

Central Lancashire Online Knowledge (CLOK)

Title	What women emphasise as important aspects of care in childbirth - an online survey
Type	Article
URL	https://clock.uclan.ac.uk/id/eprint/36811/
DOI	https://doi.org/10.1111/1471-0528.16926
Date	2022
Citation	Vedeler, Carina, Nilsen, Anne Britt Vika, Blix, Ellen, Downe, Soo and Eri, Tine S. (2022) What women emphasise as important aspects of care in childbirth - an online survey. BJOG: An International Journal of Obstetrics and Gynaecology, 129 (4). pp. 647-655. ISSN 1470-0328
Creators	Vedeler, Carina, Nilsen, Anne Britt Vika, Blix, Ellen, Downe, Soo and Eri, Tine S.

It is advisable to refer to the publisher's version if you intend to cite from the work.
<https://doi.org/10.1111/1471-0528.16926>

For information about Research at UCLan please go to <http://www.uclan.ac.uk/research/>

All outputs in CLOK are protected by Intellectual Property Rights law, including Copyright law. Copyright, IPR and Moral Rights for the works on this site are retained by the individual authors and/or other copyright owners. Terms and conditions for use of this material are defined in the <http://clock.uclan.ac.uk/policies/>

Carina Vedeler¹

Anne Britt Vika Nilsen²

Ellen Blix¹

Soo Downe³

Tine S. Eri¹

¹Faculty of Health Sciences, Oslo Metropolitan University, Oslo, Norway

²Faculty of Health and Social Sciences, Western Norway University of Applied Sciences, Bergen, Norway

³Research in Childbirth and Health (ReaCH) group/THRIVE Centre, University of Central Lancashire, Preston, UK

Corresponding author:

Carina Vedeler

Email: calian@oslomet.no

Postboks 4, St. Olavs Plass

0130 Oslo, Norway

Phone: +47 40862987

Short running title: Important aspects of care during childbirth

Abstract

Objective

To explore and describe what women who have given birth in Norway emphasise as important aspects of care during childbirth.

Design

The study is based on data from the Babies Born Better online survey, version 2.

This article has been accepted for publication and undergone full peer review but has not been through the copyediting, typesetting, pagination and proofreading process, which may lead to differences between this version and the [Version of Record](#). Please cite this article as [doi: 10.1111/1471-0528.16926](https://doi.org/10.1111/1471-0528.16926)

This article is protected by copyright. All rights reserved

Setting

The maternity care system in Norway.

Study population

Women who gave birth in Norway between 2013 and 2018.

Method

Descriptive statistics were used to describe sample characteristics and to compare data from the B3 survey with national data from the Medical Birth Registry of Norway. The open-ended questions were analysed with an inductive thematic analysis.

Main outcome measures

Themes developed from two open-ended questions.

Results

The final sample included 8,401 women. There were no obvious differences between the sample population and the national population with respect to maternal age, marital status, parity, mode of birth and place of birth, except for the proportion of planned homebirths. Four themes and one overarching theme were identified; Compassionate and Respectful Care, A Family Focus, Sense of Continuity and Consistency, and Sense of Security. Overarching theme: Coherence in Childbearing.

Conclusions

Norwegian women across all birth settings emphasise maternity care that authentically focuses both socio-cultural and psychological aspects of care, and physical and clinical factors. If the positive aspects of care identified in this study are adopted at all levels of the maternity care system and from all care providers, there is a high chance that most women will have a safe outcome, and a strong sense of coherence related to a positive birth and motherhood experience.

Key words

Midwifery care; Childbirth experience; Intrapartum care; Salutogenesis; Coherence in Childbearing; Thematic analysis

Tweetable abstract

Having a baby is a pivotal life changing experience and not just a clinical event, according to a survey of 8400 women in Norway. Positive birth and motherhood experiences depend on maternity staff who are **both** skilled **and** kind.

Introduction

Childbirth is an important existential life-event. Childbearing women value a positive birth, and WHO recognises a 'positive childbirth experience' as a significant end point for all labouring women.¹⁻³

Paying attention to service users' views is a crucial part of planning maternity care.^{1,4,5} It is important to provide services that women want and need.² Literature on women's negative and traumatic birth experiences is extensive,⁶⁻¹⁰ however, we found less evidence about the nature of positive childbirth experiences and the impact on good health for women and families.

Salutogenic theory focuses on what promotes good health and suggests that health is movement on a continuum of ease and dis-ease, unlike the dichotomy of healthy or sick.¹¹ There is good evidence that salutogenesis is a useful theory for maternity care research.¹²⁻¹⁴

To the best of our knowledge, this is the first study with such a large sample of childbearing women, asking for women's views on what worked well in their maternity care experience. The main objective of this study is to explore and describe what women who gave birth in Norway emphasise as important aspects of care during childbirth, with a focus on salutogenic theory.

Methods

Design

This paper analyses qualitative data and descriptive statistics from the Babies Born Better online survey, version 2.

Setting

The context is the Norwegian maternity care system, which is part of the public health care system, tax funded and provided free of charge. Virtually all women in Norway receive maternity care from the public health care system. Intrapartum care is organised at three levels; 1) specialised obstetric units, 2) smaller obstetric units and 3) alongside and freestanding midwifery units. Midwives attend all births. There were approximately 58,000 births per year and 45 birth units in the study period. The caesarean section rate in 2019 was 16%, epidural anaesthesia 36%, and vacuum or forceps 10%.¹⁵ (Appendix S1).

Study population

Women across all birth settings who gave birth in Norway during the period 2013 to 2018 were eligible to participate.

Data collection

The survey, which was translated into 22 languages, was open from March to August 2018. It was launched through social media, mainly through Facebook where the link was widely disseminated to a variety of relevant groups. We contacted specifically targeted websites like 'mumsnet' and asked them to post the survey on their web forums. (Appendix S2).

The questionnaire

The survey was an open online survey (SurveyMonkey®), comprising 22 questions (Appendix S3) with sub-questions, including closed and open-ended response options. Three sections comprised questions related to demographics and maternal characteristics; age, marital status, migration, self-rated socio-economic status, education, employment status, parity, gestational age, mode of birth and place of birth. The fourth section included two open-ended questions; the first asked for women's views of what worked well during their childbirth experience, and what they think would have improved their experience of care, the second asked for an honest description of the place where they had their baby, and reasons why they would, or would not, recommend it as a birthplace to a close friend or family member.

The Medical Birth Registry of Norway (MBRN)

To assess the representativeness of the study sample, a Norwegian population-based sample with information about maternal age, marital status, parity, place of birth and mode of birth, from the Norwegian birth cohort of all women who gave birth in 2017 was retrieved from MBRN.¹⁵

Information about educational level, employment status or sociodemographic status is not collected in MBRN.

Analysis

We did descriptive statistics to describe sample characteristics and to compare data from the B3-survey with the national population-based data sample from the MBRN, using SPSS® software (version 26).

We performed thematic analysis¹⁶ with an inductive approach to analyse the two open-ended questions (Q17, Q18), using NVIVO 12® software. Thematic analysis is a method for identifying, analysing and reporting patterns or themes within a data set. The analytical process was data driven, dynamic and continuously discussed in the research group. The stepwise process is illustrated in Figure 1. See Appendix S4 for a more in-depth description. Quality assessment was done using the CHERRIES checklist¹⁷ (Appendix S2).

Ethics

There was no patient and public involvement in this study. Ethical approval was granted by University of Central Lancashire, UK (Ethics Committee BuSH 222 and STEMH Ethics Committee Application). The study was approved by the Norwegian Data Inspectorate (ref: 60547/3/HJTIRH), no further ethical clearance was necessary (ref: 2017/1582).

Results

Altogether, 11,135 women who had given birth in Norway responded to the survey. The final sample included 8,401 women (Figure 2).

Demographics of the respondents

Table 1 shows the main characteristics of the included respondents. We compared our sample to the population-based sample retrieved from MBRN 2017, as a census group. Of the included women, 92.3% were born in Norway. The mean age was 30 years (SD 4.8), 45% were primiparas and 55% multiparas. All 45 birth units in Norway were represented, the response rates by unit were similar to the numbers for the population (Figure 3). There were no obvious differences

between our sample and the population-based sample regarding age, marital status, parity, mode of birth, place of birth, except for the number of planned homebirths (1.6% in the study, 0.2% in the population). Missing data varied from 0.04-0.7% across the variables, except for education level which was 2.6%.

Findings from the open-ended questions

The analysis of the open-ended questions resulted in four themes; Compassionate and Respectful Care; Sense of Continuity and Consistency; A Family Focus; Sense of Security, and one overarching theme; Coherence in Childbearing. See Appendix S5 for more quotes.

Compassionate and Respectful Care

To be compassionate implied that the staff were genuinely engaged and concerned with the woman's well-being, through empathy, kindness, attentiveness, love, support and understanding. Insensitivity or lack of empathy was experienced as very difficult. It was clear that childbirth was perceived as a vulnerable situation that required a sensitive approach. The data implied that simple politeness from the staff was insufficient: the birthing woman needed to feel the care as genuine and personal.

'Wonderful care from a doctor. Said nice things and supported me all the way'

'When we changed midwife, we got one that touched my arm looked me in the eyes and said; this is going well. [she said] Do this and that. [she was] Very clear'

Compassionate and respectful care was connected to the midwife's watchful attendance, perceived as the actual time present and an emotional availability, feeling that the midwife was there for her and saw her. This emotional presence was recognised as awareness and sensitivity towards the woman's signals and needs.

'The first midwife I had was so present and accommodating. Almost didn't have to say anything because she understood what I needed'

To be respected, empowered, seen and listened to as a unique individual led to a sense of partnership when things were to be decided. Having real influence and co-determination in terms of herself and the baby was important. If the midwives or doctors were sensitive and acknowledged her wishes, it could lead to a sense of being special and unique and experiencing

individual care. When this central aspect was missing, the respondents reported a sense of vulnerability, which was experienced as stressful.

'The doctor was harsh and did not speak directly to me at all, only to the midwife and nurse'

'Midwives don't have enough time, they don't see you as a separate individual, midwives don't have empathy. A feeling that the hospital had a "yes but we see this so often" attitude'

Sense of Continuity and Consistency

Continuity refers to the woman's perception of pregnancy, labour and birth and post-partum as a coherent whole, not separated phases. Being allowed to enter the hospital when she felt the need to, in the early stages of labour, was essential.

'The person I spoke to on the phone before I came in seemed brusque and incomprehensible. Asked me to wait to come in because she thought I was not in enough pain. I had to "argue" to get an examination. When I came in, I had 7-8 cm dilatation and frequent contractions'

Another facet of continuity was the midwives' availability throughout the process; the importance of not being left to yourself; and that the midwife had time for the parents and the baby after birth.

Initiation of breastfeeding was crucial for the sense of continuity, including good breastfeeding support and care throughout the postnatal period.

'Better help with breastfeeding. I felt that the staff was short of time and had completely different opinions about this. This led to a chaotic and stressful situation'

Continuation and consistency of information was a part of this concept. It seemed crucial that the staff had read the woman's birth plan and medical notes, and that previous pregnancies or births were taken into consideration. This does not merely mean that the woman saw the same person, but that all the staff cooperated on sharing and addressing prior information about her, in a way that optimised her sense of seamless care. The sense of continuity was connected to receiving the information and explanations needed throughout the birth process and to be offered a post-partum conversation.

'I was very well taken care of; the doctors had always read everything regarding me carefully. They made informed decisions!'

A Family Focus

A family focus in care involved not only the partner's inclusion in the birth process, but that giving birth to a child is about 'becoming a family' or 'expanding the family'.

'The father and I as a unit that did this together'

It was therefore crucial for the women that their partners were involved and felt included and that his/her feelings and needs were acknowledged.

'That staff listen to both the mother and father of the child. That staff include the father more. The expensive accommodation for partners meant we could not afford to be there together, very difficult and tiring as a new mother all alone without sleep'

The partners presence and support were crucial to the women. The acknowledgement of the partner's needs from the staff was also of great importance; lack of care for the partner raised difficult emotions for the woman. Involving and including the partner seemed to be a twofold matter. Firstly, to care for their physical condition, including the opportunity for rest, food and to be present throughout the stay. Secondly, that the partner felt included, that they were treated as a family and allowed to spend time together with the new-born baby.

'Better care of the father both emotionally and physically, he should automatically be able to sleep the first night at the hospital, especially if the baby is born late at night'

Sense of Security

Feeling safe was emphasised as a fundamental part of care by many respondents. While the women linguistically used the same terms, they referred to different meanings regarding what made them feel safe. It seemed to encompass both medical, emotional and relational safety. For some women sense of security meant to be emotionally and relationally cared for.

'Then you'll have a sense of peace in a safe and familiar environment, without unnecessary stress and interventions, with a midwife who knows you and your wishes'

For others, the notion of medical safety was more important.

'There's good expertise among employees, and all the facilities you may need in the event of any complications'

The sense of security was linked to confidence in the midwife's and doctor's competence, that they had experience, knowledge and acted as a team. It was essential that they presented themselves as fundamentally trustworthy, with no other aim than acting in the best interest of the woman and their baby. Such a trust would help the woman to lean on them and "let go", not worrying whether they knew what they were doing. Doubting whether the staff could offer this was associated with uncertainty about how safe their birth was, and in their capacity to negotiate it without harm.

'[I wished] the doctor and midwife had made me more secure by reading my medical record before they attempted to start - because they made flaws that made me insecure when I was giving birth'

Overarching theme: Coherence in childbearing

Coherence in childbearing encompasses all four themes. It refers to the experience of childbearing as a whole, and not perceived as a separate event disconnected from the antenatal, postnatal period or women's lives in general. It implies an understanding of each woman as a unique person with her own history, cultural background, resources, perceptions and personality. Everything she experiences will be related to this and thus, also, to how she experiences care. The following quotes illustrate what 'good' or 'poor' care felt like.

Good Care

You will be followed up as if you're the only one, not just one of many on an 'assembly line'. You will get peace and quiet because this is a small hospital, and Dad is recognised as an important part of the birth and maternity experience. You are seen, heard and cared for with warmth and care. A wonderful place to bring new life into the world.

Poor Care

They don't have respect for the female body and its ability to give birth. There was no humanity, only medicine. The environment among the staff was poor, they didn't appear to read the medical record, and everyone had to come up with their own solutions. They don't listen to one's

objections and it was so poorly staffed that the father basically had to help with everything, yet there was no room for him. I didn't feel safe and didn't get the help I needed.

Discussion

Main findings

The analysis resulted in a rich and nuanced body of information about what women who have given birth across all birth settings in Norway emphasise as important aspects of care during childbirth. The findings demonstrate that socio-cultural and psychological aspects of care are significant for women in childbirth, alongside physical and clinical factors. Some of the findings reflect earlier research, including the desire for compassionate and respectful care, continuity of care and safety. Women who gave birth in Norway emphasise that respectful maternity care encompasses more than absence of disrespectful care or mistreatment during childbirth,¹⁸⁻²¹ they also value empathetic and sensitive clinical staff.^{2,22} In our study, continuity of care was highlighted as good care and called for when it was missing. This reflects the desire for and satisfaction with continuity of care, which is a common research finding.^{22,23} The concept of continuity in this study encompasses consistency of information between clinical staff and wards, and continuity of the experience of pregnancy, labour and birth, and even continuity between pregnancies.

The Family Focus theme illustrates new and unique nuances in women's views on the importance of family-oriented care; it is perceived as pivotal that the partner is involved, included and cared for both emotionally and through the provision of good facilities, which is confirmed in studies on fathers' experiences.²⁴⁻²⁹ Furthermore, our results suggest that the value of looking after birth companions is a way of looking after the woman herself. If she does not have to worry about the wellbeing of her partner, she can commit to the labour process.

The theme 'sense of security' goes beyond 'being safe'. The findings demonstrate that the perception of the concept is individual and complex, which is also found in other studies.²⁸ This is reflected in the contrasting rationale for feeling safe; some felt safe giving birth in a highly-technical hospital ward with monitoring and emergency preparedness, while others felt safe giving birth at home with a midwife they knew well in familiar surroundings.

Strengths and limitations

This study included a large sample size, with data covering births in every unit in the country, all birth settings including homebirths and ‘born before arrival’. The study sample characteristics were very similar to those of the eligible population. It was original in taking advantage of the progress in technology as social media to explore women’s qualitative viewpoints at large scale.³⁰ In Norway in 2018, 93% of Norwegian women between 18 and 44 had a profile on Facebook, and 98% used Facebook weekly.³¹

Online-survey studies have some methodological limitations such as self-selection-, response- and recall bias³² which may have contributed to excluding some aspects of care important for specific and marginalised groups, for instance migrant women. We tried to actively address this challenge in the recruitment process, (Appendix S2). However, even if migrant women were under-represented, it is important to note that previous studies have shown that women in these groups want the same high-quality maternity care as the general population.³³

We had limited population data to match demographic characteristics such as; education, migration and socio-economic inequity. We therefore cannot be sure that our sample was representative of the population because on-line surveys might skew responses towards those who are more highly educated women with high socio-economic status. However, our sample also includes voices of more marginalised groups. More than 1800 women reported no higher education; 627 women believed they were living in ‘worse’ or ‘much worse’ socioeconomic status than the average person in the country, and 1011 women were ‘unemployed’ or ‘other’. Further studies could target specific and more marginalised groups.

Interpretation

Our interpretation of the findings identifies new nuances in the care for women during childbirth. Although the study was performed in a context with low caesarean section and induction rates, we believe that the four themes reflect the optimal characteristics of intrapartum care for all women. As the Lancet series on Midwifery concludes: “These findings support a system-level shift, from maternal and newborn care focused on identification and treatment of pathology, to a system of

skilled care for all, with multidisciplinary teamwork and integration across hospital and community settings.”⁴

The women expressed an explicit wish for family-oriented care, which raises the suggestion that women might not be able to enter the ‘flow state’, neuropsychologically, if they are concerned about the wellbeing of others in attendance who they care about.³⁴ This underlines that women view the process of giving birth as a transition towards ‘becoming a family’ or ‘expanding the family’. The theory of ‘rite de passage’ and liminality explains ambiguity and vulnerability in connection with life transitions.³⁵

The women’s notion of safety and security was complex, and depended on multiple internal and external factors.²⁸ One way for maternity staff to deal with the individual variation is to assume that if the woman’s ideas and beliefs are shared, or at least understood and respected, the associated feeling of being in safe hands may reinforce the woman’s sense of security. The sense of freedom that women reported when they felt totally secure was, as for family support, a sense of relief that they could trust the staff to deal with extraneous matters and threats. This meant that they were free to disconnect external vigilance, enabling them to internalise their focus on giving birth.³⁴

The experience of continuity comprised a sense that each stage of the process, at each level of their experience, was interconnected. This was reinforced if there was no sense of discontinuity, even when different staff were involved. The findings coincide with those of others who have suggested that women’s experiences during labour and birth does not correspond to physically defined stages, but go beyond this to a life-course concept of continuity, which needs to be recognised by staff when they encounter women in labour.³⁶⁻³⁹

The overarching theme brings these findings of seamlessness together, by incorporating the notion ‘Coherence’.¹¹ In this sense, a coherent labour and birth experience encompasses all the themes, assuming that childbirth can be experienced as meaningful, manageable and comprehensible. A strong sense of coherence (SOC) is associated with positive emotions regarding both the birth experience, and the baby, while a weak SOC is expressed through negative emotions and worries relating to labour and birth.⁴⁰ Women need to organise their childbearing experience into a coherent narrative.⁴¹ Our findings suggest that maternity care that reflects all four themes identified in this study could help women to create coherent experiential narratives optimising

their wellbeing, and that of their baby, partner and family, into the future. Beyond this, it is plausible that women who feel a sense of coherence in childbirth are more able to activate parts of the neocortex required for the neurohormonal processes that facilitate optimal birth physiology and post-birth adjustment.³⁴

Conclusion

This study shows that women, across all birth settings, emphasise maternity care that truly and authentically focuses on both socio-cultural and psychological aspects of care, and physical and clinical factors. Compassionate and respectful care is more than ‘simple politeness’; It encompasses a sense of care as genuine through ‘emotional availability’. This can be as straightforward as a kind touch and making eye contact. It involves multidisciplinary teams working together, spending enough time with the woman making sure they understand her views, expectations and values. Childbirth is a continuous experience and ‘sense of security’ goes beyond ‘being safe’. Including and involving the partner is crucial, because having a baby is about ‘becoming’ or ‘expanding the family’. If the positive aspects of care identified in this study are adopted at all levels of the maternity care system and from all care providers, there is a high chance that most women will have a safe outcome, and a strong sense of coherence related to a positive birth and motherhood experience.

Disclosure of interest

The authors report no conflict of interest.

Contribution of authorship

The conception and design of the work: CV, ABVN, EB, SD, TSE. Acquisition of data: CV, ABVN, EB, SD, TSE. Analysis and interpretation of data: CV, ABVN, EB, SD, TSE. Drafting the work and revising it critically for important intellectual content: CV, ABVN, EB, SD, TSE.

Details of ethics approval

Ethical approval was granted by the Ethics Committee of the University of Central Lancashire, UK (Ethics Committee BuSH 222, 22nd January 2014) and (STEMH Ethics Committee Application, 1 June 2020). The study was approved by the Norwegian Data Inspectorate

(ref:60547/3/HJTIRH, 4th September 2018). No further ethical clearance was necessary from the Regional Committees for Medical and Health Research Ethics (ref:2017/1582, 05th October 2017).

Funding

CV was funded by a PhD scholarship from Oslo Metropolitan University, Norway.

Acknowledgement

This study was derived from the Babies Born Better project, developed as a part of two EU COST Actions supported by the Cost (European Cooperation in Science and Technology Programme as a part of European Horizon 2020): 1) COST-Action IS0907 “Childbirth Cultures, Concerns, and Consequences: Creating a dynamic European Union framework for optimal maternity care”; and 2) COST-Action IS1405: Building Intrapartum Research Through Health—an interdisciplinary whole system approach to understanding and contextualizing physiological labour and birth (BIRTH).

References

1. Oladapo O, Tunçalp Ö, Bonet M, Lawrie T, Portela A, Downe S, et al. WHO model of intrapartum care for a positive childbirth experience: transforming care of women and babies for improved health and wellbeing. *BJOG: An International Journal of Obstetrics & Gynaecology*. 2018;125(8):918-22.
2. Downe S, Finlayson K, Oladapo OT, Bonet M, Gülmezoglu AM. What matters to women during childbirth: A systematic qualitative review. *PloS one*. 2018;13(4):e0194906-e.
3. WHO recommendations : intrapartum care for a positive childbirth experience. Geneva: World Health Organization; 2018.
4. Renfrew MJ, McFadden A, Bastos MH, Campbell J, Channon AA, Cheung NF, et al. Midwifery and quality care: findings from a new evidence-informed framework for maternal and newborn care. *Lancet*. 2014;384(9948):1129-45.
5. Koblinsky M, Moyer CA, Calvert C, Campbell J, Campbell OMR, Feigl AB, et al. Quality maternity care for every woman, everywhere: a call to action. *The Lancet*. 2016;388(10057):2307-20.
6. Gottvall K, Waldenström U. Does a traumatic birth experience have an impact on future reproduction? *Bjog*. 2002;109(3):254-60.
7. Waldenström U, Hildingsson I, Rubertsson C, Rådestad I. A Negative Birth Experience: Prevalence and Risk Factors in a National Sample. *Birth*. 2004;31(1):17-27.

8. Bell AF, Andersson E. The birth experience and women's postnatal depression: A systematic review. *Midwifery*. 2016;39:112-23.
9. Størksen HT, Garthus-Niegel S, Vangen S, Eberhard-Gran M. The impact of previous birth experiences on maternal fear of childbirth. *Acta Obstetrica et Gynecologica Scandinavica*. 2013;92(3):318-24.
10. Henriksen L, Grimsrud E, Schei B, Lukasse M. Factors related to a negative birth experience – A mixed methods study. *Midwifery*. 2017;51:33-9.
11. Antonovsky A. *Unraveling the mystery of health : how people manage stress and stay well*. San Francisco: Jossey-Bass; 1987.
12. Magistretti CM, Downe S, Lindstrøm B, Berg M, Schwarz KT. Setting the stage for health: Salutogenesis in midwifery professional knowledge in three European countries. *International Journal of Qualitative Studies on Health and Well-being*. 2016;11(1):33155.
13. Perez-Botella M, Downe S, Meier Magistretti C, Lindstrom B, Berg M. The use of salutogenesis theory in empirical studies of maternity care for healthy mothers and babies. *Sexual & Reproductive Healthcare*. 2015;6(1):33-9.
14. Ferguson S, Browne J, Taylor J, Davis D. Sense of coherence and women's birthing outcomes: A longitudinal survey. *Midwifery*. 2016;34:158-65.
15. Norwegian Institute of Public Health. Medical Birth Registry of Norway [Internett]. [updated 2020 June 4. Available from: <http://statistikkbank.fhi.no/mfr/>.
16. Braun V, Clarke V. Using thematic analysis in psychology. *Qualitative Research in Psychology*. 2006;3(2):77-101.
17. Eysenbach G. Improving the quality of Web surveys: the Checklist for Reporting Results of Internet E-Surveys (CHERRIES). *Journal of medical Internet research*. 2004;6(3):e34-e.
18. Bohren MA, Vogel JP, Hunter EC, Lutsiv O, Makh SK, Souza JP, et al. The Mistreatment of Women during Childbirth in Health Facilities Globally: A Mixed-Methods Systematic Review. *PLOS Medicine*. 2015;12(6):e1001847.
19. Bohren MA, Tunçalp Ö, Miller S. Transforming intrapartum care: Respectful maternity care. *Best Practice & Research Clinical Obstetrics & Gynaecology*. 2020;67:113-26.
20. Shakibazadeh E, Namadian M, Bohren M, Vogel J, Rashidian A, Nogueira Pileggi V, et al. Respectful care during childbirth in health facilities globally: a qualitative evidence synthesis. *BJOG: An International Journal of Obstetrics & Gynaecology*. 2018;125(8):932-42.

21. Miller S, Abalos E, Chamillard M, Ciapponi A, Colaci D, Comande D, et al. Beyond too little, too late and too much, too soon: a pathway towards evidence-based, respectful maternity care worldwide. *Lancet*. 2016;388(10056):2176-92.
22. Bohren MA, Hofmeyr GJ, Sakala C, Fukuzawa RK, Cuthbert A. Continuous support for women during childbirth. *Cochrane Database of Systematic Reviews*. 2017(7).
23. Sandall J, Soltani H, Gates S, Shennan A, Devane D. Midwife-led continuity models versus other models of care for childbearing women. *Cochrane Database of Systematic Reviews*. 2016(4).
24. Steen M, Downe S, Bamford N, Edozien L. Not-patient and not-visitor: A metasynthesis fathers' encounters with pregnancy, birth and maternity care. *Midwifery*. 2012;28(4):422-31.
25. Ellberg L, Hogberg U, Lindh V. 'We feel like one, they see us as two': new parents' discontent with postnatal care. *Midwifery*. 2010;26(4):463-8.
26. Johansson M, Fenwick J, Premberg Å. A meta-synthesis of fathers' experiences of their partner's labour and the birth of their baby. *Midwifery*. 2015;31(1):9-18.
27. Vallin E, Nestander H, Wells MB. A literature review and meta-ethnography of fathers' psychological health and received social support during unpredictable complicated childbirths. *Midwifery*. 2019;68:48-55.
28. Werner-Bierwisch T, Pinkert C, Niessen K, Metzging S, Hellmers C. Mothers' and fathers' sense of security in the context of pregnancy, childbirth and the postnatal period: an integrative literature review. *BMC Pregnancy and Childbirth*. 2018;18(1):473.
29. Ledenfors A, Berterö C. First-time fathers' experiences of normal childbirth. *Midwifery*. 2016;40:26-31.
30. Admon L, Haefner JK, Kolenic GE, Chang T, Davis MM, Moniz MH. Recruiting Pregnant Patients for Survey Research: A Head to Head Comparison of Social Media-Based Versus Clinic-Based Approaches. *J Med Internet Res*. 2016;18(12):e326.
31. IPSOS. IPSOS SoMe tracker Q4 18 [updated 20.01.2019. Available from: <https://www.ipsos.com/nb-no/ipsos-some-tracker-q418>.
32. Kalimeri K, Beiró MG, Bonanomi A, Rosina A, Cattuto C. Traditional versus Facebook-based surveys: Evaluation of biases in self-reported demographic and psychometric information. *Demographic Research*. 2020;42(5):133-48.
33. Small R, Roth C, Raval M, Shafiei T, Korfker D, Heaman M, et al. Immigrant and non-immigrant women's experiences of maternity care: a systematic and comparative review of studies in five countries. *BMC Pregnancy Childbirth*. 2014;14:152.

34. Olza I, Uvnas-Moberg K, Ekström-Bergström A, Leahy-Warren P, Karlsdottir SI, Nieuwenhuijze M, et al. Birth as a neuro-psycho-social event: An integrative model of maternal experiences and their relation to neurohormonal events during childbirth. PLOS ONE. 2020;15(7):e0230992.
35. Turner VW. The ritual process : structure and anti-structure. London: Routledge & Kegan Paul; 1969.
36. Oakley A. The sociology of childbirth: an autobiographical journey through four decades of research. Sociology of Health & Illness. 2016;38(5):689-705.
37. Schmied V, Lupton D. Blurring the boundaries: breastfeeding and maternal subjectivity. Sociology of Health & Illness. 2001;23(2):234-50.
38. Dixon L, Skinner J, Foureur M. Women's perspectives of the stages and phases of labour. Midwifery. 2013;29(1):10-7.
39. Reed R, Barnes M, Rowe J. Women's Experience of Birth: Childbirth as a Rite of Passage. New York 2016. p. 46-56.
40. Ferguson S, Davis D. 'I'm having a baby not a labour': Sense of coherence and women's attitudes towards labour and birth. [London] :2019. p. 102529.
41. Miller T. Losing the Plot: Narrative Construction and Longitudinal Childbirth Research. Qualitative Health Research. 2000;10(3):309-23.

This article has a Video Abstract presented by Carina Vedeler

Table/Figure Caption List

Figure 1. The stepwise analytical process as described by Braun and Clarke¹⁶

Figure 2. Flowchart illustrating inclusion in the study

Figure 3. Proportion and distribution of place of birth in study sample (n=8,401) and MBRN 2017 (n=56,553)

Table 1. Sociodemographic and obstetric characteristics of included respondents (n=8,401), compared to a national Norwegian sample (n=56,553) from year 2017

Table 1. Sociodemographic and obstetric characteristics of included respondents (n=8,401), compared to a national Norwegian sample (n=56,553) from year 2017

Sociodemographic	Study sample		MBRN 2017*	
	n=8,401	(%)	n= 56,553	(%)
Maternal age				
Mean (SD)	30.0	4.8	30.9	4.9
<19	60	0.7	500	0.8
20-24	940	11.3	5,872	10.4
25-29	2,904	34.8	18,672	33.0
30-34	2,944	35.3	19,943	35.3
35-39	1,257	15.1	9,429	16.7
>40	233	2.8	2,137	3.8
Education				
No higher education	1,805	22.1	-	-
Higher education 1-4 years	3,653	44.6	-	-
Higher education > 4 years	2,727	33.3	-	-
Employment				
Employed	6,701	79.9	-	-
Student	674	8.0	-	-
Unemployed	410	4.9	-	-
Other	601	7.2	-	-
Socio-economic status**				
1 (Much worse)	276	3.3	-	-
2	351	4.2	-	-
3 (Average)	5,787	69.0	-	-
4	1,313	15.6	-	-
5 (Much better)	667	7.9	-	-
Marital Status				
Married or in a relationship, cohabiting	7,863	93.7	52,984	93.7

Other	533	6.3	3,568	6.3
Obstetric characteristics	Study sample		MBRN 2017*	
	n=8,401	(%)	n=56,553	(%)
Place of birth				
Obstetric unit***	7,673	91.3	52,693	93.2
Alongside midwifery unit****	485	5.8	3,000	5.3
Freestanding midwifery unit	69	0.8	387	0.7
Planned homebirth	132	1.6	126	0.2
Born before arrival	38	0.5	347	0.6
Parity				
Nulliparous	3,772	45.0	23,841	42.2
Multiparous	4,606	55.0	32,712	57.8
Mode of birth*****				
Spontaneous vaginal delivery	6,240	74.4	42,075	73.7
Instrumental vaginal delivery*****	907	10.8	5,968	10.3
Caesarean section (emergency)	828	9.9	5,870	10.4
Caesarean section (planned)	407	4.9	3,159	5.6

*The Norwegian birth cohort Medical Birth Registry of Norway (MBRN) data from year 2017, information about educational level, employment status or sociodemographic status is not collected in MBRN

** My living standard compared to the people in the country I am currently living in. Likert scale 1-5

*** Includes specialised obstetric units and smaller obstetric units

****Not registered in MBRN, all alongside units were contacted to obtain number of births.

***** In MBRN, this refers to number of babies born and not births

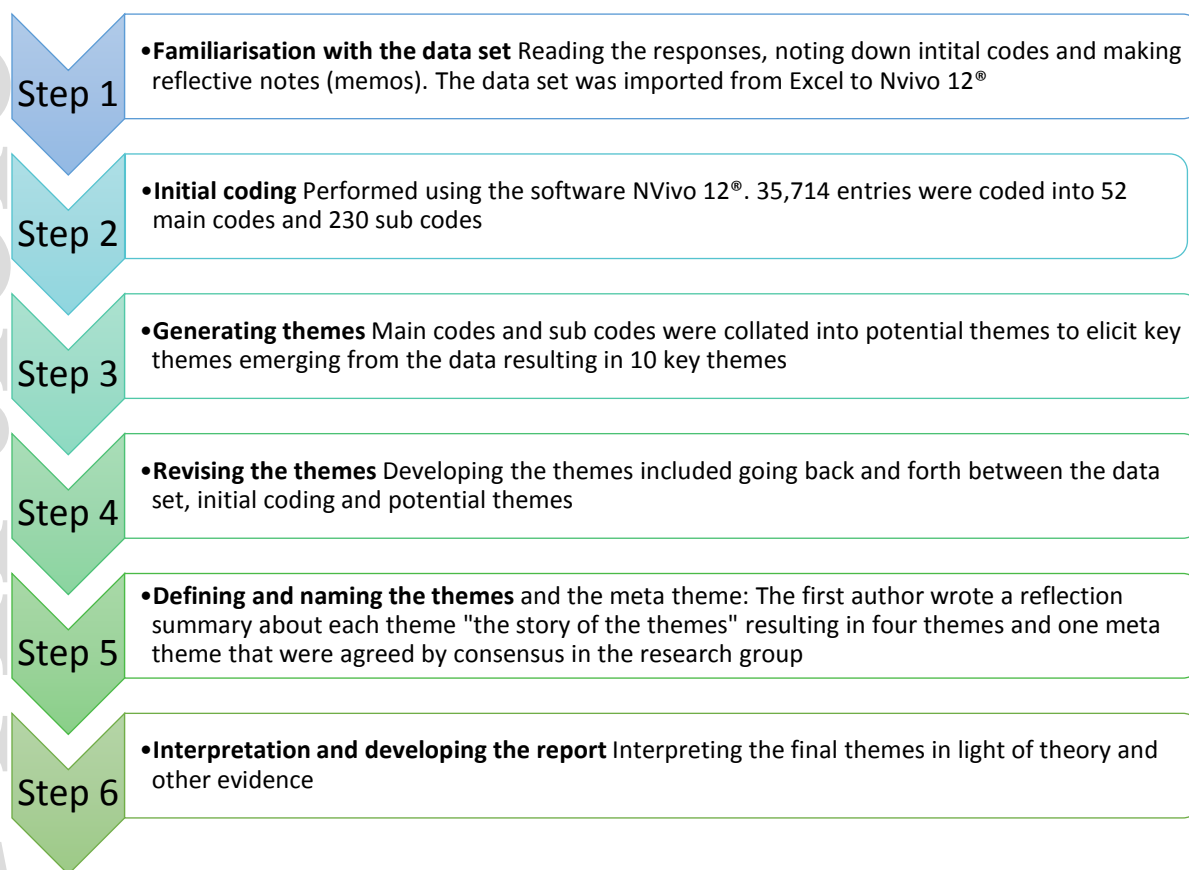


Figure 1. The stepwise analytical process as described by Braun and Clarke¹⁶

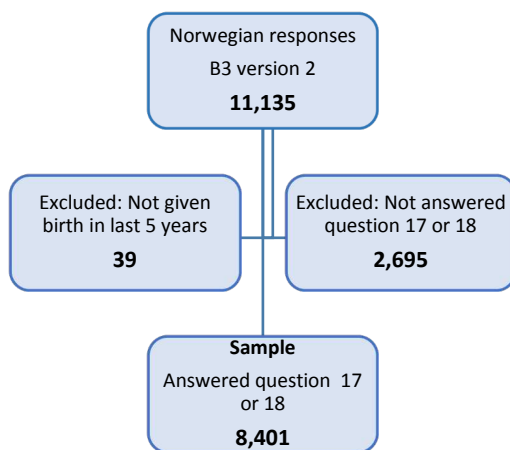


Figure 2. Flowchart illustrating inclusion in the study

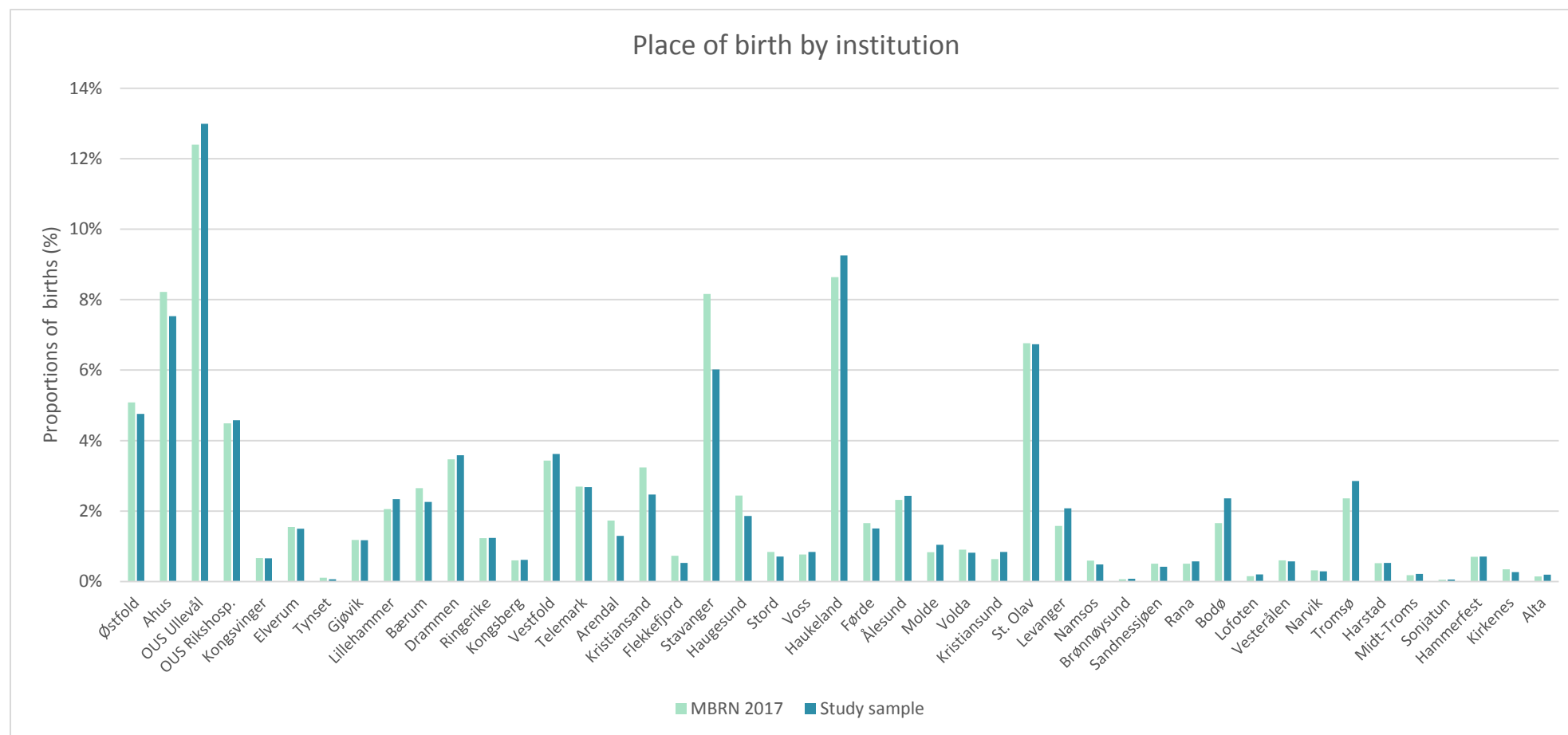


Figure 3. Proportion and distribution of place of birth in study sample (n=8,401) and MBRN 2017 (n=56,553)