their eyes - an older, experienced woman who was straight-talking but also reassuring. In my own experience, I can attest to this being a heartening thought - the ideal midwife being there with you to guide you through the unknown. In an inconsistent care system, some women may get their ultimate midwife, or they may only get them for a small part of their care. But for those that do not receive the midwife they were expecting or hoping for - or only get her for a small period of their care - the potential for disappointment or anxiety can emerge. This disconnect between expectation and reality can result in disappointment and anxiety when these hopes do not materialise.

> "I'm here, and been in labour 24 hours, you're telling me that it's all junior staff and skeleton staff on duty. This girl that I wouldn't want next time was quite young, I don't know how much experience she's got. Not that you should judge on that. I felt better after speaking to an older midwife. I felt heard then. I was reassured by the second opinion. Next time I will want people with experience" *Amelia.*

Amelia explained her expectations for what a midwife would be and her disappointment and concern when that reality was not met. Social, cultural and historical influences all play a part here in how expectations are established, and these in turn influence how experiences of care are perceived when balanced against those expectations. She also explained how she felt heard and comforted by a more experienced second opinion ("I felt better after speaking to an older midwife. I felt heard then. I was reassured by the second opinion"). This helps to demonstrate the importance of trust within the women-midwife relationship and how an inconsistency within this relationship can negatively impact upon this vital role of trust.

Some of the participants shared their stories and experiences with me of prior fertility issues and the loss of pregnancy through miscarriage. Although all of the participants in the study were preparing for the birth of their first child, for many it was not their first pregnancy or even their first experience with antenatal care. Every participant mentioned to me their fear of the unknown given that it would be their first baby, a time when baseline anxieties are already understandably high. Even for the participants that had not previously experienced infertility or miscarriage, the fear of pregnancy complications was a common theme. This was a hyper-awareness for participants across many of their antenatal appointments that maternity professionals seemed not to be conscious of, or receptive to. In many cases, the sonographer is one of the first early appointments for women during their antenatal care, and for many participants in this study, it was a particular point of anxiety for finding out if the baby was healthy.

> "I had a really bad experience with the sonographer. Actually, that was during my first scan. I didn't bring my purple book with me. I forgot it. And he basically made me cry during my first scan. I did make a complaint about him and asked to not have him ever again. I hadn't even had my scan at this point. I'm there crying on the bed. And yeah, and I'm like, my scan. Yeah, we don't even know if there's a baby inside me. And we've had a run-in because you've been rude to me. I've come back at you. And then you've come back at me. Yeah, my baby could not have a heartbeat. I couldn't have a baby in there. And you're the one going to be delivering this news to me if that is the case. Like, I would 100% go private if I had the money. 100% Yeah." *Brooke.*

Brooke referred to her preference for private care, if that would have been an affordable option for ("Like, I would 100% go private if I had the money. 100% Yeah."). The

barriers she faced in not having adequate space to express her emotions in her appointment were related to the restrictions of the care system (“I didn't bring my purple book with me. I forgot it. And he basically made me cry during my first scan.”). Women described a number of critical periods in their journeys, including in early pregnancy (particularly the first appointments and scans) and in late pregnancy (the lead-up to labour). Fear culture and social influences impact the knowledge of potential complications at these stages for women. These points in the journey were generally where anxieties were heightened for most women, regardless of whether they were medically justified or not.

For those participants who shared their experiences of previously lost pregnancies as a result of miscarriage, there were some assurances of increased early antenatal monitoring. This was offered to these participants as earlier scans in pregnancy and additional ultrasound scans beyond the standard two to three. The additional care provided to these participants in early antenatal care was described as reassuring, but once out of the first trimester started to be described more as excessive and unnecessary.

> “We had two failed pregnancies and found out that we were having [the baby] just after Christmas. So I was closely monitored through both blood tests and scans. And so I felt reassured by all that, although somewhat, some of the appointments I felt were unnecessary, frankly, and not particularly helpful. That said, the pregnancy went really smoothly other than huge sickness and exhaustion. I felt it was just a little bit excessive and a little bit patronizing in a way too, I felt like I was being done unto unnecessarily. Yeah, I get, you know, there's a procedure to follow, but I just felt a little bit burdened by this extra responsibility. I had a scan at 16 weeks as well, and he [birth partner] was there for that one. I think if he hadn't been allowed to be there for

the early scans, that would have been really hard because that's when we previously found out that we'd lost our babies" *Rose.*

In this quote by Rose, she explained her discomfort in the high level of monitoring she received and how this over-surveillance felt imposing ("I felt it was just a little bit excessive and a little bit patronizing in a way too, I felt like I was being done unto unnecessarily"). The over-focus on risk is a key feature of the scientific model of birth and deters from the more person-centred approaches preferred by women (Baptie et al, 2020). Medical professionals' perceptions of high-risk can affect their care practices, and the experience of that care for the women affected. Further, Rose refers to her miscarriages negatively as "failed pregnancies". Western cultural framings that typically value and validate scientific explanation over others (religious, for example) tend to lay the blame at the feet of the woman as somehow failing biologically. This perspective can be internalised by women and negatively impact their emotional and psychological well-being and experiences of care (Kilshaw & Borg, 2020).

One participant, in particular, highlighted to me the additional stress and anxiety added to their fear of miscarriage, as a result of unsympathetic responses by care providers. Several participants with prior experience of pregnancy loss explained how they had had to lower their expectations of antenatal care.

"The experience of having a miscarriage the first time when I was like three months pregnant, and I went to the hospital, that was really stressful. And they seemed to act like it was really routine. I was really upset, and they didn't show a lot of sympathy. So I think from that experience, I lessened my expectations. Okay, so you're really super excited when you have your first baby. And you realize that, you know, they're

just doing their job. Because of previous miscarriages, I had a scan at six weeks. And that was all good. Yeah. And then I think had a scan at 12 weeks as well. I had like one miscarriage and then what they call chemical pregnancies. And yeah, that reassured me. And then I booked a private scan at 10 weeks just because I was like really nervous. And then that was fine. And then I had the 12-week scan after that. Maybe subconsciously, I didn't really think about it, but I probably was just super excited to have a happy, like healthy pregnancy." *Abbie.*

Abbie illustrated how the distress she experienced in her prior miscarriage was exacerbated by the standardised way in which it was treated by her care team ("..they seemed to act like it was really routine. I was really upset, and they didn't show a lot of sympathy"). But she goes on to reference the reassurance she felt when she was offered additional scans thereafter, as well as in her decision to opt for a private scan for a second opinion (... "that reassured me"). What is interesting to note here are the impacts of her prior experience on her subsequent expectations of care ("So I think from that experience, I lessened my expectations…..I was probably just super excited to have a happy, like healthy pregnancy"). She also valued the reassurance of a second opinion to ease her anxieties about miscarriage, both through the NHS and through private means. Collaboration in her care was important to her and the knowledge that her care was being monitored and coordinated effectively across multiple teams. The importance of trust is central here to how comfortable she felt in her care relationships, and why this sense of trust is so critical to how women experience and perceive their antenatal care.

Summary

Three key themes became evident to me through the course of my reflexive thematic analysis. These were not being listened to; impacts of poor communication; and fear of the unknown on antenatal experiences. At the core of each of these issues was an underlying systemic belief in the scientific model of birth. This prevented women from being positioned as equals within their own care, leading to an imbalance of power within the medical-patient relationship. This status quo prevented women from feeling empowered to make informed choices about their own care and affected the quality of their relationships with their care team. Further, the level of trust that women felt with their care team was impacted by this relationship breakdown, causing women to experience stress and anxiety that could have been circumvented. Adopting a more person-centred approach to care can provide women with more consistency in their care team and relationships, allowing trust and rapport in this care team to develop. By positioning women as central to their own care, the adequate sharing of information with women aids to empower them to make their own choices as well as relieving unnecessary anxieties caused by feeling uninformed. Finally, greater awareness by medical professionals in understanding pivotal moments for women within their antenatal care (e.g. early antenatal scans and the lead-up to labour) would help to inform their approach to better managing these interactions. It could also offer an opportunity to set reasonable expectations for women and care professionals alike for how the care plan will be delivered. Giving women the space to express their emotions and have their interactions more personalised could also offer a number of benefits to women's emotional outcomes, including reducing stress and anxiety, and improving their sense of trust and satisfaction in the care they received.

Chapter Four - Discussion

4.1 Discussion of Findings

4.2 Implications

4.3 Limitations & Recommendations

4.4 Conclusion

Discussion

In this research, I aimed to explore the perceptions of women's antenatal care experiences within the British National Health System (NHS). Health models, health systems and health professionals can influence women's maternity experiences and outcomes; these influences can be positive, negative, or both (Webb et al, 2021). In my research, it was important to understand how the standardised approach to maternity care delivered within the NHS influenced these experiences for women (NHS, 2014). In much of the Western world, medical viewpoints are often valued over more holistic perspectives on health, pregnancy and birth (Cook & Loomis, 2012). This is also apparent in the NHS maternity care system (Johanson et al, 2002). As a result of this systemic perspective, health professionals within these systems often favour scientific, biomedical approaches to maternity care (Cook et al, 2012). In my research, the impacts of these perspectives within professional roles were explored through an analysis of the experiences of women receiving maternity care in the NHS. The five key professional roles within the NHS antenatal care framework are GPs, obstetricians, sonographers, midwives and doulas (NHS, 2017). Midwives and doulas in particular tend to be more holistic in their stance on pregnancy, labour and birth, although many of their practices are still underpinned by medical foundational knowledge (Miller, 2019). The relationships between pregnant women and their midwives was of particular interest in my research, especially with respect to the continuity of this relationship and how this impacted the care experiences of participants.

Findings from my research indicate that several areas of the NHS framework could be refined in order to improve women's experiences of antenatal care. Considering participants' experiences in relationship to the landscape of care, several recommendations could be taken up. These include providing clearer communication to women in their antenatal care, for example providing more notice to women regarding upcoming appointments; making women

aware of the benefits of preparing and sharing their birth plan with their care team in early pregnancy; tailoring the information provided to women to make it feel less generic and more personalised; clearer organisation of key contacts for women to make it simpler to find phone numbers for the relevant departments when needed, and better communication within and between care teams to prevent women having to repeat themselves at appointments. Addressing how care teams ease or add to the fear of the unknown women experience in their antenatal care is another opportunity within the current care framework. The aspects identified as requiring improvement in my research provide an opportunity to introduce a person-centred care model, balanced against the scientific approach to care, and still accounting for economic and organisational viability. Successful delivery of balanced care models has been demonstrated in countries including Canada, New Zealand and Australia (Sandall et al, 2015).

Participants described two key periods within the antenatal care journey as critical to their perceptions and satisfaction with care. These were women's interactions with care staff in early pregnancy (the first appointments with their care team) and in late pregnancy (the last appointments in the lead-up to labour and birth). In particular, women's relationships with their midwives influenced their trust in a hospital's capabilities, the staff's abilities, and in their own self-confidence leading up to birth (O'Brien et al, 2021). The key roles highlighted by participants as particularly influential (both positively and negatively) were midwives, sonographers, and in late pregnancy, obstetricians. These interactions between care staff and women offer an opportunity to improve outcomes through the implementation of relatively simple and economic improvements to the current care framework. Professional development training for these key roles on how to improve interactions with women, particularly during these critical periods, could aid in achieving this (Redshaw et al, 2019). Further, women could be encouraged to be more active participants in their own care, rather than passive

patients; this may help mitigate the negative impacts of not feeling heard. For example, care staff could adapt their dialogue with women to be more conversational and less instructional, to demonstrate to women that care decisions are their own choice (Chang et al, 2018). Encouraging this open and equal dialogue earlier in the antenatal care journey could help provide more time and space for women to consider their options and make informed decisions (Fenwick et al, 2002). This way of engaging also provides the opportunity to alleviate or even avoid the stress commonly experienced by women in the period prior to the onset of labour, when the pressure to induce birth can impact birth locations and preferences and cause great distress (Chang et al, 2018).

Within care systems such as the NHS, resources are limited and must cater to a huge population, aiming to provide satisfactory outcomes for as many as possible (NHS, 2021). In this research, the aim was not to determine how successfully such a model catered to women at a population level, but rather how the model catered to women's needs at an individual level. A major drawback to models adopting a purely population-level approach to care is the presumption that a positive outcome in antenatal care can be assessed using purely physical metrics (Humphrey, 2006). In the NHS framework, survival rates for mother and baby are the key measure of success (Hunter et al, 2017). In my research, all participants and their babies were delivered safely and successfully using this measure. But if positive outcomes are measured purely as survival for mother and baby, other vital influences on well-being risk being ignored or missed altogether (Department of Health, 2011). These include psychological outcomes that impact the wellness of mothers and babies, and how care is experienced and remembered by women. As participants' stories attest, these experiences can be negatively or positively impacted by factors such as the level of continuity in antenatal care, the relationships between women and their care teams, and a woman's expectations of care (Jansen et al, 2013). Poorer psychological and emotional outcomes related to

unsatisfactory experiences can contribute to postnatal depression, PTSD and even influence how a mother bonds with her baby (Webb et al 2021; Gottvall et al, 2003; Thompson et al, 2016; Bai et al, 2019). These have longer-term and wider-reaching effects beyond birth survival rates (Webb et al, 2021). A number of participants in this study described their challenges with the after-effects of receiving what they considered to be unsatisfactory care. There is also the risk of overestimating success rates and underestimating the prevalence of unsatisfactory care outcomes when using survival rates as the single measurement of success. As participants described, interactions between women and professionals can also be positive or negative for women, confidence building or disempowering (Respectful Maternity Charter, 2019). Wider sociocultural influences such as the fear of birth commonly represented in popular media can also influence women's expectations, experiences and outcomes of maternity care and was also referenced in several participants' accounts (Luce et al, 2016).

Participants' stories illustrate the importance of models that account not only for their physical outcomes but also allow them to be heard and seen as their full selves. Participants all communicated their gratitude and thanks to the NHS and understood that resources were limited. But participants also described their frustrations with systemic constraints preventing them from being heard fully, such as the need to regularly repeat themselves at antenatal appointments. This repetition was even more frustrating for participants knowing their case notes were made available to all care staff, but that this familiarisation with care notes was often missed, owing to the inconsistency in their care team. The period immediately prior to labour and birth was referenced by all participants in my study, with respect to the pressure they faced to accept a medical induction. It was at this stage in particular that participants felt they had no choice regarding the direction of their own care. Ethics of care from a feminist perspective closely examines these ties between gender and power, in particular how the distribution of power in favour of male-dominated medicalised views can lead to women

being disadvantaged and unheard in their care (Rogers, 2006). Participants recalled that their birth plans (favouring a natural birth) were threatened, and the locations of birth were even impacted by the requirements of care professionals to adequately monitor women in more medicalised settings.

All of these experiences ultimately reflect the lack of control that women faced in their care. Their own expectations, needs and preferences were often secondary to the opinions and decisions of care professionals. Within the collective of care professionals, participants often praised their midwives and appreciated their efforts, but struggled the most with the doctor-patient and sonographer-patient relationships. Participants described these as anxiety-provoking interactions and did not describe experiencing these conversations as being based on mutual respect or equality. Because obstetricians have the skills to manage complex and high-risk pregnancies, they can be more likely to apply high-risk interventions to low-risk pregnancies unnecessarily (Fox et al, 2019; Health Direct, 2022). Sonographers are responsible for monitoring and diagnosing conditions during pregnancy, an experience that can be particularly anxiety-provoking for women in the first trimester of pregnancy (Sholapurkar et al, 2021). Both roles are highly specialised and require a great deal of focus (Najafzadeh et al, 2019). This need for focus often comes at the expense of the 'bedside manner', in order to minimise distraction (Najafzadeh et al, 2019). But a poor sense of rapport between professional-patient comes at the expense of patient satisfaction (Redshaw et al, 2019). In addition to this lack of satisfaction in obstetric and sonography care, both of these roles hold the most potential to affect the direction of experiences and outcomes of the antenatal journey for women compared to other maternity roles (Miller, 2019).

Person-centred care models can benefit women in this way by advocating for greater continuity in care, enabling the kind of relationship between mother and midwife to develop (WHO, 2007). These models can blend a scientific approach to care with holistic elements to

ensure the best possible outcomes for women and their babies are achieved (WHO, 2007). Holistic considerations beyond continuity in women's care teams also involve providing women with clear expectations of what the care journey will entail from the outset and enabling women to have greater control and voice within their own care experiences. Balancing the medical and scientific understanding of birth with holistic and natural perspectives on birth is key to this approach (WHO, 2007). Participants' accounts of the satisfactory and unsatisfactory aspects of their care in this study lend support to this theory and approach to care. The blended approach of a person-centred care model fundamentally involves a reorganisation of power, whereby women are seen as equally knowledgeable and central to their care decisions as care professionals. In my research, participants frequently recounted their desire to have their preferences heard and understood, as well as a desire to feel more active within and central to their own care journeys.

I aimed to contribute to a clearer vision of what a blended approach to antenatal healthcare could look like within the NHS, in order to suit women's needs better and achieve more positive outcomes for women. Participants' responses indicate a preference for more person-centred care, specifically for greater continuity in their midwife team and more personalised care. This kind of model centres the woman at the heart of her own care, and it also addresses the power imbalances seen within care teams (for example, between care staff and women, and between doctors and midwives) by validating the importance of the midwife role in relation to the outcomes and experiences of women in their antenatal journeys (WHO, 2018). Such an approach to medical care can empower women to make informed decisions regarding their own care, through improved communication management (Chang et al, 2018). The preference for women to be provided with continuity of midwifery care, to aid in relationship and trust building was also evident to me in my analysis of the data. Participants described how the fear of the unknown, along with not being heard and being poorly

communicated to in their antenatal care, negatively impacted their experiences. There is a need for clearer and less ambiguous information about antenatal care options, in particular how inductions should be presented to women as optional. In fact, a very recent survey of 2,000 women in the UK who had recently given birth or were currently pregnant, found that 50 percent felt they did not have enough information to make an informed decision about induction (Patient Information Forum, 2021).

Experience Factors

Participants' perceptions of care and their care experiences were impacted by the medical status quo and balance of power in the care professional-patient relationship. This status quo is ingrained and in many cases enduring (Johanson et al, 2002). In my research, participants described occasions where interactions with care professionals' where medical opinions could be authoritative and dominating over their own opinions. These findings were also reflected in a similar study conducted recently by Shabot (2020). As a result of these interactions, participants recounted often feeling disempowered to instruct on their own care preferences and their subsequent deferring to medical opinion. This deference by women is not exclusive to this research; it has been noted in several other contexts (Cook et al, 2012). In my research, this passive reaction by participants in many cases negatively impacted participants' sense of trust in the patient-professional relationship.

Given the need for women to feel a sense of control in their own care, the negative impacts stemming from the lack of provision for this need are not surprising (Better Start, 2021). The most obvious form of this trust breakdown was in participants' diminished satisfaction levels in their care, if they felt they were misinformed, or pressured into accepting care paths that they were not comfortable with, particularly the induction of labour. This breakdown in trust in the relationship also impacted participants' trust in themselves.

This finding was consistent with those of comparable studies exploring trust and satisfaction (O'Brien et al, 2021). Attanasio et al (2014) similarly determined that positive birth outcomes were associated with women's comfort and confidence levels in their antenatal care. Participants in my research commonly reflected on knowing or sensing that labour was near, but not being believed by care professionals. Common medical advice dictates active labour as three contractions in a ten-minute period, sustained for a prolonged period of time, typically about an hour (Intermountain Healthcare, 2017). The adherence to this definition by medical professionals caused significant distress to several participants, to the point where they were conflicted by their own embodied knowledge of labour and the medical advice they were receiving. In all cases, participants' deferred to the medical advice, at least initially. This would lend credence to the theory that women defer to prescriptive care, despite favouring more supportive care, in the face of medical authority (Cook et al, 2012). For participants in this study, it also led to the eventual ignoring of medical advice by multiple participants. Several participants described reporting to the hospital against medical advice when they were certain that they were experiencing active labour, but their labour contraction times were atypical to standardised measures. In all cases, participants' senses of oncoming labour turned out to be correct, despite medical advice insisting that women were not yet in labour. More than half of the participants gave birth very quickly after the onset of labour (in less than an hour) contradictory to the common belief that first babies are normally slow to deliver (Tine et al, 2010).

Negotiating credibility with the midwives at the hospital and attempting to avoid being sent home for reporting to a unit prematurely in labour can exaggerate the sense of vulnerability that women can experience at this critical stage of care (Tine et al, 2010). At Chelsea and Westminster hospital, a trial room called 'The Nest' has been introduced, to assist women in the early stages of labour. The aim was to provide women with the

reassurance of being in the hospital, without requiring space on busy midwifery-led units or labour wards prematurely (Chelsea & Westminster NHS Foundation Trust, 2012). It is staffed by doulas and is an additional option for women who live further away from the hospital, or lack the confidence to manage early labour at home. Although not all participants explicitly stated their preference for continuity in midwife care, the knock-on effects of inconsistent care indicated a preference for a more stable midwife-patient relationship. The midwife role was particularly important during this period of time for participants as a result of the impacts of the COVID-19 pandemic, where uncertainty and instability during maternity care were intensified (Dandato, 2020). Birth partners were often not able to attend antenatal appointments or in some cases even labour (Black et al, 2020). This midwife-patient relationship became even more important in these instances (Dandato, 2020). How women perceive their support system and sense of control within their own care journey is central to how they experience their care (Black et al, 2020). In my research, participants expressed their sense of relief when their birth partner was able to join them for key periods in their care, and also their anxiety when this was not attainable. Respectful antenatal care is also valued by women, including the participants in this study, the main aspects of which are a sense of privacy and dignity (Redshaw et al, 2019). These factors help to realign traditional power imbalances by valuing women's embodied knowledge and experiences alongside respecting medical expertise. Participants' accounts of respectful interactions with their midwives, where their choices and opinions were listened to and heard, reflected positively in their sense of satisfaction in that aspect of their care.

Caring and respectful relationships with care providers can significantly contribute to the overall birth experience, the quality of patient-professional relationships, improve the strength of communication and promote greater continuity of care (Redshaw et al, 2019). Developing a sense of rapport with care providers throughout the antenatal journey can foster

a sense of feeling understood and listened to by care staff (O'Brien et al, 2021; Redshaw et al, 2019). These factors can all contribute positively to a woman's antenatal care experience. As participants' stories attest, continuity in care staff and rapport building go hand-in-hand. This lack of opportunity to build rapport with an ever-changing care team also impacts the power dynamic of the patient-professional relationship. Unequal power dynamics in health systems manifest themselves through gender inequalities that "undermine quality of care and obstruct women's capacities to exercise their rights as both users and providers of maternity care" (Betron et al, 2018, p. 1). In a recent study, Vedam et al. (2019) found that, one in six women reported some form of mistreatment during their antenatal care, including experiencing a loss of autonomy, or being ignored. In my research, participants expressed this loss of autonomy and sense of being ignored in the context of being rushed at their antenatal appointments. Participants mostly reported that midwives were rushed in their appointments together and that often the midwife was unknown to them. Participants expressed a sense of needing to be brief in such appointments, but also described the conflict they experienced when they lacked the space to inform the midwife of their individual history and needs. The prevalence of these negative interactions is far lower amongst women who have home births (5%), or a vaginal birth with a midwife or community midwife, compared to women who experience a hospital birth (28%) (Vedam et al, 2019). Participants' accounts in this study support this finding, of a distinct lack of autonomy specifically within the hospital setting.

Participants' accounts also attest to the ways in which antenatal experiences are impacted by women's past experiences; for example, several participants had a prior history of miscarriage. This provided them with some prior understanding of the NHS antenatal care process, and they were reassured by extra care measures offered to them, such as additional ultrasound scans, as a result of this prior history. However, it also provided an added layer of anxiety and fear of the unknown to the pregnancy more generally. The impacts of prior failed

pregnancies, miscarriages, chemical pregnancies, stillbirths, or even the loss of a child have all been shown to affect anticipations, expectations and perceptions of care (Lamb, 2002). Overarchingly, these prior histories did aid in affected participants seeing the bigger picture of their care more easily. Participants with a prior history of miscarriage enjoyed a greater level of satisfaction in their care after they were assured that they were experiencing a healthy pregnancy. These reports by participants support other studies showing women with a history of miscarriage may experience increased anxiety in the first trimester of pregnancy, but then lower levels in subsequent trimesters compared to other women (Tsartsara & Johnson, 2009). Participants with no prior history of miscarriage, and resultantly with no prior personal knowledge of the antenatal care framework, may have higher expectations of their care and display lower overall satisfaction in their care experiences. Expectations of care and how care is subsequently experienced by women are intricately linked (Tsartsara et al, 2009). Dahlen et al (2010) suggest that women's experiences and perceptions of antenatal care can be positively mediated by four factors: preparation; choice and control; information and communication; and support. As participants' stories attest, these expectations were also influenced by friends and family members' experiences, and the wider social knowledge and expectations of what pregnancy and birth might be. The negative effects of social comparison on the disparity between women's expectations and experiences of antenatal care can be mediated by keeping women informed in early pregnancy care to set realistic expectations and to empower women to make choices to improve their sense of control (Gibbins & Thomson, 2001).

Poor communication referenced by participants highlighted issues with both internal communications (between care teams) and external communications (between the care team and the patient). Chang et al (2018) similarly reference the need for improved communications in maternity care as an effective intervention method. In my research,

participants described care plans being poorly communicated from the outset of early antenatal care; substandard handovers between departments or individual members of staff; insufficient communication around antenatal appointments; and an absence of personalised communication for women. As a result of participants not feeling central to their own care, nor included sufficiently in their care plan, medical advice was in some instances ignored. This can lead to potentially dangerous outcomes for women and babies, and is fueled by low morale and poor relationships (Smith & Dixon, 2008). Sometimes as a result of seeing a multitude of care professionals, as opposed to a single trusted contact, participants were left with a sense of uncertainty around whether they could trust that their needs would be communicated and delivered and without a sense of real advocacy amongst their care team. Relational continuity in maternity care has been shown to be a key factor in positive birth experiences and in making positive communication much more likely (Tuominen et al, 2014; Dahlberg et al, 2013). Providing insufficient communication to participants regarding their own care, and the indication that participants were not being listened to by having to repeat themselves regularly to their care team, positions women as inferior in their own care. It demonstrates the power dynamic of the superior medical professional over that of the inferior patient. Withholding information from women in their antenatal care, such that they are rendered incapable of making fully informed choices, is considered medical abuse (Pickles, 2017; Chadwick, 2017). The assumption that medicalised care can be imposed upon women without a full explanation (including the presentation of all options, and what the subsequent cascade of interventions might involve for those options) is in itself unacceptable (Shabot, 2020). Yet, participants in my research all described their experiences of feeling imposed upon at some point in their care (most often in the lead-up to labour). This enduring dominance of medicine in maternity care, and in obstetrics specifically, reflects the structural inequalities affecting women in their antenatal experiences to this day (Shabot, 2020).

All participants were first-time mothers, although some participants had had prior antenatal and miscarriage experiences. As previously mentioned, fear of the unknown and pregnancy can be very much synonymous for some women (Berhanu et al, 2022). Though fear of childbirth can be experienced by women anywhere in the world, the underlying cause for this fear may differ depending on the social context (Berhanu et al, 2022; Preis et al, 2018). For instance, in Ethiopia, social support systems may inadvertently cause fear in women through shared storytelling, as in the UK. But the fear of complications during childbirth is linked more closely to the high maternal mortality rates in Ethiopia, compared to predominantly social causes in the UK, such as the dramatising and medicalisation of childbirth in mainstream media (Berhanu et al, 2022; Statista, 2019; Luce et al, 2016). How pregnancies are categorised at the outset of pregnancy by the NHS as either high-risk or low-risk can also serve to fuel this fear (Witteveen et al, 2016). Being categorised as high-risk can influence how a woman perceives and experiences her pregnancy and exacerbate underlying anxieties (Sinaci, 2020). Being categorised as low-risk can also cause fear in women by making them feel dismissed or less important (Scamell & Alaszewski, 2011). Women who communicate their anxieties to the NHS can be referred to mental health networks for added support (NHS, 2022). These referrals however, though helpful for some women, can also serve to exaggerate feelings of anomalousness, or feeling as if they have been treated as mentally unstable (Darwin et al, 2015). As described above, prior miscarriage was also a significant cause of fear and anxiety among participants. Regardless of participants' past experiences, however, participants expressed consistent anxiety about the unknown. This was most commonly referenced with respect to how labour, delivery and birth would transpire. One participant even referenced her anxiety over future births as the details of her future care team would equally be as unknown, despite having now experienced a delivery. This fear of the unknown, desire for a second opinion and consistency in advice was

the reasoning behind several participants opting for private care at certain stages of their antenatal care.

Discrepancies between care expectations and care realities is also a contributing factor to women's anxieties of birth (Lally et al, 2008). Participants commonly referenced their concerns around inexperience within their care team, based on the apparent age of the staff. Most participants had visualised an older, experienced, straight-talking woman as the midwife that would walk them through their antenatal care, and their labour and birth. In concordance with the results of other studies, when expectations of the ideal midwife fail to live up to women's realities the stage can be set for anxiety and upset (Alderdice et al, 2020). In my research, when participants' idealised archetypes were not realised, anxieties crept in. 'How much experience could she possibly have when she looks so young?' was a common reflection of participants in reference to their midwifery team. From my own personal experience, I can understand women's anxieties on this issue, regardless of how speculative the basis might seem from a professional perspective. Understanding these common issues for women and how these issues are perceived offers valuable insight into how negative effects might be mitigated, through more proactive communication and information sharing on the topic of midwife archetypes.

Cultural influences introduced through popular media and social interactions can impact womens' expectations of care, as well as contribute to feelings of disappointment when these expectations are not realised. This fear culture around pregnancy, labour and birth in the Western world can be pervasive and enduring (Preis et al, 2018). Participants' accounts reflect and validate the impacts these influences can impose on women. They are fed by an ingrained cultural belief in the validity of science and medicine over natural, holistic and spiritual approaches to maternity care. In many parts of the world, women successfully give birth without medical intervention (Johanson et al, 2002); in the West, there is an ingrained

fear of giving birth without the safety net of medical support (Luce et al, 2016). Several participants attested to the reassurance they experienced by being at or near a hospital during labour. This sense of safety can lead to both women and health professionals favouring medical interventions over women's personal preferences (Nilsson et al, 2018). Women who value or prefer a more holistic approach to maternity care can feel silenced in this environment (Jansen et al, 2013). In my research, participants reported this sense of suppression in their care most acutely in the early and late stages of their care. This perceived lack of control for women in their care can exacerbate anxieties and fear of the unknown (Better Start, 2021). Greater awareness of medical professionals in understanding how women experience these interactions could improve equality in care for women, by levelling this power imbalance. A lack of exposure to feminist ideals in medical training may contribute to medical interactions being doctor-led rather than women-centred, or patient-led (Zahid et al, 2015).

Implications

It is not my intention for this research to serve as a basis for a complete restructure of the NHS, nor to criticise how the antenatal service is currently delivered. Rather, it is to highlight the importance of holistic birth preferences for women, its intricate links to psychological well-being, and how medical and holistic approaches may be blended for improved outcomes for women. A major issue with the current science-based NHS system is that it applies a risk focus to women in pregnancy based upon a medicalised view of health (Humphrey, 2006). Any anomaly within this standardised framework results in a woman's pregnancy being labelled as abnormal, or high-risk (Humphrey, 2006). As participants in my research attest, these labels can result in women being subjected to cascades of potentially unnecessary medical intervention. Though beneficial in certain circumstances, such interventions have

also been shown to be detrimental to wellness outcomes when applied without cause (Webb et al 2021; Gottvall et al, 2003). Some small adjustments to the NHS framework could see such experiences improved for women. Success measures delivered by the NHS under the current regime could continue, with the addition of psychological wellness outcomes and satisfaction levels in care included to enhance its effectiveness.

A key channel to support this is to support the constant refinement of the academic and theoretical basis for antenatal care standards and care pathways, by recognising lived experience. In my research, I have aimed to contribute to this recognition of lived experience by exploring participants' accounts of their antenatal care experiences. The scientific view of birth favours medicalised views over others, and medical professionals hold the power in subsequent antenatal care relationships as a result. The NHS health system that this antenatal framework is built upon internalises this very perspective and a rebalancing of this status quo could deliver more for women in their antenatal care. Participants' accounts suggest that the areas of their care that they were least satisfied with and that required the most change (but also provided the greatest opportunity for improvement) were underpinned by this status quo. Such a rebalancing does not necessitate medicalised or scientific perspectives being trivialised, but rather that holistic and scientific approaches could be blended together more closely to achieve an improved function of the system. However, for this to be achieved, the representation of holistic perspectives within professional maternity training could be more widely incorporated and acknowledged, and professional hierarchies reconsidered.

A one-size-fits-all approach fails to recognise the personal nature of how antenatal care is experienced and the value of trusting relationships between women and their care teams. Most participants in my research indicated a strong preference for continuity in their care relationships, although none of the participants were offered this. The socio-cultural context of scientific authority, male dominance in medicine and the passive patient also fail to

deliver for women their psychological well-being needs (Webb et al 2021; Gottvall & Waldenstrom, 2003; Jansen et al, 2013). Non-holistic and non-person-centred care models perpetuate this status quo, and exacerbate fear culture surrounding pregnancy and birth, communication issues and not being heard (Neiterman, 2013). To embrace a person-centred care model that validates holistic views on health may benefit the key issues affecting women's perceptions of antenatal care experiences. On a personal note, I would have loved and appreciated if my desire for a natural birth had been understood and respected by my own care team. However, they lacked an appreciation and understanding of my position. As such, they did not place the same importance on how our care interactions transpired as I did. This was greatly impacted by my lack of a consistent midwife with whom I could build a relationship and an understanding, to ensure my needs were respected and advocated for. I recognised similarities in participants' accounts to my own experiences and can appreciate the importance of these issues for women with lived experience of antenatal care in the NHS.

Future system changes and policies could benefit from an understanding and appreciation for women's psychological needs in antenatal care as well as their physical care needs. As participants in my research indicate, the NHS could also benefit from the provision of a broader scope for individual preference in care options. Maternity care systems should be making use of women's voices more, as a resource to learn from and to better shape the care that is ultimately designed to deliver for their needs. If women's voices are omitted from this process, or inadequately represented in the design of these systems, how can they ever presume to deliver adequately for their needs?

Antenatal care experiences influence attitudes and set expectations for care for women for subsequent maternity care experiences, such as labour and birth (WHO, 2016). Participants' responses highlighted several areas where changes could be implemented to improve these experiences. For example, care staff should be aware that their interactions

with women can influence how that care is perceived, either positively or negatively. The lack of consistency in care highlighted by participants in my research indicates that the lack of personalisation in their care could also be improved. Such improvements could also take into account how information is presented to women, in particular, with interventions presented as a choice, rather than a directive.

Overwhelmingly, participants were positive about their pregnancy experiences; one participant did express displeasure from enduring morning sickness and exhaustion, but later referenced enjoying her pregnancy apart from those aspects. There were also conflicting experiences with respect to how women formed relationships with their care team. Three standout features relating to these perceptions of care were how familiar the participant was with that care team (continuity of staff), how positive the relationship was within the relationship (how familiar and trusted that care provider was to the participant) and what their expectations of care were based on their own past experiences (participants with a history of miscarriage tended had prior experience with antenatal care teams and expectations were more aligned to care realities). These conflicts reveal the complexity of antenatal experiences and perceptions of care for women. Opinions and lasting sentiments around antenatal care are not formed or based on a single interaction. They are multifaceted, cumulative, subjective, socially influenced and enduring. An unanticipated insight of this research was the overwhelmingly positive response of women in recalling their antenatal experiences overall, despite each participant having faced what I considered to be significant challenges in their care journeys.

Limitations & Recommendations

The research questions, though informed by my own knowledge of the subject and lived experience in antenatal care, were unquestionably limited by my specific perspective. Despite

my efforts to minimise bias, there were as a matter of course, limitations to the application of my research. I acknowledge and declare the following; though I was careful to ensure that the key themes identified were not simply parallels of the interview questions, without my specific reference to key topics, many of the key insights might well have gone unmentioned by participants. If vital learnings from this research came from these interview questions, then other insights relevant to the research question may well have been missed by not asking the right question. This could indicate that information power was not fully achieved, through either the impacts of dialogue or participant specificity (or both). Much effort and attention was given to the avoidance of using leading questions within the interviews, to minimise bias within the interviews themselves.

Unlike quantitative studies, the qualitative approach to research focuses on smaller sample sizes with richer data analysis. In this way, far-reaching implications to the research are neither possible nor intended. Interestingly, memory loss did not seem to be problematic for participants in recalling their experiences, despite it being a culturally accepted view that women forget the details of their labour and birth (Barha & Galea, 2017).

I analysed the data using reflexive thematic analysis and approach the research from a feminist perspective. If I were to do this research again, I would recruit more broadly in terms of geography (more diverse areas of the UK), recruitment channel (alongside the NCT), risk level (including multiple births and more complex needs) and age and experience (history of prior birth) of the participants. I would be interested to understand how these experiences might differ in different parts of the country, where access to care can differ, and how women with successful past pregnancies might develop perceptions and expectations of future antenatal care. Women from minority backgrounds have poorer outcomes and experiences in pregnancy and childbirth (Jomeen & Redshaw, 2012). None of the participants in this study identified as being from any minority group, and therefore limits the applicability of this

study. This disparity in outcomes for women of minority groups suggests that the urgency for a more person-centred approach to care is perhaps more urgent than this research alone could highlight. It would also be of interest to understand how these needs might differ for women considered as high risk, for example, those experiencing multiple birth pregnancies (i.e. expecting twins, triplets etc), or for women with more complex medical histories and needs.

Women with a personal history of miscarriage were accepting of care standards and appreciative of extra reassurances such as added care measures. Women without a personal history of miscarriage tended to report high levels of anxiety relating to the care they were receiving. A greater alignment between expectation and reality could serve to prepare women for more realistic antenatal care experiences. How the service is communicated to women in early pregnancy could hold the key to repositioning women's expectations of care, and subsequently improving their perceptions and levels of satisfaction in that care.

Further, systemic improvements could be considered to improve women's experiences, perceptions, satisfaction of and outcomes in antenatal care. Some basic but immediately effective examples include the reorganisation of how key contacts are communicated to women early in their antenatal care. Discussing and encouraging the preparation of a birth plan with women in early antenatal appointments is another quick and easy improvement to the current system that positions women as active participants in their own care, encourages the use of their own voice and incorporates their own priorities into the experience. It also gives women the chance to feel heard and regain a sense of control in a situation where many women feel they have little (Better Start, 2021). By encouraging birth planning in early antenatal care greater collaboration between women and care providers could also be achieved, improving relationships by building rapport and trust (Waller-Wise, 2016). Addressing this expectation vs reality issue also prevents the added and unnecessary pressure that women can face in the time-limited situation of labour, where they can feel

forced into accepting unwanted medical interventions that result in unanticipated cascades of intervention (Cook et al, 2012). These techniques, though simple, help to address and reset expectations and realities for women in their antenatal care, aiding to improve the perceptions and satisfaction of the care.

On a grander scale, the framework through which NHS antenatal care is delivered could benefit from a more person-centred approach. This would entail a culture shift both within the NHS and the medical professional hierarchy more broadly, to address the imbalance between holistic and scientific perspectives on maternity care. Scientific perspectives on maternity care tend to dominate over holistic perspectives, and medical professionals also tend to be male-dominated compared to a more female-dominated, more holistic midwife profession. Underpinning this is the lack of voice and input that women have in this area of women's health. In existing models of care, men often ultimately dictate what is best for women's care, despite the fact that they can never truly understand or appreciate how holistic the experience of pregnancy, labour and birth can be for some women. Until more women are involved in shaping the care that is designed for them, it can never really fully deliver.

The validity of the midwife role, and of non-hospital midwives, to represent feminist ideals in maternity care may offer the potential to rebalance power between medicalised and holistic opinions in medical settings. In particular, a midwife-led continuity of care model not only centres women as central to their own care journey, but it also serves to validate the role of the midwife in the eyes of the medical hierarchy. Two critical periods reported by participants included early antenatal care appointments (particularly the first scan with the sonographer) and late antenatal care appointments (in the lead-up to labour, and in facing pressure to accept a medical intervention to induce labour). By educating care professionals to make them aware of these critical interaction periods for women, and guiding them on how

these interactions could be more positively delivered, women could achieve a greater sense of satisfaction in their care and experience minimise stress during these already stressful periods.

Future research in this area could focus on midwives' attitudes toward a more blended approach to the NHS maternity framework. The success of such an amendment to the current framework would only be possible with their support. It would also be of interest to explore how other care professionals within NHS maternity care (such as GP's sonographers and obstetricians) perceive the person-centred approach to care and the midwife-led continuity of care model specifically. As mentioned previously, there is also abundant research that suggests women from minority groups experience significantly poorer care outcomes in maternity services (Waters, 2022). It would be helpful to explore the current research through the lens of women from a variety of minority backgrounds to explore more about the barriers they face and specific needs that they may have, in order to accommodate these needs.

Conclusion

The NHS support 700,000 women every year in pregnancy and childbirth. The vast majority of these interactions are considered successful, resulting in the survival of both mother and baby (CQC, 2013). I would, however, argue that this single measure of success is inadequate, and that it fails to account for the psychological well-being of mothers and babies. For more holistic factors to be acknowledged by the medical profession as vital to care experiences, systemic perspectives must begin to change. Blended care is an approach that incorporates both the scientific basis of medical care and alternative techniques to maternity care. Person-centred care models adopt the blended care approach, and have been shown to do so with positive results. In particular, the midwife-led continuity of care model is most preferred by women and produces the best outcomes for women and babies (WHO, 2007). In my

research, participants' accounts support the need for a more holistic, blended approach to antenatal care in the NHS. In particular, they support the theory that a continuity-of-care model would be beneficial, and support the development of stronger midwife-patient relationships. My research suggests that three key areas within the current NHS framework are negatively impacted by the unblended, scientific perspective that currently informs it. These are the impacts of not being heard, the impacts of poor communication, and fear of the unknown.

For any of the findings or recommendations of this research to be fully acknowledged, the value systems that underpin the current care model must evolve. These include professional, academic, institutional and cultural views on what maternity care is, should be, and how the experiences and outcomes associated with it are measured. For this to truly reflect women's needs, women's voices ought to be at the forefront of this evolution. Women deserve a maternity care experience that is positive and that produces the best possible outcomes for them. Women's individual and collective voices hold the key to unlocking these improvements to the current care model. Participants shared with me their desires to have more of a voice in their care, more control over decision making, and a greater level of transparency in their care plans. Participants' accounts illustrate systemic issues of power imbalances between both women and medical professionals, and within the medical hierarchy itself; fear culture surrounding birth that is both perpetuated and validated by the medical perspective and care model on childbirth; and the gender inequalities that exist within an aspect of healthcare that should advocate for and serve women more completely.

For antenatal care expectations and experiences to be more closely aligned, and to improve psychological outcomes, women could be encouraged to be active participants in their care plans. For expectations and realities to be more satisfactory for women, their potential care pathways (including how each pathway could result in a cascade of

interventions) could be more proactively provided in early antenatal care and transparently communicated. Several participants discussed the perception that information was being withheld to them in their antenatal care appointments, making it seemingly impossible to make a fully informed decision on their own care. This lack of control, equality, autonomy and facility for individual preference is a reflection of the negative effects that can impact psychological well-being, but that are not currently recognised as outcome factors under the NHS maternity care model.

Finally, a greater awareness of the key periods in antenatal care that are of particular importance for women could serve to improve well-being outcomes more broadly. Participants' accounts suggest that early antenatal care and late antenatal care interactions are of particular importance to womens' sense of trust, competence, confidence in and satisfaction with the NHS. A desire for greater continuity in their midwifery team was a key component of these reflections. How women experience and perceive their antenatal care is greatly impacted by their experiences and impressions in these critical interactions and through these patient-professional relationships. These periods could offer the opportunity to introduce change within the NHS antenatal framework in a strategic and impactful manner, that delivers for both system and individual, and that supports a more holistic approach to centring women and psychological outcomes within the care system.

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Appendices - Appendix 1

INFORMATION SHEET

Hello and greetings. My name is Shelley, and I am a Masters research student conducting a study on continuity of care during antenatal checkups and how it impacts on emotional experiences. This research will help us to better understand the needs around antenatal care beyond just the physical, and to understand emotional experiences related to pregnancy care.

I want to speak with women over the age of 18, who have experienced NHS antenatal care in the UK within the past 24 months. Women will also be members of the NCT. Participants must have access to a phone or computer and Wi-Fi in order to join an online meeting to take part in the research.

What will participation look like?

If you decide to participate, we will schedule a meeting on Zoom (or Skype, Google Meet), depending on your preferences. Before the interview, I will invite you to complete a consent form. Please feel free to ask about any questions relating to the research project / consult with people you trust prior to deciding to participate.

Participation is completely voluntary. If you do not wish to participate, you do not have to. You can also choose to:

- Stop participating at any time before or during the interview / data collection
- Withdraw your data up until one month after your interview

What Are the Benefits of Participating?

Benefits could include enjoying talking about your experiences. This project may help future NHS antenatal processes and experience improve. You will also receive a £20 gift card to thank you for your time.

What are the risks of participating and how are they being managed?

Risks to participation are minimal; you are welcome to share as much or as little as you want in response to questions and to not answer questions that make you feel uncomfortable. There is the potential for you to feel upset discussing your experiences if they were challenging for you. Should any distress arise for you, there is also a list of resources at the end of this form.

What will be done with my information?

Interviews will be audio recorded and transcribed. Recordings will be stored on password protected computers. If any identifiable data is shared within the research team, we will use secure (password

protected) means to do this. Recordings and transcripts will be securely deleted 5 years after the close of the research.

Analysed data may be used in any of the following ways:

- My Master's thesis
- Academic publications
- Academic and/or community presentations
- Policy briefings
- Knowledge translation outputs (e.g. blog posts, infographics, webinars, etc.)

You will be invited to choose a pseudonym (fake name) that will be used to identify you in any outputs from the research. If you do not have a preferred pseudonym, we will select one for you.

Participant's Rights

You are under no obligation to accept this invitation. You have the right to decline to answer any particular question or to withdraw your data or any part thereof at any time until one month after your interview. Participants may ask any questions about the study at any time during participation, ask for the recording to be paused/turned off at any time during the interview, and be given access to a summary of the project findings when it is concluded.

Project Contacts

If you have any questions about the research, please contact:

Student Investigator: Shelley Grierson, School of Psychology, College of Humanities & Social Sciences, Massey University, Albany Campus. Phone +44 7 472 510 642 Email shelley.grierson.1@uni.massey.ac.nz

Supervisor: Dr Andrea LaMarre, Lecturer, School of Psychology, College of Humanities & Social Sciences, Massey University, Albany Campus. Phone +64 6 356-9099 ext. 43106 Email a.lamarre@massey.ac.nz

Support Resources

A full list of mental health crisis teams is available here:

SHOUT 85258 (free text service) https://giveusashout.org/	NCT 0300 330 0700 https://www.nct.org.uk/	Mind 0300 123 3393 https://www.mind.org.uk/
Family Action 0808 802 6666 07537 404 282 (text support) familyline@family-action.org.uk https://www.family-action.org.uk/	British Red Cross 0808 196 3651 contactus@redcross.org.uk https://www.redcross.org.uk/about-us/contact-us	

This project has been reviewed and approved by the Massey University Human Ethics Committee: Northern, Application NOR 22/11. If you have any concerns about the conduct of this research, please contact A/Prof Fiona Te Momo, Chair, Massey University Human Ethics Committee: Northern, telephone 09 414 0800, x 43347, email humanethicsnorth@massey.ac.nz

Appendices - Appendix 2

School of Psychology
Albany Campus
Auckland

Perceptions of Continuity in Antenatal Care and Emotional Outcomes

PARTICIPANT CONSENT FORM - INDIVIDUAL

I have read, or have had read to me in my first language, and I understand the Information Sheet attached as Appendix I. I have had the details of the study explained to me, any questions I had have been answered to my satisfaction, and I understand that I may ask further questions at any time. I have been given sufficient time to consider whether to participate in this study and I understand participation is voluntary and that I may withdraw from the study, up until one month after my interview.

I agree/do not agree to the interview being sound recorded.

I wish/do not wish to have my recordings returned to me.

I wish/do not wish to review my transcript.

I wish/do not wish to receive a summary of the research findings.

I agree to participate in this study under the conditions set out in the Information Sheet.

Declaration by Participant:

I _____ hereby consent to take part in this study.

[print full name]

Signature: _____ Date: _____

Appendices - Appendix 3

MASSEY UNIVERSITY
TE KUNENGA KI PŪREHUROA
UNIVERSITY OF NEW ZEALAND

School of Psychology
Albany Campus
Auckland

'Continuity in Antenatal Care: Exploring Perceptions of Care and Emotional Experiences'

Interview Guide

Introductory questions

1. What made you want to participate?

Pregnancy and birth experiences

I would like to talk to you about your pregnancy and birth experiences.

2. Can you please tell me a little bit about your pregnancy experiences?
3. When did you give birth?
4. How was your birth experience?
5. How did you find pregnancy overall?
6. What did you feel went well or not so well?

Care experiences

I would like to talk about your experiences of receiving care.

7. How would you describe your care experiences in general?
8. How many care professionals (including midwives) assessed you during your pregnancy?
9. What was your relationship like with your midwife(ves)?
    a. Did you have the same community midwife for each of your checkups / appointments?
    b. Did you feel heard in your checkups / appointments?
    c. Did you feel your needs were consistently addressed by your midwife(ves)?
10. Did you feel confident in the lead up to labour / birth about your care providers?
11. Did you give birth in the same clinic as your antenatal appointments?
    a. What was this like for you?

12. Did you have a birth partner?
    a. If yes, were they able to be involved in your antenatal checkups / appointments?
        i. What was this like for you?
13. Was there anything that impacted how you engaged with your antenatal care?
    a. Why / Why not?

Care continuity

14. Did you feel supported by your care team throughout your antenatal care?
15. Do you feel like you received the kind of care you hoped for?
    a. Did you experience any gaps in your care experience?
16. How did this experience impact your overall impression of your antenatal care?

Emotions

17. How did you feel emotionally when you were experiencing antenatal care?
18. How do you feel that this impacted on your pregnancy experience and emotions?

Closing & Recommendations

19. What are the first words that come to mind when you describe your overall antenatal experience?
20. What would you change about the antenatal care framework?
21. Is there anything you would have liked to change about your antenatal care specifically?
22. Is there anything that could have been adapted in your antenatal care to have improved your emotional experiences?

Appendices - Appendix 4

AUTHORITY FOR THE RELEASE OF TRANSCRIPTS

"Continuity in Antenatal Care: Exploring Perceptions of Care and Emotional Experiences"

I confirm that I have had the opportunity to read and amend the transcript of the interview(s) conducted with me.

I agree that the edited transcript and extracts from this may be used in reports and publications arising from the research.

Signature: ..... **Date:** .....

Full Name - Printed

.....