AIMS Ireland

Association for Improvements in the Maternity Services - Ireland

AIMS IRELAND SURVEY REPORT

What Matters To You?:
A Maternity Care Experience Survey

MARCH 2010

Association for Improvements in the Maternity Services Ireland (AIMS Ireland)

Supporting Women, Promoting Change

www.aimsireland.com

AIMS Ireland – What Matters To You? – 2009

In July 2009, AIMSI launched an electronic survey asking women for feedback on their experience of care as users of maternity services. The survey closed on December 31st 2009 and a total of 367 respondents completed the survey all of whom were self-selecting and anonymous.* The survey was accessed via the AIMS Ireland website (www.aimsireland.com) and also through a number of parenting website forums. A report on the results is now complete and both qualitative and quantitative data have been integrated to produce what we hope is an informative and helpful commentary on women's experiences and perceptions of maternity care and services in Ireland.

For further information or to submit feedback on this report, please contact info@aimsireland.com.

Thank You

AIMS Ireland Committee

** Please note there are a number of questions where response rates will be higher than 367. This is due to the fact that the respondent has the opportunity to pick multiple answers, e.g. Q.20.*

What Matters To You? – A Maternity Care Experience Survey (2009)

Survey Introduction

AIMS Ireland is interested in finding out what matters most to pregnant women and their families. How were you affected by previous experience? What improvements would you like? This will help us gain a better understanding of what is most important to the women we represent with regard to their care during and after pregnancy. We ask that anyone who has had a baby in Ireland in the past 4 years to complete this survey. Please only complete the survey once (that is, for your most recent baby). All surveys are anonymous. We endeavour to include as many of your additional comments as possible. Results will be published on our website and in order to raise awareness, we also copy our reports to interested parties such as service providers, government, HSE and media. This survey will take approximately 15 minutes to complete. If you would like to discuss your experiences in more detail, or if you need any further support or information relating to your experience of maternity care, please contact AIMSI Support and Information at **support@aimsireland.com** or **info@aimsireland.com**. Thank you for your participation.

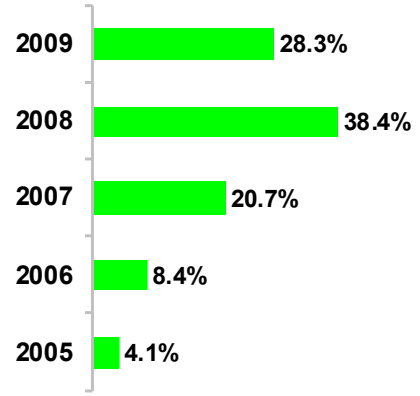
What Matters To You? - Survey Results:

Date Activated	**July 1st, 2009**
Total Participants:	**367**

Information / Choices of Care and Services:

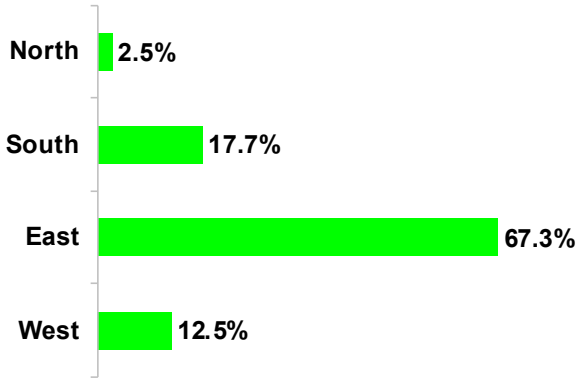
Question: 1. When did you have your last baby in Ireland?

Number of responses: 367



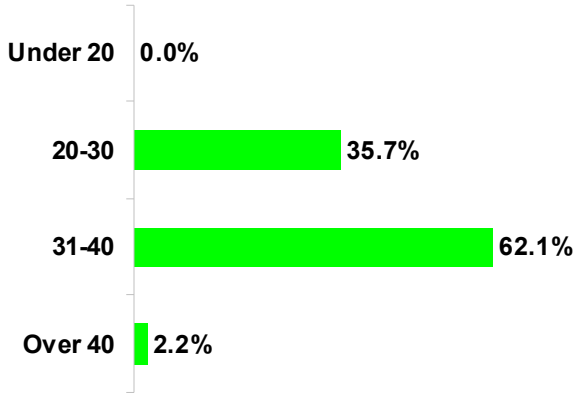
Question: 2. Where in Ireland did you have your baby (which geographical region)?

Number of responses: 367



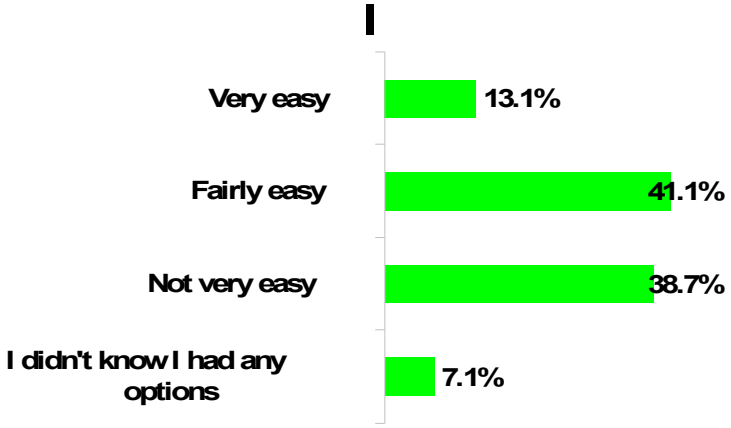
Question: 3. What age were you when you had your baby?

Number of responses: 367



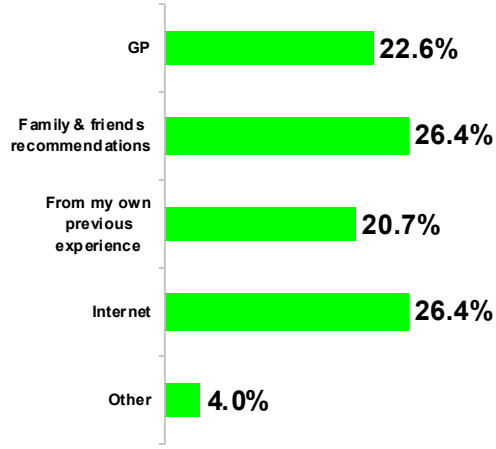
Question: 4. How easy did you find it to gather information about care options that were available to you?
(For example: combined or shared care with GP, midwifery scheme such as DOMINO, midwife-led hospital care or MLU [MLU only available in Cavan GH & OLOL Drogheda], consultant-led care, home birth etc.)

Number of responses: 367



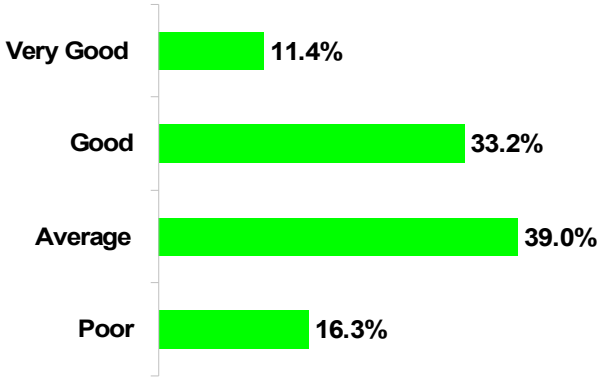
Question: 5. Where did you obtain the information you used to make your choice of care? (Please tick all that apply)

Number of responses: 576



Question: 6. How would you rate the information you obtained regarding choices of care available to you?
(For example: combined or shared care with GP, midwifery scheme such as DOMINO, midwife-led hospital care or MLU, consultant-led care, home birth etc.)

Number of responses: 367



Question: 7. For additional comments on obtaining information, please detail here:

Number of responses: 103

In relation to women's experiences of obtaining information, **GPs** emerged as their central source, as well as **family, friends, hospital consultations** and **internet forums**, although one woman commented that the internet *"while hugely helpful, is only ever anecdotal" (p.8*). Women's satisfaction with the availability of information was extremely varied, and largely depended on the type of information being sought.

> *"Very easy to gather. Hospitals have all of the information." (p.1)*[*]

> *"Hard to contact maternity hospital and they certainly weren't forthcoming with information on first contact." (p.5)*

However, the majority of statements pertaining to information can be characterised by a sense that information relating to care models that deviate from the dominant medical model (hospital-based, consultant-led, combined care with a GP), while available, is not provided to women as a matter of course. This is more commonly sought independently by women through media such as internet forums or the recommendations of friends. One woman commented that

> *"GP only gave info on combined care after I said I was going public, nothing said about DOMINO or homebirth or any other options. I knew about DOMINO only because my sister had gone with them in 2006." (p. 7)*

Consequently, many women were simply **unaware of any other options**, and several comments illustrate this:

> *"I was not even aware that you could have any other type of birth other than the normal combined care." (p. 8)*

> "*I didn't know I had options other than a hospital birth through the antenatal clinic and doctors." (p. 1)*

Receiving **inadequate information** regarding choices of care models was a clear source of dissatisfaction for women, particularly in relation to midwifery-led units (MLUs). One woman explained that

> *"It wasn't hard to find the information online but it took time. In the short period of time that I had to make a decision about care, I was only aware that I had to choose public/semi-p/private care but I wasn't aware of combined care, DOMINO or midwifery schemes. If I had access to more information I would have chosen differently." (p. 9)*

In this way, several women were unaware of the types of care they could have accessed until it was "too late":

> *"I was told by my GP that I had two options, I could either go private, or I could go with shared care with my GP. It was much later that I heard of other options, but it was too late." (p. 9)*

> *"It was only when I joined a parenting site during my pregnancy that I realised the different options that were available to me but by then it was too late." (p. 6)*

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[*] *Page numbers in italics following quotes refer to a document containing the collation of open-ended response categories.*

Provision of selective or incomplete information meant that some women felt that *"combined care was pushed because it suited them more" (p. 8).* Others found that their GPs had little information themselves about alternative care models:

> *"I did not receive any info on first visit to GP. Was informed about MLU […] through family. On asking GP second visit he didn't know much about the service." (p. 3)*

Obtaining information in relation to **home birth** was particularly difficult for women, not least because many of their enquiries were met with surprise and trepidation by GPs and other health professionals who *"acted like I was having bub on Mars" (p. 1).* Other comments include the perception that there was

> *"Absolutely no support from GP or hospital, who clearly considered it an irresponsible alternative and had no qualms about telling me that." (p. 7)*

Practical information about home births was also difficult to gather:

> *"I'm finding it extremely hard to get information about home birth grants from HSE or HBA. No-one seems to know what is happening with the grant." (p. 4)*

It is clear that information relating to the availability of **care options in different locations** is also a source of confusion for many women. The lack of care options in rural areas is particularly acute; in addition, information on those options that do exist is in short supply, and some women appear unsure of whether there may be a greater choice than they are aware due to a lack of information about what is available in their area.

> *"There isn't much choice where I am (Mayo). One hospital and one independent midwife." (p. 5)*

> *"Combined care is the only option in my area, as far as I'm aware (Mid-Tipperary)." (p. 4)*

The issue of choice is further explored in women's answers to questions 8 to 12 below.

Finally, a striking number of women commented on the urgent need for the provision of **one single resource** containing information on details of the care options available in their area. It was emphasised that all of the relevant information should be offered as a matter of course at the initial point of contact with the maternity care services: in most cases women's GPs.

> *"No one resource available to let you know what your various options might be." (p. 2)*

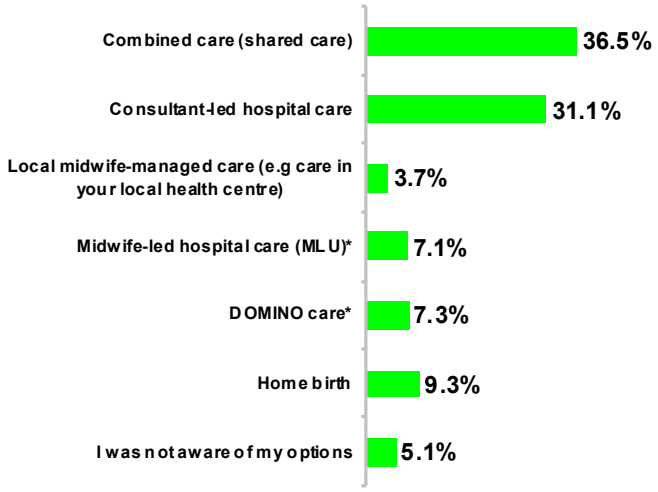
> *"It would be great if there was a pack available that could be given out by GP's as they are usually the first person you go to to confirm your pregnancy before you make your choice." (p.2)*

> *"Information varies greatly. No single source for up to date information. Most information on word of mouth. Hospital policies very secret indeed—usually only find out when you get there in labour!" (p.2)*

> *"I went to two different GPs following my pregnancy and found neither of them were helpful or informative regarding options available for maternity care. If I had known more about the different types of care available in advance, I think I would have chosen an alternative type. I think this problem could be overcome by doing a small leaflet or brochure in each regional area outlining what options are available." (p. 4)*

Question: 8. What type of care was available to you? (Please tick all that apply)

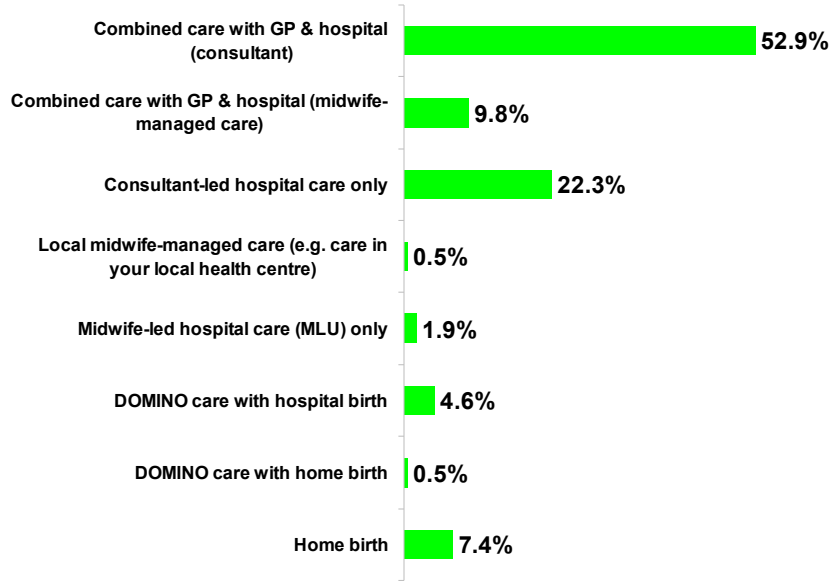
Number of responses: 849



* Midwife-led hospital care (MLU) is currently only available in Cavan GH & OLOL Drogheda; DOMINO care is currently only available in the NMH, the Rotunda, Wexford & Waterford RH

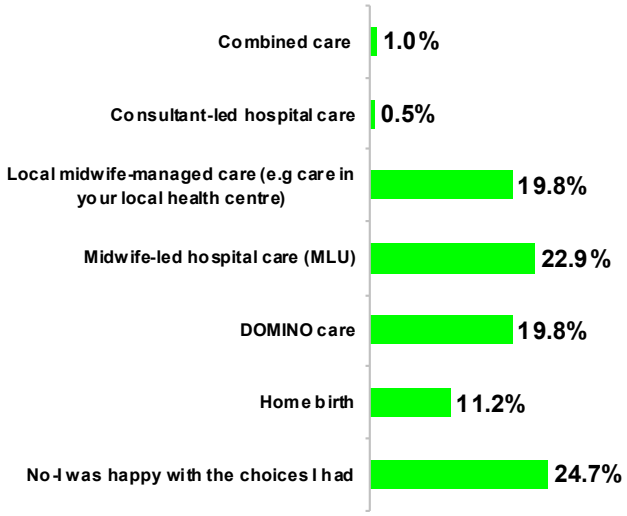
Question: 9. What type of care did you choose?

Number of responses: 367



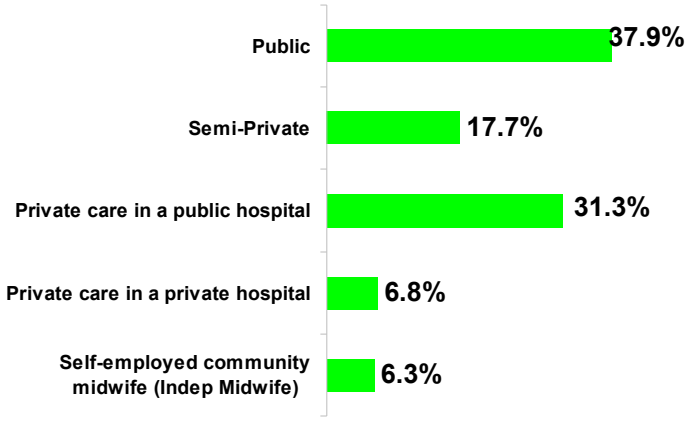
Question: 10. Is there a type of care you would like to have had available to you that wasn't? (Please tick all that apply)

Number of responses: 580



Question: 11. What type of service did you use?

Number of responses: 367



Question: 12. Please give any additional comments regarding any aspect of choices of care and services in Ireland.

Number of responses: 106

The choice of care and services are largely determined by a number of central factors, including **location**, the **availability of information** about different care options, **disparity between supply and demand** of services, **financial and seasonal constraints**, and **exclusion criteria** relating to specific schemes.

Geographical location and **regional variations** in the types of care models available to women emerged as the most significant issue in determining what options of care and services were available to them.

"If you were in Dublin there seems to be a lot of choice, but if you are in the midlands, like me, then your choice is very very limited." (p.12)

"It's frustrating that your address is what decides the options that are available to you (p.10)

"Different choices in different areas makes the choice limited for some women, so it's a bit of a postcode lottery as to the care choices." (p. 13)

Repeated comments were made in relation to the **urban/rural divide,** which suggest that women located in rural areas feel at a disadvantage to those living close to large, centralised maternity units and hospital-based MLUs:

"The DOMINO scheme was excellent, but it should be extended beyond the small catchment area in which it currently operates." (p.20)

Certain areas were mentioned as having few choices available to women:

"There is no MLU, no DOMINO scheme, or home birth option in the Limerick area." (p. 17)

However, proximity to maternity hospitals and an urban location is not always a guarantee of choice due to **catchment area demarcation:**

"Even though I am 5.5 miles from the […], 5 miles from the […], I am not in the area for DOMINO, and the […] doesn't provide it." (p. 12)

In addition to this, options are often limited by the **excessive demands** on staff and services. This is particularly true of care provided by independent, or self-employed community midwives (SECMs).

"Desperate shortage of self-employed community midwives. Nearly didn't find one." (p.19)

"Home birth choice is too limited. They get booked up far too quickly." (p. 11)

This also applied to consultants.

"I was provided with a list of consultants from my GP but what I found astounding was that the first 5 were fully booked." (p. 14)

And to MLUs, leading to comments such as

"Not enough midwives employed in this country to take care of all the options that COULD be made available to us. MLU units are thin on the ground in this country and it's a shame!" (p. 11)

Again, **inadequate information** meant that some women's choices were too limited.

"It was too medicalised. I had, unknowingly, made a poor choice of consultant. I would prefer, if I have another pregnancy, to opt for homebirth with an Independent Midwife, and the second choice being DOMINO with the […]." (p. 17)

Further restrictions on choices of care and services were imposed by **financial constraints**, since certain schemes e.g. home birth in most areas is not covered by public maternity cover.

"It will probably not be possible for me to have a home birth without a grant, as we do not have the money." (p. 21)

"I can't have a homebirth because we do not have the money. It should be an option. Surely it saves the hospital money and bed spaces?" (p. 14)

Other practical considerations had to be taken into account when making decisions regarding care options. As one woman explained,

"*I had all the options available to me, however due to my EDD, no IM [independent midwife] would take me on for a home birth (Christmas Day)." (p. 21)*

Another felt she had no option but to avail of public care because

"The private consultants were all on holidays when I was due in August." (p. 13)

Several women also commented on the **exclusion criteria** determining eligibility for home birth and MLU schemes:

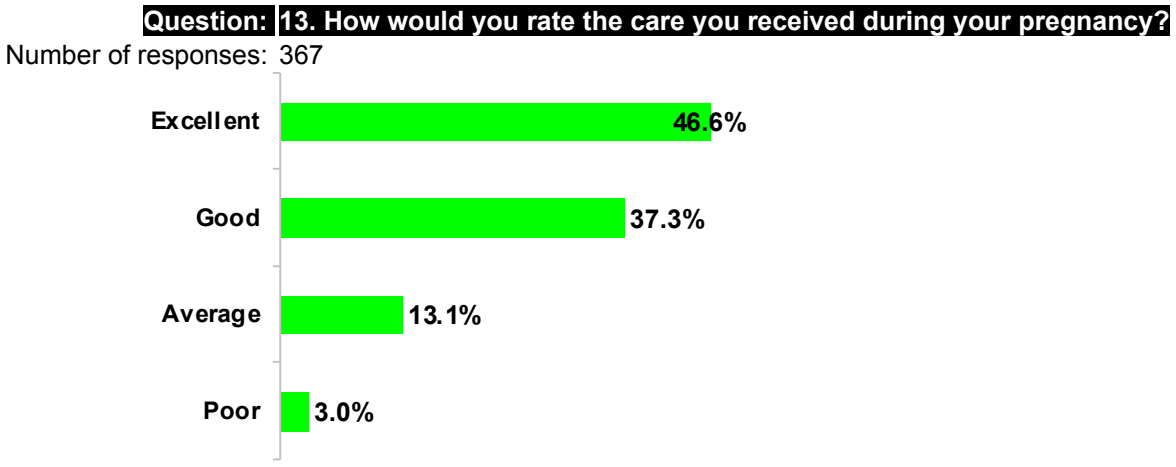
"MLU in […] and […] have too many conditions." (p. 15)

"Very little real choice available and MLU criteria much too restrictive." (p. 13)

Other reported experiences in relation to choice were varied, and included concerns over **hygiene:**

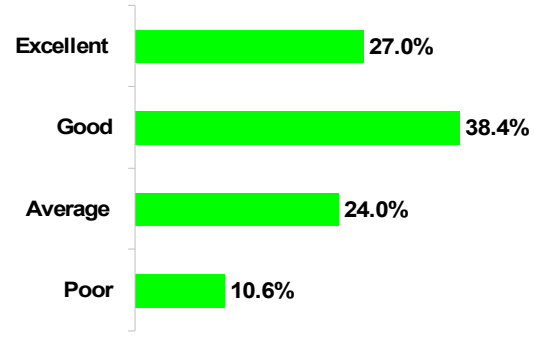
"I felt I had no choice than to attend a private hospital for the standard of hygiene and attention I wished to receive." (p. 10)

Antenatal Care:



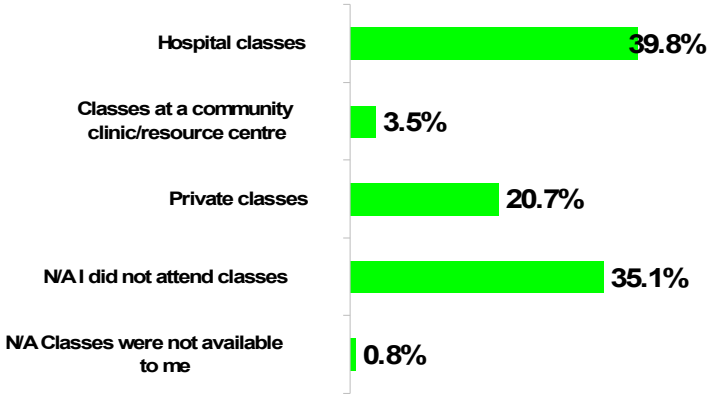
Question: 14. How would you rate the information you were given throughout your pregnancy?
(For example: diet, exercise, cautionary advice, what to expect during pregnancy/labour)

Number of responses: 367



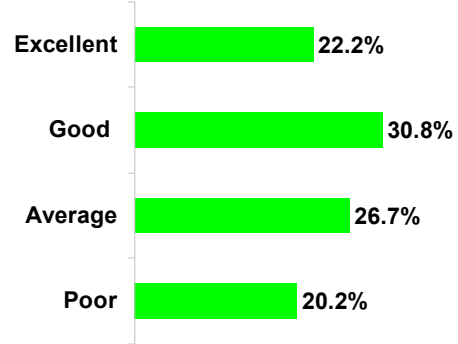
Question: 15. What antenatal classes did you attend?

Number of responses: 367



Question: 16. How would you rate the antenatal classes in terms of preparing you for the birth and postnatal period?

Number of responses: 243 (Total responses=367; *n/a=124 not graphed)*



Question: 17. Please use this section to provide any additional comments regarding your experience of antenatal classes.

Number of responses: 150

Women's experiences of antenatal classes varied enormously, depending on what type of class they attended, which included **privately run classes**, often encompassing birthing techniques such as yoga or hypnobirthing methods, as well as classes run by **Cuidiú** teachers, community-based **hospital-run classes**, and classes run by **hospital physiotherapy units**. Again, as with responses regarding information and choice, it appears that there is **little standardisation** or uniformity of service provision across different regions. Common sources of dissatisfaction include classes being **outdated:**

> *"The videos we watched were from the 70s." (p. 28)*
>
> *"Outdated information based on [instructor's] own experience of giving birth 25 years previously." (p. 24)*

Or that classes were **overcrowded:**

> *"There were too many people there (over 50) to get anything more than an overview." (p. 21)*
>
> *"There was only standing room for some." (p. 26)*

Some classes displayed an emphasis on **lecture-type delivery** of class content:

> *"There was little discussion about things, We were told 'this is how things will happen." (p. 27)*

Many women attended privately run antenatal classes because hospital-run classes were **booked up**—*"not enough antenatal classes available and all booked out" (p. 26)*—or because none were available to attend outside of normal working hours.

> *"I did not feel I could take four mornings off work to attend. I think the hospital class should be made more accessible to working women." (p. 25)*

For some, **oversubscription** to classes also meant that women's partners could not attend.

> *"Physio classes in […] were really good. Small class size but partner could not attend." (p. 23)*

There was a strong sense that information provided at antenatal classes was **inadequate** and focused on fairly narrow aspects of the birthing experience, in particular on **pain relief** in a hospital setting.

> *"All the info about birth was only relating to hospital births, too much emphasis on medical pain relief and not enough info about natural birthing." (p. 22)*
>
> *"The hospital-run classes seemed to focus a lot on pain management during labour." (p. 23)*

This was disappointing for many women who felt that they were

> *"Basically prepped on the hospital's way of delivery." (p. 31)*

Or that

> *"The classes were premised on an assumption of childbirth painful, problematic, to be managed by drugs and one which frames childbirth as a medical problem to be solved." (p. 24)*

In addition, the **manner in which information was delivered** was unsatisfactory to many women.

> *"The midwife was very graphic and told awful stories of experiences she had seen." (p. 30)*

Instructors were also described as *"flippant" (p. 24), "dismissive" (p. 26), "condescending" (p. 24)* and *"jocular" (p. 31),* and recurrent comments suggested that women felt the classes were

> *"Entirely designed to tell you how to behave in a hospital and how to make the staff's job easier." (p. 31)*

Several areas emerged as being inadequately addressed during antenatal classes. For example, women having their second child reported that the **information** provided did not prepare them for the challenges involved in looking after a baby and another child. This was linked to several calls for more information to be provided about the immediate **postpartum period**, and the possible difficulties encountered by many women.

> *"More information is needed on postnatal care and healing . . . I wasn't prepared for the shock of feeling so bad after the birth, and how long it lasted." (p. 24)*

Some felt that classes should also provide information on **post-natal depression**:

> *"There was no information on postnatal depression with which I suffered after the birth, and didn't know where to turn." (p. 22)*

One of the most significant issues raised in relation to antenatal classes was the lack of information provided about **Caesarean sections**, leaving many women uninformed and unprepared. One woman commented that she

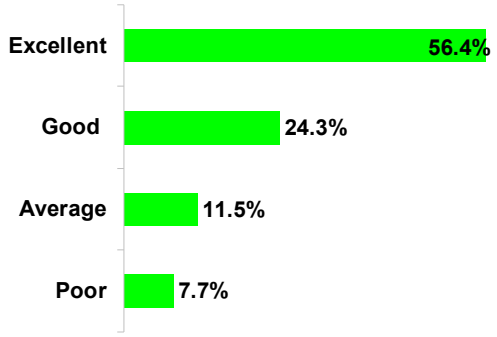
> *"Had no preparation whatsoever for this scenario even though I had attended all the antenatal classes." (p. 29)*

Women who had Caesarean sections felt that information about such an eventuality was *"completely glossed over" (p. 30)* and that classes focused *"solely on vaginal birth" (p. 31).* Consequently such lack of knowledge was a source of stress with women feeling that no attention had been given to the possibility of *"special circumstances" (p. 29).*

Labour and Birth:

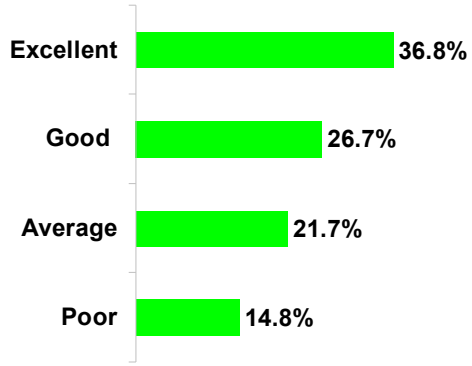
Question: 18. How would you rate the care you were given during labour?

Number of responses: 337 (Total responses=367; *n/a=30 not graphed)*



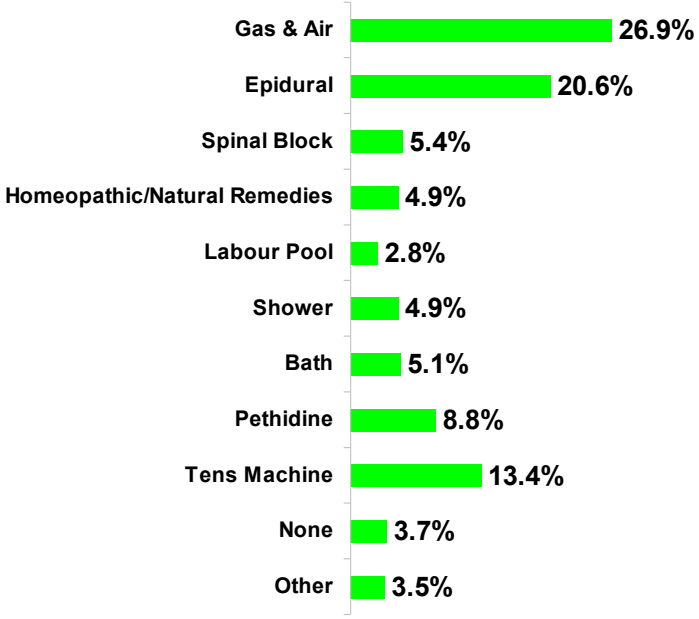
Question: 19. How would you rate the information you were given during your labour? (For example: pain relief options, any procedures and reasons for them and side effects for you and your baby)

Number of responses: 337 (Total responses=367; *n/a=30 not graphed)*



Question: 20. What type of pain relief did you avail of during your labour and / or birth? (Please tick all that apply)

Number of responses: 761



Question: 21. For additional comments on 'Other' in Q. 20, please detail here:

Number of responses: 75

Alternative (non-medical) pain relief methods were used by several women. **Hypnobirthing** techniques were mentioned by many, as well as reliance on the support of a trusted birth partner for support

> *"The one on one support from a midwife was great." (p. 40)*

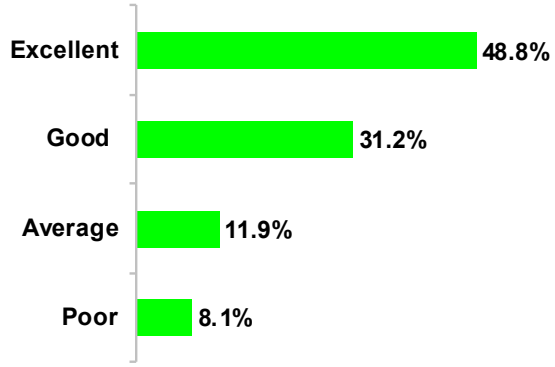
Few women were able to avail of **water (bath/shower/birth pool**) as a means of pain relief in hospital. One woman noted that

> *"The baths in […] were not very useful as there was no assistance available to get out of them." (p. 41)*

Responses relating to questions about pain relief reveal that while women were aware of many different methods, both medical and non-medical, employment of them was not always possible, either due to circumstances such as a very fast labour, or hospital policies which were at odds with the wishes of the labouring woman.

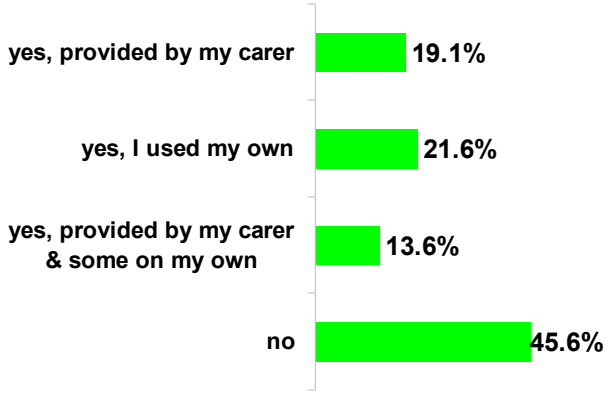
Question: 22. How effective was your choice of pain relief?

Number of responses: 336 (Total responses=367; *n/a=31 not graphed)*



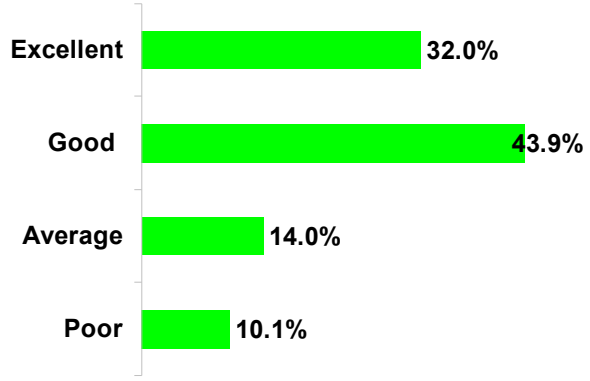
Question: 23. Did you use any labour aids*?
* Examples of Labour Aids: birth ball, heat pack, hypno birthing, doula, etc

Number of responses: 324 (Total responses=367; *n/a=43 not graphed)*



Question: 24. How effective was your use of above labour aid(s)?

Number of responses: 178 (Total responses=367; *n/a=189 not graphed)*



Question: 25. For additional comments on any other labour aids used, please detail here:

Number of responses: 85

The use of a **birthing ball** was frequently mentioned as a labour aid. Again the variation in the different experiences of women is clear in that while some found it provided pain relief and helped to progress labour.

> *"It helped with rotating my hips and also with gravity to help the baby down. I sat on it and bounced through all the contractions." (p. 46)*

Others found that

> *"It did nothing for me . . . just felt like I'd fall off." (p. 48)*

Hospital policy with regard to the use of birthing balls varied and some women were unable to use them in the labour ward.

> *"I was told I couldn't bring my ball into the labour ward." (p. 42)*

Hypnobirthing techniques were mentioned by several women, which were described as *"the main source of controlling pain" (p. 43), "excellent" (p. 43)* and *"just so useful" (p. 44).*

Some women mentioned using **homeopathic remedies**, though again hospital policy with regard to their use was unclear and one woman felt that she *"had to do it in a hidden fashion" (p. 43).*

Other labour aids included **Tens machine** which *"worked reasonably well" (p. 46),* support from a partner and being able to move around. Restricted mobility due to being *"hooked up" (p. 44)* to monitors such as CTG machines was mentioned as restricting access to labour aids such as birthing balls.

Question: 26. Was there any type of pain relief or labour aid you would like to have had available to you that wasn't?

Number of responses: 144

Access to a **birthing pool** during labour was the form of pain relief most desired by women despite being unavailable in most hospitals. Hospital policy towards birthing pools received some criticism:

> "*Why was I allowed in the bath and not in the pool?" (p. 52)*

Many women felt that labour wards were lacking in physical birthing aids as they did not have access to **birthing balls, heat packs**, birthing stools, or a "***birthing rope*** *(which is hanging from the ceiling and mother is holding it during pushing)" (p. 58).*

Some women felt that there was not sufficient awareness amongst the staff of the range of pain relief options or positions that would aid labour and birth.

> *"I was only offered medical pain relief and told to stay in bed . . . . would have liked to be told about other options." (p.54)*

Restricted mobility limited the forms of pain relief available to some mothers leading to calls for greater access to the *"**walking epidural**" (p. 50).*

Many women expressed a desire for greater access to alternative (non-medical) pain relief methods, including **Tens machines**, **doulas**, **homeopathy** and **aromatherapy**.

Question: 27. Please give any additional comments regarding any aspect of labour care and pain relief.

Number of responses: 107

Comments focused on the **care available** more than the pain relief chosen. Women's experiences of labour care varied enormously, with some satisfied with the care that they received:

> *"Midwives and consultant very supportive of my wishes." (p. 59)*

Others had mixed experiences:

> *"Some of the individual nurses were fantastic, others very unsatisfactory." (p. 62)*

And others had very poor experiences:

> *"Felt that midwife could not care less about the pain I was in and I felt completely powerless. It was all hospital policy and I had absolutely no rights." (p. 63)*

Some women also felt that midwives were not informed about or supportive of **alternative** forms of pain relief and some asked that they

> *"Not undermine . . . [a woman's] ability by asking if . . . [they] want pain drugs, as if . . . [they're] not coping." (p. 59)*

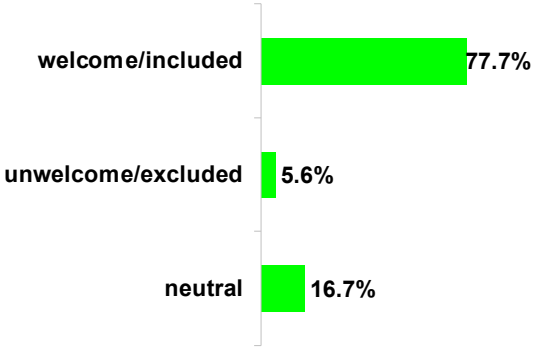
> *"Midwife unsupportive of my desire to avoid epidural." (p. 63)*

Most were satisfied with their pain care but many complained of **ineffective epidurals**, and that at times were not believed when they did not work.

> *"Was left 6 hours with an ineffectual epidural as the midwives wouldn't believe me when I told them I could feel cold when they did the ice test." (p. 59)*

Question: 28. If you had a birth partner, how do you feel he/she was treated during your labour and birth?

Number of responses: 353 (Total responses=367; *n/a=14 not graphed)*



Question: 29. For additional comments on birth partners, please detail here:

Number of responses: 79

Women felt **restricted by hospital policies** limiting them to only one birth partner with many expressing a desire to have their mother, a doula or other person present to support them.

> *"I would have liked to have my mother there for some of the labour and my partner at the end. It is very unfair that you have to choose." (p. 73)*

> *"I had to choose one birth partner only and my husband definitely wanted to be there, but I don't see why my Mum and husband couldn't have both been there." (p. 77)*

The restriction to one birth partner often led to problems for the woman if her chosen partner had difficulties during the labour.

> *"You should be allowed have a second birth partner as my husband was not able for it. He was upset seeing me in pain and worried when I was having trouble in the pushing stage. I needed more emotional support and encouragement which I did not get from my midwife." (p.71*)

> *"He passed out and was well looked after by some midwifery students." (p. 72)*

The attitude of staff to birth partners in the labour ward was mixed:

> *"I found that the hospital staff really relied on my husband during the labour as it reduced their time looking after me. However when the baby was born he was ignored and seen as a hinderence [sic]." (p.77)*

> *"I suppose invisible would be a better word!" (p.71)*

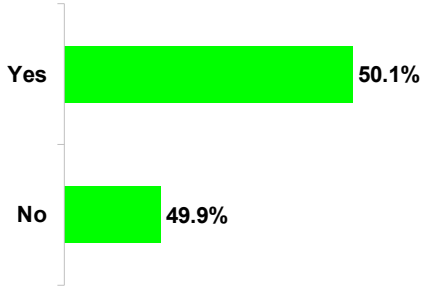
> *"Husband felt very welcomed and informed by midwives." (p. 72)*

The need for a birth partner was recognized by all and many felt that birth partners are not adequately recognized or supported.

> *"The value and benefit of the support you get from a birth partner cannot be overstated." (p. 72)*

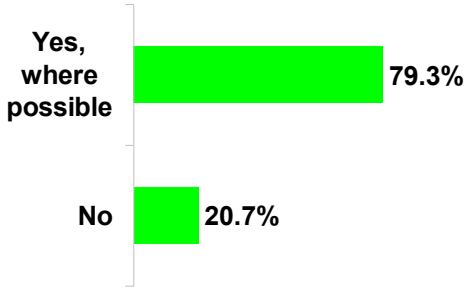
Question: 30. Was an obstetrician present at the birth?

Number of responses: 367



Question: 31. If you had a birth plan, were your wishes respected?

Number of responses: 135 (Total responses=367; *n/a=232 not graphed)*



Question: 32. For additional comments on birth plans, please detail here:

Number of responses: 91

Many reasons were given for not writing a birth plan. Some did not feel the need to commit the plan to paper as their birth partners were aware of their wishes.

> *"I had a birth plan in my head and my birth partner was familiar with it." (p. 78)*

Others felt that birth plans were viewed negatively by hospital staff.

> *"The idea of a birth plan was almost laughed at. I was told to let the professionals do their work." (p. 85)*

> *"I would have liked more information on these. The idea of a birth plan was totally dismissed in the hospital classes." (p. 81)*

Some of those who did write birth plans experienced a positive reaction from staff.

> *"[The staff] were very encouraging of using a birth plan and made every effort to follow it where possible." (p. 84)*

"Midwives read my plan and used it to best understand my expectations of birth experience." (p. 80)

Most of the respondents who had written birth plans found that staff were not receptive to birth plans.

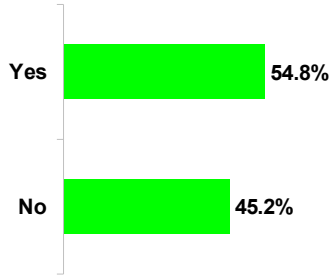
"I was told because I was being induced, my choices were therefore taken away from me and I had to do what I was told." (p.78)

"Midwife openly admitted she didn't bother to read the birth plan." (p. 82)

Staff's **attitude to birth plans varied within care facilities** with many women commenting that a change in staff could lead to a change in attitude towards their birth plan. Many women felt that an ongoing relationship with your midwife made a birth plan unnecessary as there would be *"plenty of opportunity for discussion prior to the birth" (p. 80).*

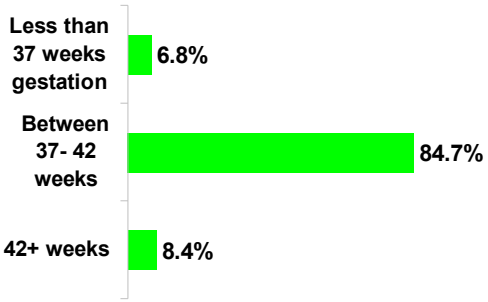
Question: 33. Was this your first baby?

Number of responses: 367



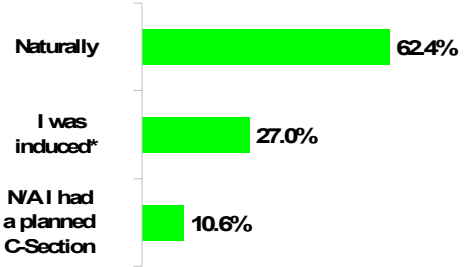
Question: 34. At what stage was your baby born?

Number of responses: 367



Question: 35. How did your labour start?

Number of responses: 367



* Some examples of induction methods: cervical sweep, ARM (breaking of waters), pessary/gel to soften cervix

Question: 36. Please give any additional comments regarding any aspect of care during the birth.

Number of responses: 91

Women's **experiences of care varied enormously**, from *"excellent" (p. 93)* to *"chaotic" (p. 89)* and *"awful" (p. 91).*

> *"They made both myself and my husband feel like it was the first baby they had ever delivered." (p. 89)*
>
> *"I feel lucky with the care I received from the hospital midwives." (p. 88)*

There were many positive comments on midwife-led care with calls for more midwives to become available.

Common sources of dissatisfaction included being treated **rudely, bullied or ignored**. **Procedures were not fully explained and consent was not obtained** for procedures in many cases.

> *"I was given no information and not included in any decision making." (p. 95)*
>
> *"I only saw the consultant once who came in said we will give her another hour then it's a c-section and walked out. He did not even speak to me . . . [he] spoke to the midwife." (p. 95)*
>
> *"I felt bullied, threatened and scared into procedures I did not want and some others were performed without even asking my permission or telling me." (p. 88)*
>
> *"Doctor doing stitches was on the phone the whole time, took 3 calls and wasn't polite at all." (p. 89)*
>
> *"Obs was not a nice man—'I've been doing this for forty years so I know best' (literally said that)." (p. 91)*

Many attributed the poor care to **overworked staff and under-resourcing.**

> *"Although the midwives both in the labour ward and antenatal ward were very nice they were so busy they were unable to provide adequate support to me making my labour a more scary and stressful experience." (p. 88)*
>
> *"Fainted and felt helpless with the baby . . . Needed a little help and the nurses were under resourced." (p. 91)*

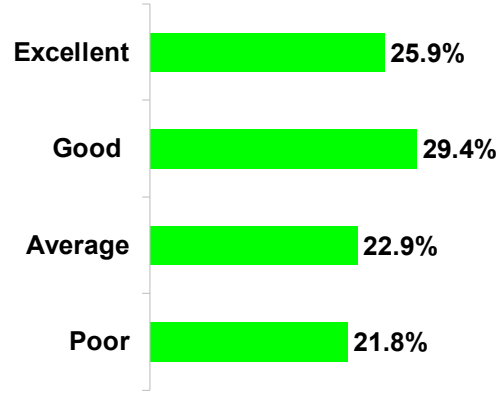
Although most complaints related to the care provided by staff, there were also some complaints regarding the **physical conditions.**

> *"Shared room during labour is disgusting in 2009!!!" (p. 88)*

Post-natal Care:

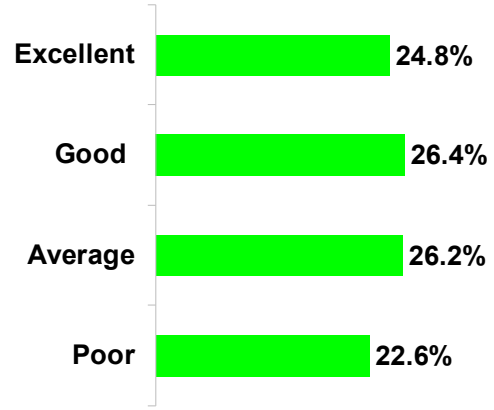
Question: 37. How would you rate the care / support you received after your baby was born (that is, postnatal care up to 6 weeks after the birth)?

Number of responses: 367



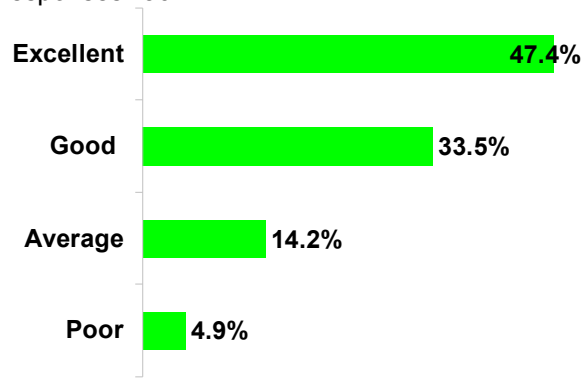
Question: 38. How would you rate the quality of information you were given relating to yourself after the birth of your baby? (For example: caring for stitches, follow-up appointments, pain relief advice, postnatal depression or PND etc.)

Number of responses: 367



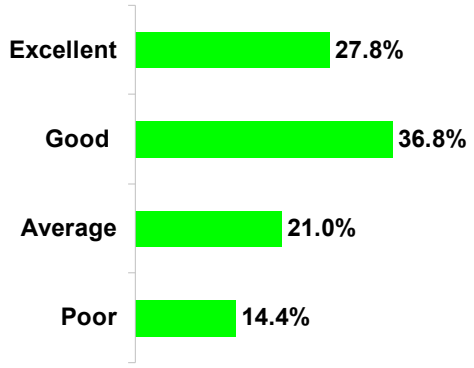
Question: 39. How would you rate the care your newborn(s) received?

Number of responses: 367



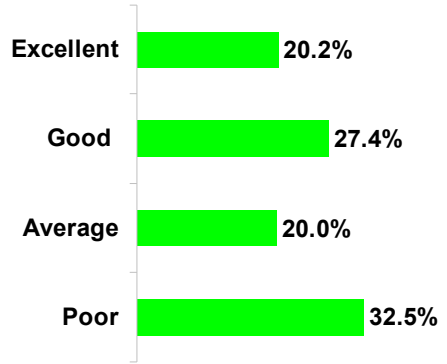
Question: **40. How would you rate the quality of information you received relating to your newborn(s)?**
(For example: infant care such as bathing, cord care etc., feeding advice, contact information for local support groups, vaccinations or any information leaflets)

Number of responses: 367



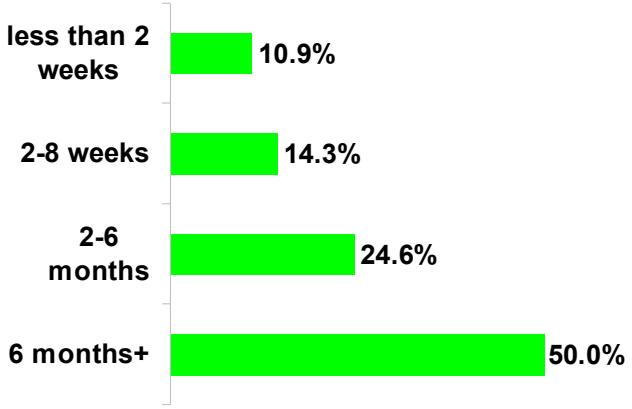
Question: **41. If you breastfed your baby, how would you rate the breastfeeding support / information you recieved?**

Number of responses: 296 (Total responses=367; *n/a=71 not graphed)*



Question: **42. If you breastfed your baby, for how long?**

Number of responses: 292 (Total responses=367; *n/a=75 not graphed)*



Question: 43. Regarding yourself, please comment if there was any type of post-natal care / support / information you would like to have had available that wasn't. (For example, lactation consultant, nursery care, parenting classes. If none, please specify n/a.)

Number of responses: 227

In relation to post-natal care, many respondents felt this was a particularly under-resourced area. The lack of good quality **breastfeeding support** appears a major issue. Women spoke of contradictory advice being offered by midwives and not enough lactation consultants available to offer round-the-clock support. Outside of the hospital setting, women suggested that the availability of **lactation consultants** for home visits, health centre appointments or even telephone support, would be hugely beneficial.

> *"An independent lactation consultant is needed. The midwives are quite busy on the ward and I observed on more than one occasion women persuaded to bottle feed their babies unnecessarily." (p. 102)*

> *"I feel that a lactation consultant is an absolute must. I would expect 1 or 2 follow-up calls to check all is going well in the first few weeks after birth. The s/he should be available at the very least part-time in local health centres, for one-on-one sessions." (p. 116)*

Some women also spoke about the lack of follow up by medical staff post-natally, particularly those who had difficult births. Women ask for more understanding in these situations together with better **de-briefing** and explanation.

> *"I would have liked the opportunity to discuss the birth with a doctor . . . this should be done routinely in all cases when complications have arisen . . . A major disadvantage of the public system is the lack of continuity of care and the time pressures on staff does not lend to any kind of in-depth discussion. A post birth information service should be available at all hospitals." (p. 105)*

A number of women who experienced **pre-term birth** criticized the lack of support and information regarding **neo natal care and procedures in NICUs** and upon discharge from hospital. More written information, counselling and support services were suggested.

> *"My baby was born at 32 weeks and I think it would have been very useful to have someone to take time to talk to my husband and I about what to expect . . . A support service either from within the hospital or in the form of a parent support group would be excellent." (p. 108)*

Continuity of care was also highlighted. Women talked of feeling unsupported in the days and weeks following discharge and spoke of their wishes for more visits from PHNs, similar to community post-natal care provided in UK and European health systems. The **inequity** between community midwifery services available in one **catchment area** versus others was also highlighted.

> *"More planned home visits. Women are discharged from hospital so quickly now, but there is no follow up apart from the Public Health Nurse on Day 5 for the gutherie test. However, if you are lucky enough to be in the catchment area for the community/midwifery DOMINO scheme, a midwife will call everyday and give undivided attention and that advice and support so essential in those first few days." (p. 97)*

Finally some women requested the availability for **optional nursery care** in hospital for those with difficult births or complications, more **parenting classes** and **basic first aid** for newborns.

Question: 44. Regarding your newborn(s), please comment if there was any type of post-natal care / support / information you would like to have had available that wasn't. (For example: skin-to-skin contact, tests, procedures, vaccines, leaflets. If none, please specify "n/a".)

Number of responses: 171

Many women wished for more **skin-to-skin contact** with their babies which was denied them because of stitching and Caesarean section recovery.

> *"I would have liked more skin to skin contact—I feel my baby was taken from me unnecessarily to have the stitches done." (p. 124)*

> *"It is hospital policy not to allow babies in the recovery room due to sensitivity of other patients who may also be recovering . . . however on both my C-sections I was alone in the recovery room and could have had my baby with me without any disturbance to anyone." (p. 129)*

Some mothers outlined the need for more **information** on the **basic tests and procedures** that are carried out on their babies after birth. For those with special care or premature babies they wished for more advice on feeding and general care.

> *"I feel I wasn't given any guidance on his development and wasn't given any advice on whether my baby should be cared for differently than full term babies" (p. 122)*

> *"Information and assistance with skin-skin, breastfeeding and bonding in these circumstances would be very beneficial as I believe that breastfeeding and bonding in general were hampered by this early separation." (p. 124)*

Other women spoke of their wish for more **explanation** around **infections** their babies had got—what they were, the causes and the guidelines on care. One woman commented *"my baby got MRSA and the advice I got about this was minimal" (p. 127).* Others spoke about their babies **birth injuries** and how little or no adequate information was given to them by staff.

> *"Baby had a bad injury which was not commented upon by midwives/consultants. Yet it was noted in my hospital notes. I was given no instructions as to how best to care for it and baby cried for 10 weeks. A visit to an osteopath on advice of a retired midwife resulted in instant relief for baby." (p. 127)*

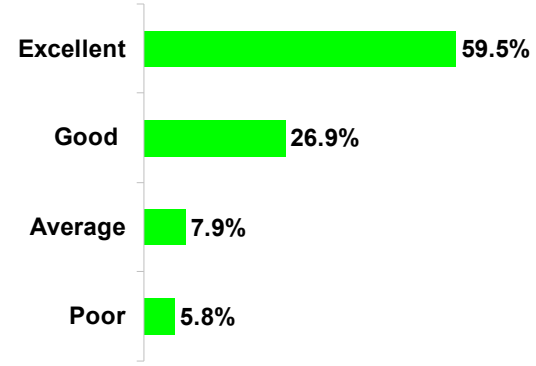
Unhelpful comments from medical staff regarding their baby's condition was commented on by some women who were looking for **communication** that was more sensitive and informed.

"My baby was 'twitchy' after the birth and one medical person said 'maybe you drank too much coffee or were on drugs before the birth'? Another pediatrician said 'Mummy's not doing her job properly' at our 6 week check (private), because my son had a flat head. But the consultant confirmed afterwards to me that it was because of the birth position—Op. It left me nervous and upset for a long time afterwards." (p. 131)

The delay of the **BCG vaccination** for babies, up to months after their birth, was also a source of concern for a number of mothers.

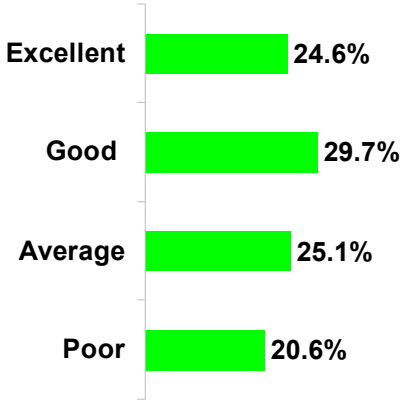
Question: 45. If you had a postnatal midwife, how would you rate the care/support your post-natal midwife provided at home?
(For example, those on Early Transfer Home or DOMINO schemes)

Number of responses: 89 (Total responses=367; *n/a=278 not graphed)*



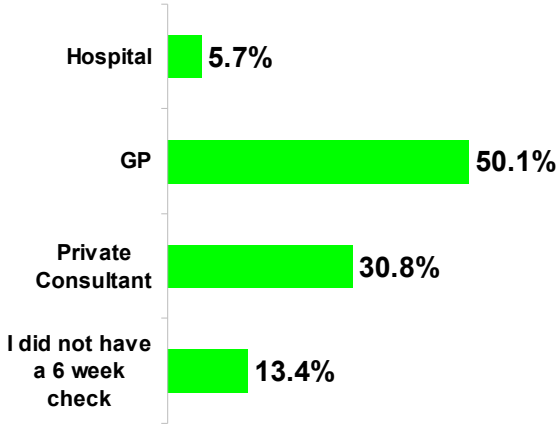
Question: 46. How would you rate the care / support your Public Health Nurse (PHN) provided at home or in your health centre?

Number of responses: 363 (Total responses=367; *n/a=4 not graphed)*



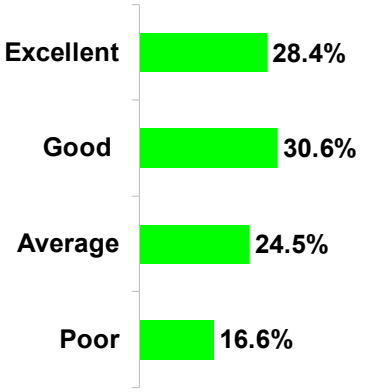
Question: 47. Where did you have your 6-week check? (mum's personal check up, as separate from baby's)

Number of responses: 367



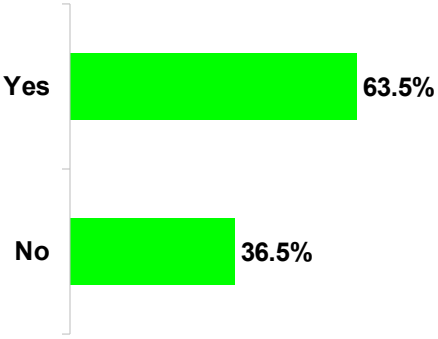
Question: 48. How did you rate the care at your 6-week check?

Number of responses: 315 (Total responses=367; *n/a=52 not graphed)*



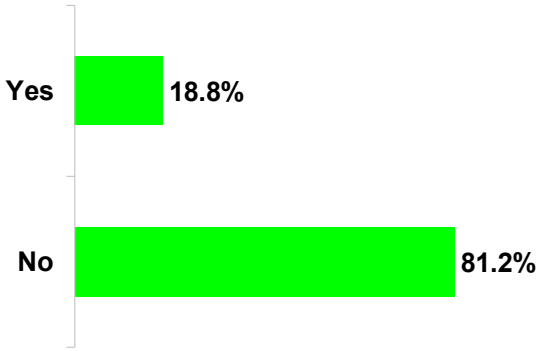
Question: 49. Was your psychological well-being discussed with you at any time post natally by your care-giver (GP, consultant, midwife, PHN)?

Number of responses: 367



Question: 50. Did you go on to suffer from Postnatal Depression after the birth of your baby?

Number of responses: 367



Question: 51. For additional comments on care and services (screening/information/treatment) in relation to Postnatal Depression, please detail here:

Number of responses: 82

Screening, information and treatment for post-natal depression (PND) ranged from excellent to very poor. Some women felt that **good pregnancy and birth experiences** protected them from developing PND.

> *"Maybe I was just lucky but I do feel the relaxed environment I had my pregnancy and birth in helped me greatly here." (p.132)*

> *"I believe that I got the adequate support to have a healthy normal birth which protected me from PND." (p. 134)*

Women talked about the **attention given** by medical staff and PHNs to their emotional well-being.

> *" I was regularly asked questions probably intended to work out if I might have PND. I didn't but appreciated that staff were being vigilant about it." (p. 135)*

> *"I found that the PHNs at the baby clinic asked after my psychological wellbeing each time I visited and I appreciated it." (p. 138)*

For some women who were diagnosed with PND, **care and support** was excellent.

> *"My PHN and GP were excellent in dealing with my PND, the PHN was such a support to me." (p. 139)*

However, for others, treatment and care was not so good. Many women spoke of their surprise that their emotional well-being was **not discussed** at all.

> *"It was never ever discussed with either GP, obstetrician or PHN." (p. 136)*

> *"As a mum with a history of PND I was stunned this never came up with the hospital." (p. 135)*

Where PND was diagnosed or high risk for same was recognized, **communication** between staff and **continuity of care** was sometimes lacking.

> *"Although it was confirmed I had ante natal depression by a hospital doctor, the midwives in the labour, delivery and post natal wards didn't know this. In particular I was treated very badly by one of the postnatal midwives and as a patient suffering from depression and an infection following birth. I think this was so cruel." (p. 133)*

> *"I was very upset leaving the hospital and had a very high Edinburgh score but did not get to see anyone about it and it was never followed up which I thought was poor." (p. 132)*

Some women were reluctant to bring up how they were feeling with carers, either because they were **afraid,** or having brought it up, they felt it was **not adequately addressed** and avoided mentioning it again.

> *"I suffered from [PND] but nobody knew, I lied to all caregivers about my mental state. Unfortunately it wasn't hard to fool them." (p. 133)*

"I became convinced that my baby might be taken from me or I would be seen as 'unfit' if I admitted to suffering with PND." (p. 138)

"I think there is still a stigma attached to it. I believe people still pass under the radar because they don't want to feel that they have failed in some way!" (p. 133)

"Neither PHN or GP are equipped to deal with post natal mental health issues and after trying to talk with both no constructive or helpful replies I have not raised the subject again." (p. 139)

Numerous women spoke about the importance of **continuity of care** and the essential role of PHN and GP post-natal care in the community. Respondents also suggested that partners should be given more **information** about the symptoms and treatment of PND. It was felt that leaflets currently available were not comprehensive enough to fully explain the complexity of the condition.

"I don't think the leaflets on PND do it justice. It isn't as clear cut as the leaflets would suggest." (p. 134)

Question: 52. Please use this section to provide any other comments regarding your experience of post natal care.

Number of responses: 84

For many of the women who responded, post-natal care was **inconsistent and inadequate**. Many women wished to have more **continuity of care** and greater frequency of PHN **home visits.**

"Postnatal care in Ireland seems to be inconsistent, depending on the quality of your individual public health nurse and/or hospital." (p. 141)

"Post natal care is quite lacking. You go from being in hospital environment for almost a week (after a section) to home with NO support at all. Can be very scary. Would love to have regular/daily visits for the first while from PHN other community midwife (like in the UK)." (p. 147)

Good experiences of post-natal care were characterized by **supportive** but under-resourced PHNs:

"Public Health Nurses under a lot of pressure, but provided great support and follow up." (p. 146)

There were a number of criticisms of the **quality of post-natal care** provided by GPs:

"On 6 week check up GP asked 'is everything ok'. Last 1-2 mins, no physical/emotional check up provided." (p. 141)

"GP did not conduct a proper 6 week check, just asked a question or two at my baby's check-up, despite my having had pre-eclampsia and a blood count of 7.7 on leaving the hospital. My hospital notes stated that the GP would check blood pressure and blood count but she made no reference to this." (p. 143)

As well, there were criticisms of the GPs' role in discussing the **birth experiences** of women:

> *"The GP may not be [the] best placed to discuss any issues around the birth and potential implications for future pregnancies." (p. 143)*

Many women commented on the importance of **family** and a good **social network** to support them in the early weeks of motherhood:

> *"It was crucial for me to meet other first time mothers and to tap into the support of family members during the early weeks and months with my newborn." (p. 142)*

Internet-based parenting forums were also helpful to many mothers at this time:

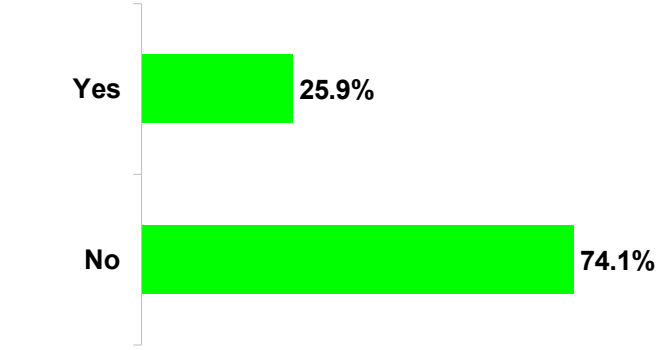
> *"You're left to paddle your own canoe! and only for internet sites like […] and […] you would have no support!!!" (p. 143)*

Finally, for those with difficult birth experiences, it would appear **early debriefing** and **lack of follow up** did little to ease upset and distress:

> *"In my case, delivery was difficult, resulting in physical and psychological trauma that in my opinion was discussed with me too early (ie the following day). Due to exhaustion and general feelings of blurriness I took none of this information in and it was only later that the enormity of what had happened hit me and took a long time to heal. I felt very much cast adrift and left to my own devices postnatally." (p. 145)*

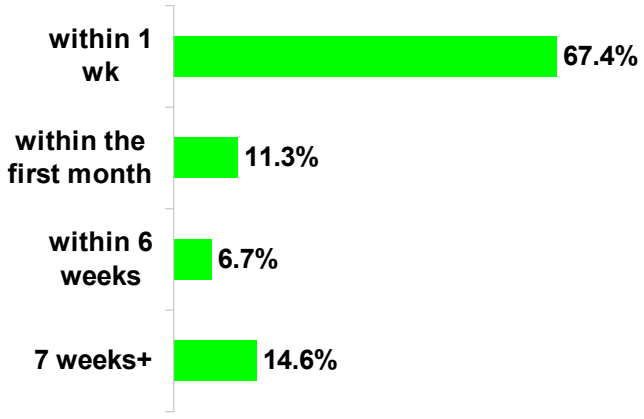
Question: 53. Were you given a patient/client satisfaction form to fill out after the birth of your baby?

Number of responses: 367



Question: 54. How soon after the birth did you complete it?

Number of responses: 88 (Total responses=367; *n/a=279 not graphed)*



Question: 55. Please use this section to provide any additional comments / feedback on your experience of maternity care and/or services in Ireland.

Number of responses: 159

Overall, as one would expect, respondents reported both positive and negative experiences with maternity care and services.

Comments from mothers regarding **good birth experiences** include:

> *"Fantastic care in hospital, midwives and doctors very open and happy to explain/demonstrate." (p. 152)*
>
> *"I found the care I received excellent, both from my obs and during labour and birth, and also after my baby was born." (p. 148)*
>
> *"The care I received with an IM [independent midwife] was superior to the care as a private and semi-private hospital client. For me the issue of continuity was key." (p. 150)*
>
> *"I had a wonderful experience in the home-birthing of my third son and would recommend the community midwives in […] unreservedly." (p. 150)*

Whilst those with **bad experiences** reported:

> *"Overall—ill informed, still very consultant-focused, not as parent-empowered a process as it should be, and the focus is on medically good outcomes (which is important), but sometimes to the detriment of the overall wellbeing of mother and baby." (p. 152)*
>
> *"A few people treated me so badly during my labour and hospital stay. My labour was very traumatic and I still suffer flashbacks. I am pregnant again and dreading having to go back and face them." (p. 167)*
>
> *"Under CLU care as a public patient I felt overlooked at my visits with the various consultants." (p. 151)*

Additional comments and feedback outlined a number of specific areas where women would like to see improvements made such as; **choice, information, consent, evidence based practice, one partner policies, breastfeeding support, hygiene and facilities, security, post-natal support in and outside hospital, continuity of care, birth debriefing** and **trauma support** *and* **service user participation** *and* **feedback**. In their own words:

Choice:

> *"It is time for Ireland to get in line with countries such as the UK, New Zealand etc and adopt a more midwife led care policy with more options available to women, smaller midwife led units in more counties rather than big maternity hospitals miles away, and home birth more easily available and promoted." (p. 155)*
>
> *"I am from England and have a lot of feedback from friends who have used services over there. It sounds to me like services are a bit behind here still—the lack of birthing pools for one where it is common practice at home." (p. 153)*
>
> *"In general I feel the choices and information are very poor. I would like the option of using a birth centre and not have a medicalised birth but that option isn't available to me." (p. 159)*

Consent:

> *"The practice in maternity hospitals of not obtaining consent for medical procedures during labour should be changed." (p 159)*
>
> *"On numerous occasions throughout my pregnancy I was asked to hop up on the bed with no explanation of what was to happen. When I asked if an internal [w]as to be performed I was then told yes. I refused all internals during my pregnancy. I feel a first time mum would think these to be the norm!" (p.152)*
>
> *"Never asks for consent for serious interventions such as episiostomies [sic]." (p.163)*
>
> *"I had to lie flat on my back with a fetal heart monitor and when I did get to sit up it was for an epidural which was forced on me." (p. 164)"*

Evidence-based practice and support for normal birth:

> *"Routine interventions are carried out, often without supporting evidence of their worth." (p. 153)*
>
> *"A woman going into the hospital maternity system has to perform within a certain time limit due to whatever shortages/limitations exist. Human bodies do not function in this way." (p. 166)*
>
> *"Maternity care in Ireland is unfortunately dominated by a view of birth that sees it as a medicalised, problematic procedure that needs to be fixed by doctors. Women are disempowered and we've lost confidence in our ability to do something that we've been doing for thousands of years." (p. 152)*
>
> *"The Irish maternity system is simply not geared up to support normal birth for the most part." (p. 153)*
>
> *"[We need] more midwifery led care and Ireland must start adapting evidence based and women centred care! Even the MLU's are not evidence based—blanket policies should not exist in midwifery led care but should be based on a personal assessment." (p. 160)*

Information:

> *"More independent/unbiased information on the choices which are available." (p. 165)*
>
> *"Unfortunately when I had my complications I was not spoken to about it or the repercussions, prior to, during or after the procedure. Information provided was so poor that I wasn't even advised whether I had stitches when I asked. Unfortunately this has completely overshadowed the otherwise excellent care received, and I find it difficult to see beyond this point." (p. 163)*

Post-natal Support:

> *"My baby was never taken into the nursery, even when I was having a shower, I had to ask other mothers to mind her." (p.158)*
>
> *"No help at night with baby in hospital in a single room and baby screaming all night as my milk had not come in. I feel that there is very little support for sections." (p. 162)*

"I was very happy with the midwifes and the care during delivery, less so with the care after birth on the ward and felt hassles more than helped by the 'care' after I was discharged from hospital." (p. 151)

"Postnatal community care should be available for every woman in Ireland for a minimum of 1 week post delivery regardless of where they live." (p.156)

"There is an urgent need for the issue of PTSD [post-traumatic stress disorder] in relation to birth trauma and injury to be dealt with." (p. 168)

Continuity of care:

"There is an assumption made that women go private because they think consultant led care is better . . . In my view, women opt for private care if they can afford it, to try [to] ensure continuity of care and in the hope of more privacy and better nursing care after the birth, all of which could be provided by Midwife led care if the current health system was more efficient." (p. 165)

Security and Privacy:

"2 strange teenagers entered my cubicle while I was changing my clothes. It was quiet time, fathers not allowed, yet they managed to get IN MY ROOM." (p. 158)

"A separate waiting area for labouring mothers & partners. I feel that it is VERY important." (p. 160)

Hygiene, facilities and infrastructure:

"Facilities are dirty and inadequate numbers of toilets and washing facilities available post natally." (p. 156)

"Why can't post natal and scbu [special care baby unit] be beside one another. Mums need better access to babies post natally, I didn't see my babies for 24 hrs understand I was too sick but its gut wrenching not to see them relying on my husband to take photos and show me." (p. 168)

"No space for cars to park to pick up infant in hospital on discharge." (p. 163)

Hospital policies:

"I really object to the 'one-partner' policy at […]. While I myself am unlikely to have availed of the option to have more than one person in attendance, there are so many situations where this would be such a help. I do not feel it is a patient-centred policy." (p. 165)

"Would have liked nursery care options." (p.151)

"I think the policies of active management of labour in Irish hospitals are outdated and do more harm than good." (p.155)

User evaluation and participation:

"I was given a form to fill out 2 days after my baby was born. I was still shell-shocked at this stage and I have no idea what I wrote down. I think you need at least two months to process the experience to evaluate it properly." (p. 155)

"Audit of services is vital to provide the service necessary for women and babies. If we are not asked for our experiences, how will anything ever change?" (p. 164)

"Women in Ireland need to stand up and defend themselves I have complained to my hospital but never heard anything back!" (p. 158)

Participant Profile

The majority of women who took part in this survey were aged between 31 and 40 years when they had their last baby (62.1%), with slightly over one-third aged between 20 and 30 (35.7%). None were aged under 20. For over half of respondents this was their first baby. Most women accessed public maternity care services (37.9%), with a slighter smaller proportion (31.3%) accessing private care in a public hospital.

The majority of participants had their last baby in 2008 (38.4%), and the greatest number of births (67.3%) took place in the Eastern region of the country, a figure which reflects the greater proportion of births taking place in centralized maternity units in the Greater Dublin Area, as well as maternity units in Drogheda and Cavan. Just 2.5% of all births took place in the Northern area.

Combined care with a GP and hospital consultant accounted for care accessed by over half of the participants. Very few women appear to have had access to midwife-led hospital care (1.9%), despite (22.9%) reporting that they would like to have had the option. Just under one-quarter (24.7%) reported that they were happy with the choices they had.

The profile of women who completed this survey deviates from the wider maternity population in certain categories. For example, 7.4% of respondents to this survey had a planned home birth, which is far higher than the national average of under 1% of all births. The respondents also showed a relatively low uptake of epidural pain relief (20.6%). Other deviations include the fact that none of the respondents were aged under 20 years when their last child was born, a category which accounted for 3% of mothers in 2009 (CSO, 2010).

DISCUSSION

Information About Care Options

Whilst 54% of respondents found it very easy or fairly easy to obtain information, 46% either had difficulty accessing information or were unaware of their care options. Most women sourced information and recommendations from family, friends and the Internet. Others relied primarily on their GP (23%). Of the information that was received, the majority of respondents (55%), felt that it was either "average" (39%) or "poor" (16%). There appears to be a distinct bias in knowledge and information pertaining to hospital/consultant-led birth. Midwifery-led units (MLUs), DOMINO

schemes and home births are rarely mentioned by GPs, with very little support shown for women who choose to have a home birth as evidenced by a number of comments (see comments under Question 7). It may be important to note that while information about each model of care is available from the relevant service providers, e.g. information about home birth is available from independent midwives, what is needed is for all information to be synthesized and made more accessible to women. There are several calls for a single resource or pack of information at initial point of contact with health professionals, which in most instances is the woman's GP.

Models and Choices of Care

Given the general situation with regard to information provision as described above, it is unsurprising that consultant-led (31%) and combined care (36.5%) were recognized as the main models of care available to women. Just 9% of respondents understood they had access to a home birth option, while 7% of respondents were aware of the possibility of access to DOMINO care and 7% to midwifery-led units.

The most common model of care chosen was that of combined care with GP and hospital consultant (53%), with consultant-only care chosen by just over 1 in 5 women. One-quarter of respondents confirmed they were happy with what was available to them, although a considerable number (75%) called for more choice in midwifery care in the form of MLUs, DOMINO care and local midwife-managed care, in that order. Of particular note are comments regarding the disparity of care options available between rural and urban areas. Several women living in rural locations felt they were at a disadvantage to those living in closer proximity to larger cities and towns, and that the urban maternity population had a far greater array of care choices. However, even women in urban areas complained of geographic inequity in the quality of choice. The issue of inadequate supply of services to meet demand is also a consistent theme. Respondents remark on the shortage of midwives and consultants affecting services available and choices for women.

Pregnancy—Care, Information and Antenatal Classes

A significant proportion of women (47%) rated their care during pregnancy as "excellent" and a further 37% rated it as "good". In terms of information provided during pregnancy, overall feedback was again positive, with nearly three-quarters of women rating it as either "good" or "excellent". However, there is potential for improvement, with just under 1 in 4 rating it as "average", and a further 11% as "poor". In terms of antenatal classes, almost 35% recorded non attendance. Of the women who did attend, almost half (47%) rated classes as either "average" or "poor", raising questions as to how these classes can be improved or made more accessible. The issue of whether women expecting their second or a subsequent baby may have been less likely

to attend antenatal classes was not addressed by this survey. Comments from women draw particular attention to quality of content, delivery, class sizes, and lack of information on topics such as Caesarean section and post-natal depression. In addition, often there appears to be a narrow focus of discussion on labour and birth policies of a particular hospital or unit. (See women's comments under Question 17.)

Labour

Whilst the majority of women found their care to be of a high standard, with 80% having received care they considered "excellent" or "good", a significant minority of women (8%) reported that their care in labour was "poor" and a further 12% reported that it was "average". 15% of women felt that the information provided to them while in labour was "poor", a figure which suggests that a large proportion of women in labour are not adequately communicated with by carers. In spite of this, there seems to have been little opportunity for women to make their views known to their carers, with satisfaction surveys being carried out very soon after the baby is born.

Birth Partners and Birth Plans

In relation to birth partners, a significant majority (78%) reported a positive experience. However, the potential benefits of a supportive birth partner appear to be insufficiently realised in hospital environments, with just over 1 in 5 being treated with indifference (17%) or excluded (6%). Women complain of restrictive hospital policy allowing only one birth partner and many would have liked extra support from mothers, doulas or another nominated person.

For various reasons the majority of women did not have a birth plan (63%). Continuity of care with a midwife meant some women felt that there was no need. Others felt their birth partners were fully informed and capable of speaking on their behalf when necessary. Finally, the varying attitudes of staff had a substantial impact on women's experiences, with some more accommodating than others. There is evidence to suggest that a lack of respect was shown towards women who produced birth plans with some women feeling mocked, belittled and at times ignored.

Overall Care During Labour and Birth

In relation to overall care during labour and birth, experiences were extremely varied. Of particular interest is the type of labour women had. For example, 62.4% of women went into labour spontaneously, 27% were induced (this category of women include those who underwent interventions such as ARM) and 10.6% had planned Caesarean sections. These figures, together with the fact that 55% of women were having their first baby may have considerable bearing on the experiences of women and will inform or affect decisions around care for future pregnancies

and births. For example, for those who had Caesarean sections, home birth may no longer be an option due to current exclusion criteria for home birth.

There are a number of areas which have emerged as particularly salient and which require the attention of service providers: respect, informed consent, implementation of evidence-based research in practice and the support of normal birth, staff numbers and infrastructure. Some of these areas are more easily addressed than others. As an example, the critical issue of informed consent has again emerged as a major concern for women. Given that the importance of informed consent is recognized by service providers, its implementation must be realized. Previous AIMS Ireland surveys have highlighted improper procedures in this area but unfortunately there are still some extremely serious anomalies that need to be addressed by healthcare professionals and service management alike (see women's comments under Questions 32 and 55).

Care After Birth

Care after birth is the area that fared the worst in the survey and is in most need of improvement. In all, 45% of women felt their care was "average" or "poor", and nearly half of respondents report receiving inadequate information. Whilst women rated the care received by their newborn more highly, 5% of women thought the care of their baby was poor and 14.5% thought the information they received was poor.

Lack of adequate breastfeeding support is reported by several participants with almost one-third of women, 33%, rating the support for breastfeeding as "poor". This lack of support clearly affects both initiation and duration of breastfeeding. In this survey, an extremely high proportion of women, 1 in 5 women, did not breastfeed. Several calls are made by women for more help from lactation consultants, as well as increased flexibility in terms of consultations and visits in both hospital and community settings.

When asked whether there were other sources of post-natal support and information they would like to have had but were unavailable to them, women highlight a number of other areas including birth debriefings, optional nursery care in hospital, information and advice around pre-term birth and NICU, parenting classes and greater continuity of care. Regarding continuity of care, women request more visits from public health nurses (PHNs) and also report that the nature of this service could be vastly improved. Rating the quality of care provided by PHNs, 55% of women rated is as either "excellent" or "good" and 25% considered it average. However, a further 1 in 5 women rate the care provided by PHNs as "poor"—as PHNs are the only direct line of support

most mothers have in early motherhood, this is a striking figure. For those 24% of women who had a postnatal midwife, 86% rated the care as ”excellent” or “good”.

In terms of post-natal care for their babies, women ask for more skin-to-skin contact post birth, more information on tests and procedures and better explanation around morbidity such as birth injury and infection. Poor communication and insufficient provision of information to women emerges as a key theme in post-natal care. Greater consistency in the communication of information, as well as opportunity to discuss their well-being and that of their baby with a health professional, has the capacity to greatly enhance women’s experiences in the immediate post partum period.

Post-natal care from 6 weeks:

Most women attended their GP or private consultant for the routine 6-week check for themselves and their babies. It is important to note that 13% of women did not attend a 6-week check at all. Satisfaction rates of those who did attend are disappointing: 25% rate it as average, 17% as poor (see Question 52 for women’s comments). Of critical importance to women is the care pertaining to emotional well-being. A considerable percentage of participants (37%) were not asked about this, yet almost 1 in 5 respondents went on to suffer from post-natal depression (PND). Many women indicated that their experience of pregnancy and birth was a significant contributing factor to developing PND. For those who suffered from PND, experiences in seeking and receiving support varied enormously (Questions 50–51). Women call for more information for themselves but also for their partners in relation to symptoms and treatment for PND. The issue around fear of reporting PND was also reported by a number of women, and raises the question of whether there is a greater stigma attached to PND than is adequately acknowledged by services aimed at supporting women post-natally.

Women also call for greater continuity of care in the community, and emphasize the importance of roles played by GP and PHN. It is suggested that these be supported in order to maximize the provision of quality services. Women talk about the importance of being given the opportunity to discuss their birth experiences with their midwife or obstetrician and note that the lack of such opportunities results in a reliance on peer support such as Internet-based parenting forums. Timing of such proposed discussions with health professionals is also considered important, with women reporting that early discussion, i.e. in the days following childbirth, is not always a good time given physical and emotional challenges post birth, and does not allow for a period of reflection and recovery.

Service User Evaluation

Despite the recent drive for service user involvement in the health services, it is surprising that 74% of women were not given any type of client satisfaction form post birth. For those that did complete an evaluation sheet, 67% did so within the first week of having their baby. Given womens' comments above and recent research on the "halo" effect, we would question the validity and worth of these questionnaires or surveys in the early days postpartum. Alternative methods of quantitative and qualitative data collection and analysis should be considered by service providers in order to maximize women's valuable contribution in this area.

CONCLUSION

There is a great deal that we can learn from the data gathered by this survey. As can be expected from any area within the health services, this survey reveals that women's experiences of the maternity services encompasses aspects that include both positive and negative elements. Whilst it is important to acknowledge the good and often excellent care experienced by many women using these services, it is critical that where issues of concern are highlighted as they have been by women in this report, that they too are acknowledged and addressed in a practical manner.

As noted earlier, it is clear that some issues—such as **communication**, **respect** and **informed consent**—may be easier to influence or change than others. Areas requiring more training and investment include the adequate provision of **information** and **support** both in the ante- and post-natal period**.** More fundamental change and innovation is required in the areas of **choice, access, continuity of care** and **service user evaluation**. Finally, a greater challenge which can be seen to underpin the concerns raised by women in this survey, is to adopt and nurture a culture where **evidence-based practice** and the **support of normal birth** underpins every aspect of care.

Change happens incrementally. If we were able to address just a few of these issues and concerns in the short term, it would go a long way toward creating a better, woman-centred maternity service, and a more satisfying and empowering experience that for women and their families is unquantifiable.

RECOMMENDATIONS

1. The HSE via Health Promotion should fund the creation of a **maternity care information pack** detailing all models of antenatal care available by region. This pack should be available to women at first point of contact with a healthcare professional regarding their pregnancy, usually their GP.

2. The HSE needs to consider **extending access to MLU, DOMINO and home birth care** to all women. Development of community midwifery alongside integrated MLUs is critical as centralised units discriminate against alternative models of care for all women, ensure busy overcrowded units for all women and particularly discriminate against the rural population who have to travel long distances for care.

Midwifery-led models of care are recognized internationally as supporting normal birth and providing holistic and woman-centred care, with equally positive health outcomes, and higher satisfaction rates in many areas, compared to consultant-led hospital care. (For evidence and recommendations supporting the expansion of midwifery care models see Begley et al 2009 Hatem et al 2008, KPMG 2008, HSE 2004.)

3. The Government and HSE must address the **shortage of midwives** and in some cases the shortage of access to consultants for women in Ireland. These are seriously under-represented by international standards.

4. Service providers need to consider a comprehensive review of their **antenatal education** programme. Focus should centre on availability, flexibility, inclusiveness, quality of content and delivery. Information must be up to date and cover wider aspects of education in its curriculum. Service providers should also consider a review of postnatal education to include first aid for newborns.

5. All maternity units should consider a review of their **birth partner policy**. If students and various other health professionals can attend and/or merely be present in a woman's birthing space in labour and during birth, an additional birth partner for a woman should likewise be accommodated.

6. All maternity service providers should consider putting a draft template for a **birth preferences/plan** on their website or included in women's notes. This should be filled in and discussed antenatally as a matter of course. Units should offer women information on birth preferences during antenatal classes.

7. Service providers should immediately review **informed consent practices** and urgently address any education or training deficits. Failures in this area present a serious issue in relation to the rights of service users. It is incumbent on health professionals that a code of practice be consistently honoured in order to promote a safe and open caring environment.

8. Maternity units should review **the implementation of evidence-based practices and procedures** in **support of normal birth.** There is evidence to suggest that procedures such as ARM (artificial rupture of membranes), episiotomy and artificial acceleration of labour (e.g. oxytocin drip) are routine in Irish maternity units, yet international best practice guidelines and research indicates that these procedures, routinely administered, serve to perpetuate intervention in normal birth and **in turn increase the complexity and cost of care**. Critically this can often negatively impact women's labour and birth experiences. (Goer 1999, Smyth et al 2007)

9. Service providers need to review and evaluate how **breastfeeding support** can best be given in busy post-natal wards. Breastfeeding solutions should always be offered for breastfeeding problems. Continued in-service training should be provided for post-natal midwives and for SCBU staff. All maternity units should consider updating their practices so that they are eligible for the Baby Friendly Hospital Status. With more mothers than ever now initiating breastfeeding, increased provision of lactation consultants in maternity units should be considered.

10. Service providers should explore the role of **maternity care assistants** to support women **rooming in** who are recovering from surgery or other post-natal complications.

11. Maternity hospitals and other service providers should review **service user evaluation** processes. In the immediate post-partum period service providers should offer an opportunity for **birth debriefings** between mother and health professional. However, the intensity and depth of discussion will be dependent on the physical and emotional well-being of the mother. **Post 6-week evaluations** are recommended for all users in order to obtain a true measure of service user experience and satisfaction levels rather than the current common practice of asking a mother to fill in an evaluation form whilst she is still in the care of those whom she is evaluating.

12. The HSE should review the **continuity of care** available to a mother once she returns to the community. This will include reviewing the resources available to public health nurses (PHNs), thereby enabling them to increase their contact with mothers.

13. The HSE should review the minimum **requirements of the 6-week check** to ensure consistency and quality across providers. In addition, the HSE needs to increase Health Promotion around the 6-week check.

14. The HSE, via Health Promotion, needs to provide more information to mothers regarding **post-natal emotional well-being.** Information produced could be circulated to mothers via GPs, hospital staff or PHNs. The incidence of post-natal depression is high (nearly 1 in 5) and it is possible that this figure is underestimated as evidence suggests that reporting is arbitrary.

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