
**The Characteristics of Antenatal
Services from Midwives, that Women
are Satisfied or Unsatisfied with**

A Descriptive Survey

**Submitted in part fulfilment of the degree of Master of
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**Dedicated to my daughter Bryndís Elva Bjarnadóttir the wind
beneath my wings and the inspiration of my life**

Abstract

Aim of the study: The aim of the study is to find out the characteristics of antenatal services from midwives, that women are satisfied or unsatisfied with.

Design: A descriptive survey using a questionnaire with both close-ended questions and open-ended questions.

Data collection: The data collection took place during two weeks in May 1998, in three different places in Iceland. Systematic sample, where every other woman that came to the three antenatal clinics, were asked to fill out a questionnaire.

Findings:

Altogether 256 questionnaires were distributed at the three clinics, and 232 were returned completed. That means that the average respondent rate was 91,3%.

The research illustrates that 68,6% (n=157) of the women in the three clinics were very satisfied with the service they received from their midwives in general, and 29,7% (n=68) claimed that they were rather satisfied. One point three percent (n=3) said they were neither satisfied nor unsatisfied and 0,4% (n=1) said they were very unsatisfied.

The characteristics of the antenatal services that women were satisfied with, according to the variables that had significant difference with their satisfaction in general, were the following:

- Satisfaction with the time they had to talk to their midwives
- Satisfaction with information received
- Satisfaction with the presence of their midwives
- Satisfaction with their perception of the midwife's interest in her work
- Satisfaction with their relationship with their midwives
- Satisfaction with their opportunities to telephone their midwives
- Satisfaction with the time between visits
- Satisfaction with the length of waiting time

It was not possible to identify what characterised the antenatal services which women were unsatisfied with, as few women claimed they were rather or very unsatisfied. However it maybe postulated that these characteristics are the opposite of what characterises the services which women are satisfied with.

As 68% of the women were very satisfied, the question that can be raised, is if it is agreeable that 32% were not very satisfied with the services from the midwives in general? The women that were rather satisfied might have expected or hoped for other types of services. The results of this study can be a support in the changes that are occurring in the antenatal services in Iceland and be a guide for further research and furthermore for changes to be based upon.

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1. The introduction

1.1. Background to the study

In my work as a nurse and a midwife I have often thought about how much I needed to know more about women's views about their pregnancy. From my point of view, being pregnant is a special time for every woman. A time of change when she needs a special kind of care from the health providers.

I have often discussed with my clients their view regarding antenatal services and they have taught me many things about what kind of antenatal service they want.

An example of this is that they have told me about how much they need to have a good relationship with their midwife and how important it is to have information about their choices regarding the service.

Pregnancy is the time when a woman starts to develop a relationship with her child. That is one of the reasons why a good antenatal service is so important. The wishes of expectant mothers are very important and midwives must take notice of every wish they have in the antenatal service (Waldenström, 1996).

At that special time in a woman's life she must know that her wishes will be listened to and that she gets support in the new role she is dealing with.

The support is also very important because becoming a mother can cause considerable stress in a woman's life. How a woman handles that stress can make the difference in how she perceives the new role she is handling, perhaps for the first time. The level of stress in parenthood is connected to events that occur during the pregnancy (McKay, 1997).

During the past few years antenatal services have been changing, from fragmented care and the focus has been moving to expectant parents wishes, where women meet the same midwife as often as possible. For example, a small unit at the National Hospital in Reykjavík was established two years ago which offered continuity of care during the antenatal period, birth and the first days of the postpartum period. A service where women can choose whether to have care from the midwives at the hospital, or at home for the first days in the postpartum period was started in Reykjavik five years ago and in Akureyri two years ago.

It is my experience as a midwife for nearly ten years, that the health providers have not taken enough notice of those changes. We have not offered women a real choice by giving them information so they could choose for themselves what to do. We have been manipulating them, and very often health providers have misused their power. Midwives have not been strong enough to fight for women's right to have a real choice regarding the service they are using.

However, the focus has gradually been moving on how midwives and doctors can provide the maternity service that expectant parents are satisfied with.

Furthermore, it is important to take note of how few studies have been done about what kind of antenatal service expectant mothers would like to have, and how little has been written about that topic.

No studies have been done in Iceland concerning the kind of antenatal service women want. With antenatal services changing here in Iceland, it is important to explore expectant mothers' attitudes to the antenatal service and by doing that, we could have some ideas of what kind of service women want and what they do not want

1.2. Aim of the study

The aim of the study is to find out the characteristics of antenatal services from midwife, that women are satisfied or unsatisfied with.

1.3. Research questions

The research questions are;

- What characterises the antenatal service that women are satisfied with?
- What characterises the antenatal service that women are unsatisfied with?

1.4. Methodological choices

In view of the research questions, I decided to use descriptive survey and questionnaires to collect data. The reasons why I chose a descriptive survey have a lot to do with the advantages of surveys and questionnaires, such as; large amount of data can be collected and that it can give a lot of information. The fact that data from surveys can be used for many purposes is also one of the reasons why I decided to use

survey. Other reasons are that although using a large sample size it is not very expensive and you can use a computer to help you with the data analysis (Polit and Hungler, 1991).

The reasons why I chose questionnaires has to do with the fact that little is known about the topic, so I want to use a large sample. By using a questionnaire, that is possible. Other reasons are that I want to be able to know something about the details that women are satisfied or unsatisfied with the antenatal service, not just that they are satisfied or unsatisfied.

In this study it was decided to use probability sample and to decrease the chance of high drop out rate, I decided to use systematic sample. By using systematic sample it was possible to ask the midwives to hand a questionnaire to every other woman who comes to the antenatal service in the first two weeks in May. The first two weeks in May were chosen, because at that time the summer vacations have not started and the service is still similar to what it usually is during the rest of the year. By asking every other woman to fill out the questionnaire I could minimise the drop out rate, which is often the largest disadvantage of using questionnaires (Wilson, 1989).

All this suits the aim of the study because very little is known about the topic. I wanted to gather a large amount of data and I wanted to explore different variables regarding the perception of satisfaction or dissatisfaction with antenatal care.

1.5. Definition of key concepts

According to the aim of the study and the research questions four key concepts are defined:

- Antenatal service: The service that pregnant women get from midwives during their visits to the health clinics or hospitals.
- To be satisfied is: What women are pleased about regarding the service they get from midwives when they come to the antenatal clinic, in their health clinics or hospitals.

- To be unsatisfied is: What women are not pleased about regarding the service they get from midwives when they come to the antenatal clinic, in their health clinics or hospitals.
- Women: All pregnant women who come to the antenatal clinic, except women who are coming for the first time in their pregnancy.

2. Literature review

2.1. Introduction

In the literature review the focus is on women's satisfaction or dissatisfaction with antenatal service in general. In relation to the influence of the medical model on the antenatal services and the debate between feminine and masculine influences on the health care system is discussed. The main concept that rose during literature review were about communication, caring, choice and continuity of care, those concepts are explored and discuss. Those issues are discussed and how they affect women's perception of satisfaction with antenatal care according to the literature.

Women have stated that every new pregnancy is a new experience, and that new experience instills a new feeling and new perception that they have a need to share with others (Kitzinger, 1994). It has also been pointed out by Kitzinger that when women are pregnant, their society treats them in a different way than when they are not. Some authors claim that when women are pregnant they become a kind of common property. Suddenly people start to touch their stomach and to comment on their figure and their look (Kitzinger,1994, Flint, 1991).

Because of that, women need a lot of information and a special kind of support during their pregnancy.

Kitzinger (1994) states that the ideas women have regarding pregnancy and childbirth are very much patterned by culture. That in each culture there is a message how a woman should behave, what to expect and what is taking place inside her body. Different cultures have a different message to give to their women when they are pregnant.

Pregnant women are in a time of their life where many changes are occurring, and during that time it is very important for them to have the kind of support they wish for. To have the kind of service they want could make the difference how women perceive the pregnancy and the big changes that are occurring in their lives (Flint, 1991).

Throughout the world a gentle revolution, as Harper (1994) calls it, has been occurring for the past few years. Midwives as well as people who are using the maternity services have been calling for changes. She points out that throughout the world people have been writing and talking about the importance of changing the system that we have created.

The gentle revolution has also been taking place here in Iceland. Parents or expectant parents have, as well as midwives, been writing and talking about the old system that must be changed in the future. The Association of Icelandic Midwives have held a conferences where women like Lesley Page, Caroline Flint and Sheila Kitzinger have been among the speakers. Those women had a great effect on Icelandic midwives. Papers have also been published in the Icelandic Midwifery Journal and also in the newspapers, where women have been demanding changes, for example, demanding that they have a real choice about continuity of care all through the pregnancy, birth and the first days postpartum.

Another change that has occurred in Iceland is that three years ago, the midwifery education moved into the University of Iceland, and for the first time, a midwife was the senior tutor and the organiser regarding the education that the students received (Olafsdottir, 1995, Cufficulum of Icelandic Midwives Education, 1999).

Although some changes have been made, we still have a long way to go.

Conducting a study regarding women's satisfaction or dissatisfaction with antenatal services can be a step in guiding us on our way in the gentle revolution.

2.2. Women's satisfaction or dissatisfaction with antenatal services

Not many studies have been conducted regarding which characteristics of antenatal services pregnant women are satisfied or unsatisfied with, and none that measure exactly the same variables as this study.

In a descriptive survey by Williamson and Thomson (1996) participants in the survey were 110 women. In the audit (a new questionnaire was prepared and in that questionnaire the new sample was asked only about the variables that the women in the former study had said affected their dissatisfaction) there were 151 participants.

A self-administered questionnaire and a self-administered audit questionnaire were used. The main results were the following. Things that women were satisfied with, were that the staff were kind, friendly and understanding; regularity of check ups and scans, and the hospital staff's response to problems that came up. Things that women were unsatisfied with were, for example, the waiting time, lack of explanation, lack of continuity of care, and lack of information.

These results indicate that explanations, continuity of care, information given, the midwives presence and the waiting time are the variables that influence the women's perception of satisfaction or dissatisfaction regarding antenatal services.

A study by Dennis et al. (1995), focuses on characteristics of pregnant women, utilisation and satisfaction with antenatal services. A descriptive study with 47 participants was conducted. The results indicate that the key element in satisfaction is the amount of time the doctor spends with the client, and how easy it was to contact the doctor. The key element in dissatisfaction was if they had to wait a long time for the doctor.

In a study performed in St George's Hospital in London during the years 1983 until 1985 the benefits which accrued to the women as a result of continuity of care were many; less analgesia in labour, feelings of being in control, less interventions during labour. They were also more able to take up a comfortable position in labour, less episiotomies, less antenatal admissions, cheaper antenatal consultations, greater enjoyment of antenatal care, more normal deliveries and a greater enjoyment of postnatal care (cited in Flint, 1993).

In that study, women's satisfaction with the service at the antenatal clinic is also measured. Ninety-four point five percent (n=259) were satisfied with the service they got at the antenatal clinic where continuity of care was performed. On the other hand 86,8 % (n=230) were satisfied in the control group which received traditional antenatal service during pregnancy.

Those results raise the question if continuity of care is one of the major factors in women's satisfaction with antenatal care.

In a study by Olafsdottir (1992) where unstructured open interviews were conducted with 12 new parents and they were asked to describe an actual situation, in which they experienced either effective or ineffective teaching-coaching with midwives.

Hermeneutic phenomenological approach were used to identify seven categories: the midwife's approach, midwife's competence and skills, midwife's help in learning parenting skills, midwife's explanations of the actual situation, midwife's collaboration with the parents, midwife's continuity of care and the relationship between the midwife and parents.

Omar and Schiffman published in 1995 their results of a study of pregnant women's perceptions of antenatal care. They used semi-structured interview in which 22 women took part.

Their research questions were: what expectations do women have about antenatal care; what reasons do women have for being satisfied with antenatal care; and what reasons do woman have for being unsatisfied with antenatal care?

The main results were that the provider's relationship with the woman had the greatest influence on their satisfaction with antenatal care. The time spent with the provider did not seem to be a key element, but the relationship was. The staff also had great effects on how satisfied the woman was with the antenatal care. A caring staff had much effect on how the women perceived the antenatal service. Regarding dissatisfaction, the most common factor was the waiting time in the antenatal clinic.

Some authors have stated that satisfaction with the antenatal service could also have some long-term effects. One of them is Knapp (1996). She illustrates that the attitude of the pregnant woman towards the upcoming birth experience has been found to influence her perception of the birth experience. What feelings the pregnant woman has towards the upcoming birth must, therefore, be one of the topics that the woman and her midwife talk about in her antenatal visits. Does the woman feel prepared for the upcoming birth or not? If not, one of the tasks that her midwife has to deal with during her pregnancy, is how she can help her to gain the confidence that she needs in order to give birth to her baby.

Knapp (1996) also links the attitude of the woman towards the upcoming birth, to the childbirth experience itself, and points out how important the childbirth experience is

to women. That experience is not something in the future, which is not important. On the contrary, it can make the difference in how the woman manages to handle the role of a mother.

In a study conducted by Flint and Poulengeris (1987) where the effect of continuity of care by a small hospital-based team of four midwives were explored and compared with a control group of randomly selected women who had a normal hospital care. The major advantages were that through increased continuity of care, women experienced less waiting time, more satisfaction with the care, less antenatal hospitalisation and they felt better prepared when they went into labour. Various other advantages were shown, such as they felt more in control, they needed less analgesia, fewer epidurals and perceived the labour more positively. The feeling of being more prepared for motherhood and easier feelings of being a mother were also advantages of more continuity of care.

However, not all studies imply that continuity of care has something to do with women's satisfaction with antenatal care, the experience through birth nor the satisfaction during the postnatal care.

Waldenström (1998) illustrates in her study that continuity of care has in fact no effect on women's satisfaction, which is absolutely in contradiction with what many other authors have implied. In her study, four hundred and ten women participated in, no statistical differences were found in satisfaction with antenatal care between women that had seen only one, two or more than two midwives at their antenatal visits.

Although studies do not all imply the same results, that continuity of care is one of the major factor in women's satisfaction with antenatal care, my experience tells me that continuity of care is very important.

No studies have been performed until now in Iceland regarding women's satisfaction with antenatal care, so it is clear that this study was definitely needed. Especially if we look at the fact that maternity services in Iceland have begun to change little by little during the past few years, so we need more information about women's wishes regarding the antenatal services.

In my experience, after working both in an antenatal clinic and in a mixed delivery- and postpartum ward, continuity of care is very important for women, and also for midwives. The caring relationship which can be developed through repeated communication during the pregnancy, birth and postpartum period, is from my point of view something that has major influence on women's perception of the service they get from midwives during the childbearing process.

2.3. The influence of the medical model on antenatal service

Nolan (1997) indicates that since men started to become involved in childbirth they have attempted to persuade women that their knowledge concerning pregnancy and childbirth was not valuable. Before the seventeenth century, women learned from their mothers and their sisters and other female relatives about their pregnancy and birth. They learned through communication and women's wisdom about matters concerning pregnancy and childbirth. Through communication with other women, their confidence was built up and they started to have faith in themselves that they could be good mothers.

Other authors have also discussed the effects that the medical model has had on the antenatal service. One of them is Marjorie Tew (1990). who in her book: "Safer Childbirth?" She writes about how the antenatal services have changed during the last centuries and how the medical model has influenced the antenatal service.

She claims that looking at the pregnancy with the medical model in mind has changed people's ideas of pregnancy. Instead of looking at the pregnancy as a normal natural process the medical model changed the pregnancy into something abnormal and dangerous. Something that doctor needs to take care of.

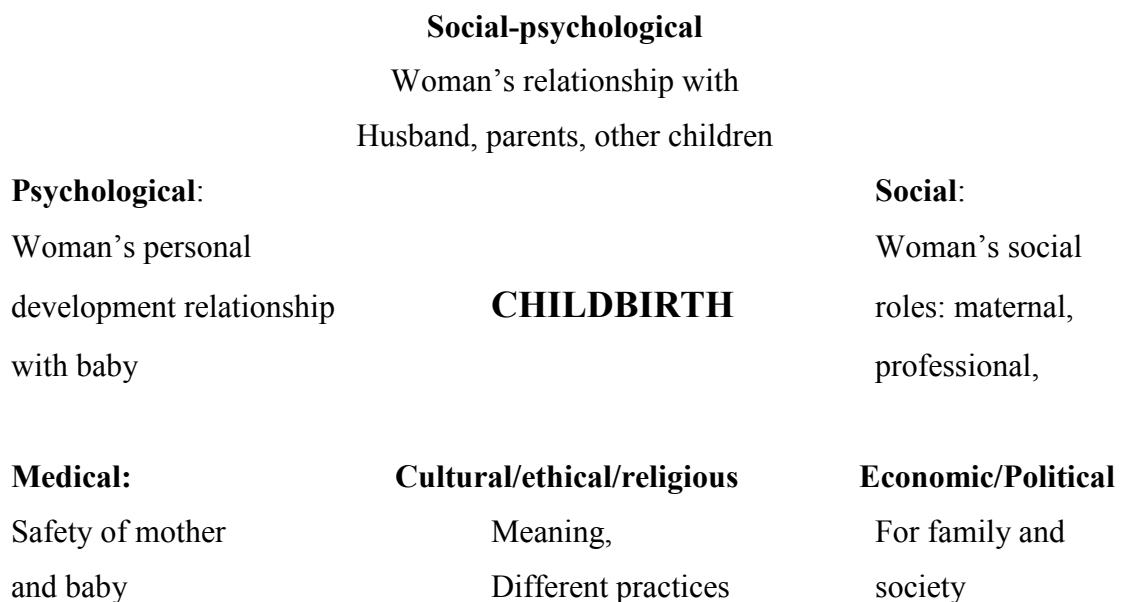
Tew (1990) also states that the major difference in the midwives and doctors attitude to pregnancy, is that midwives see the pregnancy as a normal natural process where some pregnancies can change to abnormal ones. On the other hand, the doctor's attitude is more like looking at the pregnancy as a dangerous event where maybe some pregnancies become normal ones.

Every midwife has to ask herself a question. Does she look at the pregnancy as a normal natural process or does she look at it as abnormal and dangerous? In my

opinion that is one of the major questions that every midwife has to ask herself. Our attitude has of course much effect on how we take care of our clients and also on what attitude women develop during their pregnancy.

Waldenström (1996) and Nolan (1997) both illustrate that the medical model has too much influence in the antenatal service. Waldenström questions whether a medical model is sufficient for our understanding of the complexity of childbirth, and for the provision of high quality antenatal care. She points out that when women become pregnant, decisions such as whether to continue the pregnancy or to have an abortion sometimes come in their minds as well as whether or not they should have an amniocentesis, ultrasound or if they would like to know the sex of their baby or not. That indicates that antenatal care has implications for other than the purely physical aspects of childbirth. She claims that all that new technology used during pregnancy can affect the women's feelings towards themselves and their children during the pregnancy.

Waldenström explains the different perspectives on childbirth in the following way:



(Waldenström, 1996).

Waldenström (1996) also indicates that we have to bear in mind the different perspectives on childbirth, although some could argue that the aim of the antenatal service was just to provide medically safe care. Today antenatal care plays a major role in women's lives and many new technologies have implications far beyond the original aim.

Churchill (1995) has stated that obstetricians are educated to identify and treat complications during pregnancy and birth and their background has very much to do with technology and diseases.

Looking at that fact, it is not strange that many obstetricians look at the pregnancy, birth and the postpartum period as a dangerous process where all kind of diseases can occur. Their ideology is built up with abnormal and dangerous circumstances in mind but as Churchill states the majority of childbearing women are healthy, and so are their children.

Sohier (1992) writes about the nursing power and claims that what we must do is to act from a position of strength to change the situation in the health care system. "Therefore our first task is to raise the consciousness of midwives and nurses by describing the fundamental power contained in nursing knowledge and by doing so from 'womanist' perspectives" (p. 62). By empowering each other, she says, we can centre on the incipient potency of midwifery and nursing knowledge.

2.4. Feminism and the antenatal services

Authors have written about feminism as a hot topic in nursing today. Many nurses say it is time that our discipline started to acknowledge the important message that nursing and feminism can be valuable to each other (McCloskey and Grace, 1994).

In 1985 Chinn and Wheeler state that the relationship between nursing and feminism is obscure. Before 1985 little attention was paid to the relationship between nursing and feminism and it was not until recent years that nurses have begun to look at the links between nursing and feminism.

Sampsell (1990) has stated that nurses provide care not just to men but also to women and that it is important that nurses reflect the principles of feminism. Through that reflection, women would be more likely to take action in the community and to let their opinions be heard.

Bunting and Campbell (1990) declare that the ideas of caring and nurturing that are the essence of nursing are associated with the feminine aspects of humanity.

Valentine (1992) writes about the lack of a feminist orientation in nursing. She states that ambitious nurses that fought for or demanded rights were seen as uncaring and undeserving. Perhaps that is the reason why feminism and nursing have not such strong connections as might be good for our clients.

Millar and Biley (1992) state that the ideas of power and empowerment are important issues in nursing and also in the nursing discipline. They state that there is a continuously developing connection between feminism and nursing.

Authors also write about the lack of feminist thought in nurse-midwifery. They say that although both nurse-midwifery and feminism are professions concerned with women and issues affecting women's lives, too little attention has been paid to the connection between midwifery and feminism (Valentine, 1992).

In the book *Feminist Practice in Women's Health Care*, Mavis Kirkham (1986) writes about the feminist perspective in midwifery. She states that trusting the women to be able to give birth to their children is very important because if their midwife trusts them, they trust themselves. She also points out that the woman's trust in herself to be able to give birth is connected to feminism and the feeling of being strong.

McCool and McCool (1989) stress the need to acknowledge feminism in nursing, but there is also a need to acknowledge feminism in midwifery. What could be more feminine than pregnancy and childbirth?

2.5. The feminine and masculine debate regarding the health care services

Many nurses and midwives have pointed out the constant debate between feminine and masculine attitude in nursing and midwifery. One of them is Corolin M. Sampselle (1990). She claims that western society has been shaped by the male-dominated majority culture. The question is, does that also include the knowledge of pregnancy and childbirth?

Robinson (1990) stresses that since the 1960s the influence of the medical domain has increased and midwives have been struggling to decrease that influence. She states that midwives have suffered demarcationary closure from doctors.

Gordon (1991) among other authors talks about “the masculine marketplace” and stresses how women have been forced to think like men and to act like men. Also how “the doctor-nurse game” has been changing through the years (Stein, Watts and Howell, 1990).

In many countries the medical system has expected women to hand themselves over to the health care professionals without asking too many questions. Phrases like “Just leave it to us”, “ Don’t worry, we know what we are doing” have been used (Kitzinger, 1994, p. 142).

Women who ask too many questions and want to do something that the doctor says they should not do get phrases like “ You don’t want to harm your baby, do you” (Kitzinger, 1994, p. 142).

Because their duty is to insure that everything goes well, they demand that women trust them almost without questioning (Kitzinger, 1994).

Health providers can introduce their knowledge to women, but they cannot demand that women accept it without questioning it. But that is how it has been for the last decades. Women have been forced to give birth in many countries like men want them to (Tew, 1990).

It is my experience that is also the fact regarding the antenatal services. Women have been forced to use a service that has been developed with the masculine identity in mind but not with feminine identity in mind.

Doering (1992) writes about how doctors have used “science” and “truth” in the battle between midwives and doctors. She claims that they have used those words to limit and control women in general, and nurses in particular through the propagation of a power/knowledge structure.

Hagell (1989) writes about how men’s scientific knowledge was used to nearly exclude women’s and midwives’ knowledge. Their knowledge was not considered scientific, and therefore not legitimate.

Doctors have had a problem with seeing nurse-midwifery knowledge regarding pregnancy and childbirth as knowledge in which women have a choice and can use the maternity services and give birth to their children in the way that they think best. Barbara Harper (1994) states that having choice is a political issue. She also claims

that to have a choice about where to get their maternity services where they will give birth and who will care for her are not simple issues. They are issues that matter in control and responsibility, where women have had too little choice for many years. She points out that too many women are living with the humiliation and sense of powerlessness that modern technology has caused.

Women should have the option of using technology and the health professionals should have the judgement to use the technology only when it is needed.

A lot of important knowledge has been lost because midwives and women have not been strong enough to fight for their rights and that their feelings and wishes should be respected. Among this knowledge are women's needs and wishes during their antenatal care.

The feminine values such as Davies (1995) states, for example, responsibility to others, understanding, and co-operation have not had as much effect on matters connected to pregnancy and childbirth, as they should have. On the other hand masculine features such as separation, control and self-esteem have been highly valued. It is time for women to stand up for their rights and emphasise that their knowledge is very important for all pregnant women and women who are giving birth. Diana Russell (1990) looks at the knowledge of pregnancy and birth through a socialist feminist perspective. She states that throughout the years, the male upper class has managed to control childbirth instead of the women. She also talks about the conflict between women's traditional wisdom and the male expertise centre.

Many other papers have been published on that matter in recent years. One of them is written by Alistair Hewison (1993). She stresses how medical dominance has influenced the ideas about pregnancy and childbirth and how they have come to symbolise much wider issues relating to women in society.

Janet Balaskas (1989) writes about how we have almost forgotten how a natural physiological pregnancy and birth unfolds, and because of modern obstetrics, women have lost touch with their power as pregnant women and as birth-givers.

It is my belief that women are getting their power back, at least in some countries. This movement has been getting stronger every year and women are fighting for their rights to have an enjoyable and normal pregnancy, labour and delivery as possible.

For the last few years, midwives, nurses, and of course women in general, have been demanding that their knowledge should be respected, as an important knowledge for the childbearing women. Women have been pointing out that midwives have knowledge to take care of them, because in most cases they are healthy women giving birth to their healthy children. Not patients which doctors must take care of like women with a disease.

In the battle between midwives and doctors, midwives have been losing for a long time, but they have managed to gain something back during the last decade. It has been a long battle, perhaps a battle of power. Tew (1990) points out that in this battle there have been many kinds of stereotypes; midwives, weak and feminine like their clients and doctors, strong and masculine. Perhaps the Association of Radical Midwives in Britain and many other movements have, in recent years, managed to change those stereotypes (Sandall, 1995).

During the past few years, midwives and nurses have begun to study matters such as women's needs during pregnancy and the perception of birth. Hopefully those kind of studies will help us in creating a system for expectant mother and of course fathers, that is built up with feminism attitude in mind and not the medical model in mind (Halldorsdottir and Karlsdottir, 1996a, Halldorsdottir and Karlsdottir, 1996b. Karlsdottir and Halldorsdottir, 1996).

2.6. Caring in nursing and midwifery

One of the central focuses of nursing and midwifery is caring, and in recent years many papers describing the essence of caring have been published (Halldorsdottir, 1996; Kyle, 1995).

Caring has been defined as: " being open to and perceptive of others; being genuinely concerned for and interested in the patient, as a person and as a patient; being morally responsible; being truly present for the patient; and finally, being dedicated and having the courage to be appropriately involved as a professional nurse" (Halldorsdottir, 1996,p. 31).

Looking at Halldorsdottir's definition of caring, it is obvious that the relationship between nurse and patient is very important, and therefore so must be the relationship between the midwife and her client. Communication between them the midwives presence, must have a great effect on how that relationship develops and if a caring atmosphere can be developed or not.

Looking at a phenomenological study in which 11 women took part, conducted by Karlsdottir and Halldorsdottir (1996) regarding women's perception of caring and uncaring encounters during pregnancy, many interesting results were shown. One of the results of that study was that women perceived that they were vulnerable and needed a caring midwife to take care of them. They also perceived excitement, fun and also some mood changes. From the results of that study, it can be said that pregnant women need effective oral communication to be able to build up a good relationship with their midwives.

It is my experience that a good relationship between the expectant mothers and their midwives is also important to identify the clients who need a special kind of service. For example, some kind of special support, information, or frequent visits to the antenatal clinic. Because of the vulnerability that many pregnant women feel, midwives must remember that they must have the chance to express their worries. They must also have answers to their questions to build up their confidence concerning the birth and their new role as mothers.

It has been stated that the main difference between the nursing knowledge and the medical knowledge is that nursing knowledge is about "caring" and the medical knowledge is about "curing". Also that in caring there is a sense of making decisions and consulting our clients, but doctors have a tendency to control and give orders (Kramarae and Spender, 1992).

It is my experience that through the years when the masculine effect on the antenatal service was strong, the caring concept was not much used, and the curing concept has been controlling the system we have created. As caring deals with continuity, relationship, communication, and other issues that perhaps we can call feminine issues, the caring concept has not affected the system we have created enough.

2.7. Communication between midwives and pregnant women

It has been stated that pregnant women are more vulnerable than others and, because of that, communication between the pregnant woman and the health providers is more critical. Midwives who are taking care of women and their families in the antenatal clinics must therefore be very conscious about what they are saying to pregnant women (Karlsdottir and Halldorsdottir, 1996).

Flint (1991) stresses that through communication, midwives can instill confidence in a woman who is trying to come to terms with motherhood. She also claims that through that communication, the midwife can make the difference about how the woman will cope during the birth and during the first days of motherhood. Her confidence in herself can be built up during her pregnancy and can enhance a woman's ability to be a mother. On the other hand, if that confidence is not built up during her pregnancy, it can cause difficulties and can make the woman miserable because she has not had information and has not been given the right service in her pregnancy.

McKay (1997) writes about effective oral communication. She claims that communication should take place face to face. A clear and meaningful language that all participants can understand should be used. The time should be adequate for all. She also stresses the importance of written information and also states that it might be necessary to repeat some of the most important information.

These kind of guidelines are helpful for all midwives who want to improve their communication skills and to be conscious about what they are saying to their clients. Furthermore that feelings could come up during the conversation that could be the result of their communication.

Communication in parent classes is also important, if we are thinking about that one of the developmental tasks of pregnancy is to develop ideas concerning the birth of their baby, it must be very important. Simpkin (1995) indicates that pregnancy is an important time to prepare for the birth of the baby, in order to reduce pain in labour. Through communication in antenatal visits and parent classes, midwives have the opportunity to assist parents to have the confidence they need, and the feeling that they are ready for the birth. Parents-to-be who are nervous and have little knowledge

about what they can do to reduce the pain, might have less confidence in themselves and perhaps be afraid of becoming parents.

Bearing that in mind, I think midwives should be more conscious about their communications with their clients. More conscious about how little words can harm or help the expectant mothers, to gain confidence in them concerning the birth of their baby and their role as mothers. Many studies illustrate how important it is for the expectant mother to have an effective communication with their midwives. Communication where a caring atmosphere is developed (Karlsdottir and Halldorsdottir, 1996, Olafsdottir, 1992)

It is my experience that midwives play a very important role in affecting a woman's attitude to her pregnancy. Women get all kinds of messages during their pregnancy. What they can do, and what they cannot do. Through good relationships with the pregnant women and continuity of care, midwives can support women in gaining confidence in their own abilities to become mothers.

Through the centuries, when generations lived close to each other, other women provided the support and the information that pregnant women needed. But as our societies changed, that support from other women decreased, and that is one of the reasons why the midwives relationships with their clients, the pregnant women, is so important.

Midwives have taken over the role of older sisters and mothers, to support and inform the pregnant woman during her pregnancy. That is one of the reasons why the relationship between midwives and pregnant women is very important and can influence the woman's perceptions of herself and her circumstances (Nolan 1997).

2.8. Women's choice during pregnancy

In a study conducted by Wardle, Wright and Court(1997) 1568 women were asked to fill out a questionnaire about various perceptions about their pregnancy and birth.

In that study it was illustrated that one of the key elements in satisfaction with antenatal services seems to be that women have a choice regarding their antenatal service and having that choice has been linked to a high level of satisfaction (Wardle, Wright and Court, 1997). Pregnant women should be introduced to their choices

regarding the kind of care which is offered, and by having that knowledge, women could be more in charge of their pregnancy (Wardle, Wright and Court, 1997).

Many other authors have pointed out the importance for women to have a choice regarding the service that they get from the health care system during the childbearing period. One of the authors is Frossel (1996). She claims that midwives always have to remember that every woman is a special individual being. In spite of every system that we create, we have to remember that fact and nurse her with her individual needs in mind.

It is my opinion that Frossel has made a very good point here. During the years, we have denied that every pregnant woman needs special individual care. We have developed a system, for example, how many visits the pregnant woman should have to antenatal clinic during her pregnancy, what information she gets, when she should have blood tests and so on. Of course, it is practical to have some kind of system but we have gone too far in trying to shape everyone into the same system.

By doing that we have limited the choices that women have during their pregnancy and birth.

Furthermore, the message that we are giving to the pregnant woman that does "not fit" into our system has often been "why can't you be like all the others" or "everyone thinks that is a good system, what is wrong with you". Maybe we have not said those words, but our attitude has often been giving those messages.

One of the major goals of the "changing childbirth report", providing the blueprint for a change in midwifery and obstetric practice in Britain (Department of health, 1993), was that women should be offered more choice regarding their service during the childbearing process. That women should be properly informed about various choices regarding the service so they would be able to choose for themselves the kind of service that suits them. The report indicates that the health providers have been manipulating pregnant women and giving them no choice regarding the service by giving them very little information. That the medical model has dominated for so long, and that the health providers have been developing the system with the medical model in mind, and not with that in mind that every individual has special needs regarding the antenatal care.

Other authors such as Flint (1986) and Enkin, Keirse, Renfrew and Neilson (1995) state exactly the same thing, that our health care systems have been developed too

much with the medical model in mind, which have given pregnant women very little choice.

During the past few years some changes have occurred regarding maternity services in Iceland, such as midwives post partum home care service, but from my point of view we have only just begun to reorganise our system so that in the future women will have more choice regarding antenatal services. Our journey has just started and we have a long way to go to the goal to give every pregnant woman a real choice regarding the services.

2.9. Continuity of care

Writing about choice leads me to another issue which seems to be one of the key elements in satisfaction, according to the literature review, and that is continuity of care.

Duff (1995) states that when women have the same midwife all through their pregnancy and birth, it leads to significantly more satisfaction with the service they receive. She also points out that one of the aims of the “changing childbirth report” (Department of Health,1993) is to increase continuity of care and by doing that, increase the antenatal service satisfaction.

Other authors such as Churchill (1995) and Sandall (1995) have also declared that continuity of care is very important to women during the childbearing process. However, what is continuity of care?

In the literature, continuity of care is rather poorly identified, but Wraight et al. (1993) have defined five major issues to increase continuity of care:

- "No more than six midwives in a team.
- Defined caseload.
- Total continuity from 'booking' to postnatal period.
- Midwives working in hospital and community, depending on the woman's needs.
- At least 50% of women delivered by a known midwife".

(cited in Sandall, 1995, p.203)

Flint (1993) claims that women have been offered a system where continuity of care has not been one of the priorities in antenatal care. She states that women have been asking for continuity of care for so long, and what they are asking for must be very reasonable. At the most intimate times in their lives, they have a right to demand that they are able to get to know their midwives, because through continuity of care they can build up a relationship with their midwives. A relationship where effective communication is practiced, where they get information so they have a real choice regarding the service they are offered. Flint states that only through continuity of care can that kind of relationship can be built.

Flint (1993) makes an interesting point in the discussion of continuity of care and why it is so desirable for women and midwives. She compares the system we have created to the situation of a system where we were not allowed to choose our dentist, and had to go every time to a new one that we had never met before.

I am sure that we find that idea rather absurd, but in fact that is what we have been offering pregnant women through the years. We have divided the childbearing process into a pregnancy, birth and postpartum period because some people think that is convenient for the health providers. We have also forgotten how important it is to develop a caring relationship throughout the pregnancy and what a good effect it has on the woman's perception of what she is going through, and on our satisfaction in working as a midwives.

3. Research design: methodology and methods

3.1. Introduction

Choosing a methodology for the study, there were many things to consider.

In the nursing discipline, both quantitative and qualitative research methodologies have been used for gaining new knowledge. Quantitative research methods have been used a lot for the last few decades, but there has also been debate between quantitative and qualitative researchers. However, for the last few years researchers have been using both qualitative and quantitative research methodology and used the advantages of each method to benefit nursing knowledge. It depends very much of course, on the nature of the phenomena that the researcher is going to study, if it is appropriate to use qualitative research methodology or a quantitative one (Cormack, 1991).

I decided in view of the research questions to use quantitative research methodology, a descriptive survey. Other reasons were; I wanted to use the results of Karlsdottir and Halldorsdottir (1996) study about womens perception of caring and uncaring encounters and I wanted to use a questionnaire to collect a large amount of data.

Survey research has been defined as “A type of non experimental research that aims to obtain information regarding the status quo of a situation, often via direct questioning of a sample of respondents” (Polit and Hungler, 1991, p. 656). That is one of the reasons why it is my opinion that survey suited the aim of the study.

3.2. Types of surveys

Surveys can be divided into two groups; descriptive surveys and explanatory surveys. The reason why surveys can be divided into these two groups is because of different purposes.

Descriptive surveys have the purpose “to describe the relationship among variables” (Valiga and Mermel, 1985, p. 93). Descriptive design does not ask questions about cause but can arouse questions of cause and effect. However, the results often lead to other studies that can, perhaps, answer the questions about cause and effects to some extent (Valiga and Mermel, 1985).

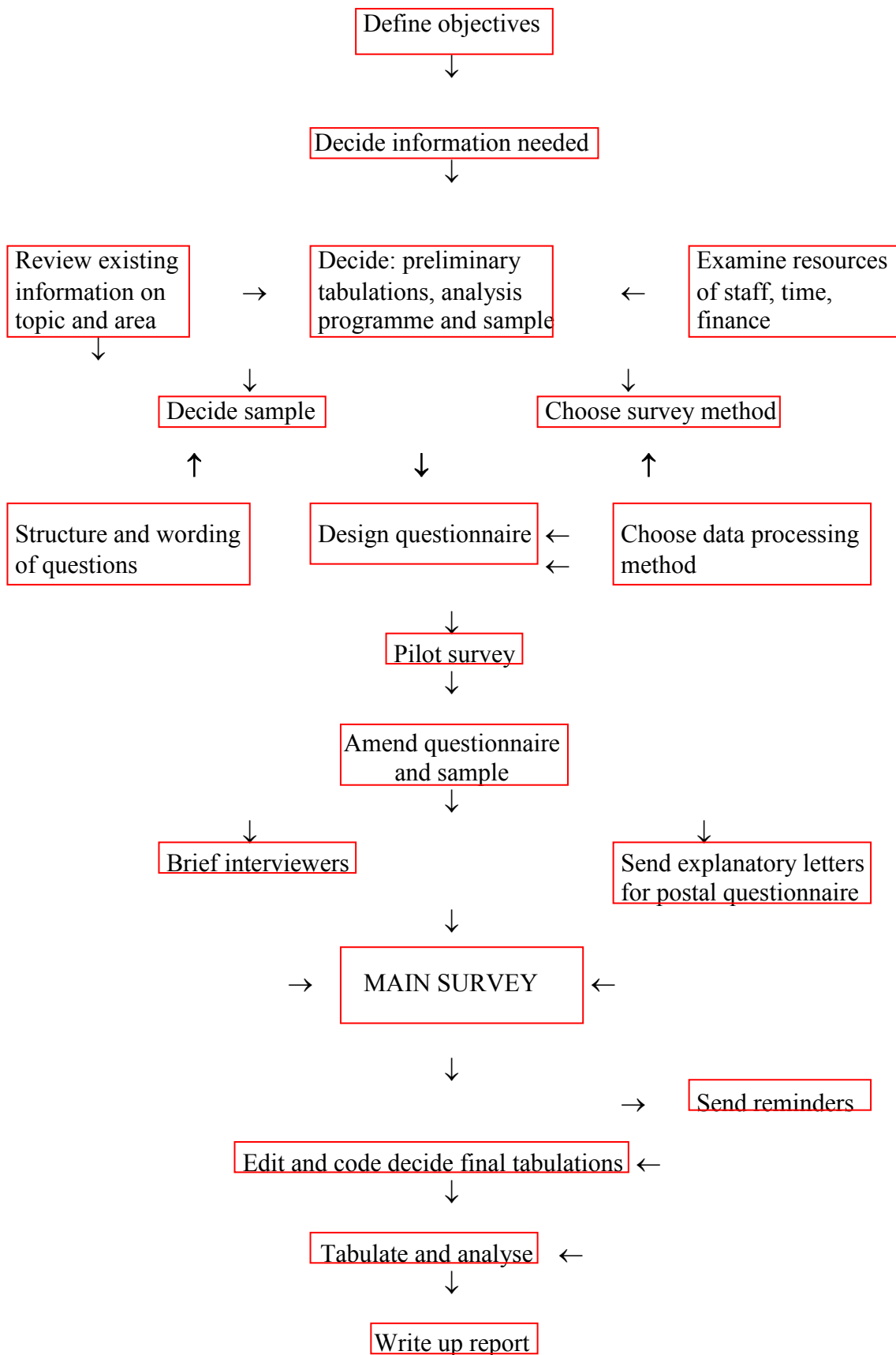
In descriptive surveys various variables are measured. I looked at different variables such as age, education, marital status, number of births and looked at variables such as

satisfaction with information given, education from the midwives, support they got from the midwives. In chapter six I will look at the relationship among variables

On the other hand explanatory surveys have the purpose “to discover relations between variables” (Valiga and Mermel, 1985, p. 93). In explanatory surveys questions like “why”, are answered and often an explanatory survey is followed up by a descriptive survey. Explanatory survey could be used to test hypotheses and to answer questions like “what is the connection between those two variables” (Smith, 1996, p. 97).

3.3. The steps in doing a survey

Performing the study, I had in mind description, which I think is very good as it describes the steps so clearly and descriptively. Cohen and Manion (1985) write that description is in the book "Research Methods in Education" in the following way:



(Cohen and Manion, 1985, p. 95)

This description by Cohen and Manion (1995) was helpful in performing my study although postal questionnaires were not used.

3.4. Research methods

One of the greatest advantages of a survey is its flexibility and broadness of scope. Many other advantages have been described, such as the ability to focus on a wide range of topics, and its information can be used for many purposes. Cost can be one of the advantages because of the large amount of information surveys can give to the researcher. Another advantage, which is very important considering the large amount of information and large sample size, is the fact that the computer can accomplish some of the analysis of that information (Polit and Hungler, 1991).

However, surveys do have disadvantages. Low return rate can be one of the big problems that researchers have to be aware of when describing the results. In addition, researchers have to be aware of other disadvantages such as the possibility that preconceived questions are irrelevant or confusing to the respondents. This, therefore, makes the data meaningless and the researcher can not use it (Wilson, 1989).

Jonsson (1997), one of the survey specialists in Iceland, states that one of the main disadvantages of surveys is the question of whether you can believe the respondents. Are they telling the truth? Secondly, are the questions worded so that everyone can understand them the same way? If you are talking to someone, you can discuss things back and forth. It is not the same problem, because if you hear that the person does not understand the question the same way you want him or her to, you can reword the question.

3.5. Ethical issues in surveys

Before the data was collected, all the ethical clearance was already prepared by antenatal services in Akureyri, Reykjavik and Hafnarfjörður and the data collection was not started before the permission from the Data Protection Commission in Iceland was granted.

When conducting a survey, many ethical questions are raised. As I used questionnaires in my study, it is appropriate to look at ethics concerning questionnaires.

Rumbold (1986) claims that ethics is concerned with the meaning of words like: right, wrong, good, bad, ought and duty. Ethics has also been defined “as a set of moral principles or a moral philosophy held by members of a group” (Smith, 1996, p. 140).

Beauchamp and Childress (1989) state that there are four main ethical principles in western society; respect for autonomy, non-maleficence, beneficence and justice.

One of the main ethical problems in using questionnaires, is whether participants actually have a choice to participate in the study or not. It is not appropriate that the person has in fact no choice at all, for example, if the person has to be afraid of some punishment if he or she does not participate. Ethical problems such as if the participant knows the true purpose of the study, and that he or she is free to stop participating at any time, are also things that the researcher has to bear in mind (Smith, 1996).

Researchers within nursing and midwifery can face many ethical questions using questionnaires to collect data and I kept them in mind when conducting the study. Among others, I used the book "Doing your research project: A guide for first-time researchers in education and social sciences" by Bell (1993), to consider ethical questions before performing the study.

I tried to guarantee the anonymity by making no list of names of the participants so there would be no way to find out their names.

Furthermore, I tried to stress that they had a choice about whether they participate or not. This was made very clear in the introductory letter, and I also asked the midwives that helped me with collecting the data to emphasise to the women that they had a choice. In the introductory letter it was also mentioned that they did not have to answer all the questions in the questionnaire if they did not want to.

4. Data collection and analysis

4.1. The Population

The population was all pregnant women who came to the antenatal clinics in The Health Clinic in Akureyri, Hafnarfjörður, and in the National Hospital in Reykjavik in the first two weeks of May 1998. However, pregnant women who were coming for the first time in their pregnancy were excluded from of the population.

These clinics are three of four of the clinics in Iceland which have the highest number of pregnant women coming for their prenatal care. The reason I chose those three clinics was that I had good connection with all three places, and the midwives working there were willing to help me with the data collection

4.2. Designing the questionnaire and data analysis

Results from the study by Karlsdottir and Halldorsdottir (1996) where phenomenology was used as a research approach to identify categories that describe women's perception of caring and uncaring encounters with midwives during their pregnancy, were used to develop a questionnaire. Using the Key categories, and books as "Designing and Analysing Questionnaires" by M. B. Youngman (1987) the questionnaire was developed.

Among other things in that booklet are the following things that Youngman (1987) emphasises;

- To begin the questionnaires with general questions and then ask more specific questions.
- Not having too many response systems.
- Not having too many choices to tick with.
- Never to have two questions in one.
- Never use double negatives.
- Watch out for complicated wording.

While designing the questionnaire, I contacted Ann Thomson and Susan Williamson, because in the years 1993 and 1994 they had conducted a survey on women's satisfaction with antenatal care in a changing maternity service in England. They

allowed me to use what ever I liked from their questionnaire and gave me good advice regarding the survey.

While designing the questionnaire, I had in mind how I would code the data afterwards, and Hjörtur Jónsson, statistician, criticised the questionnaire regarding the coding.

To analyse the data, I used "the statistica computer programme" to find out the frequency, percents and also to do the t-test.

In the research dissertation I decided to use graphs to describe the results of the survey. I used the "statistica computer programme" and p-test in analysing of the data.

4.3. The pilot study

Early in April I conducted a pilot study in one of the clinics that took part in the study. I chose one day to collect data, and sixteen pregnant women took part in the study. The women seemed to understand every question, no comments were made about the length of the questionnaire and no complaints were about any of the contents, so no disadvantages were found in the pilot study.

4.4. Data collection

The sample and the sample size in surveys are one of the key factors in the quality of the survey. When the researchers have chosen the population in their study, the next step is to decide whether to use probability sampling or non-probability sampling. In general, non-probability sampling is not suitable for survey research because the aim of the study is often to be able to generalise to some extent. However, it can depend on the nature of the phenomenon whether it is better to use probability sampling than non-probability sampling. But generally speaking, probability sampling is the best choice if the researcher is going to be able to generalise to some extent from the results (Sapsford and Abbott, 1992).

As I wanted to be able to collect large amount of data and get as much information as I could, I decided to use probability sampling.

To collect the data I used systematic sampling, which is a type of probability sampling. Systematic sampling is a modified form of simple random sampling and is often used when a list of all the population is not available.

The sample size is very often difficult to decide upon and there is no absolute answer as to how big the sample size must be in order for the sample to say something about the population. There are no rules about what is the proper sample size but the general rule is to make the sample as large as possible. A few things must be looked at before the sample size is decided upon; type of study, number of variables, sensitivity of the measurement tool, data analysis techniques and the expected effect size. Inexperienced researchers must, therefore, use advice from an experienced researcher regarding sample size (Burns and Grove, 1993).

Jonsson (1997) says, “that you get a feeling for how big the sample must be, depending on the phenomenon that you are going to study. That is something that you get a feeling for when you have gained experience in doing surveys he claims.

I contacted Jonsson (1997) regarding the sample size in this study and he told me that 50-100 women in each place would be a suitable sample size.

I decided to collect data during the first two weeks in May in the antenatal clinics in Akureyri, Hafnarfjörður and in the National Hospital in Reykjavik. Midwives in the antenatal service asked every other woman to fill out a questionnaire in the waiting room before they left after their antenatal visit. They informed them about their rights to refuse to fill out the questionnaire and also about confidentiality.

The women were asked, after completing the questionnaire, to put them into a box in the waiting room.

I contacted midwives in Akureyri, Reykjavik and Hafnarfjörður to help me with the data collection and they were all willing to help.

4.5. Validity and reliability

- Regarding the reliability, I did certain things to try to guarantee it. One of the things I did, was a pilot study in which sixteen pregnant women participated.
- I also asked my tutor and one of my friends who is a nurse and a midwife and has a master's education, to criticise the questionnaire and also one linguist to criticise

the questionnaire. I also asked them to evaluate the questionnaire with reliability in mind. I also used other studies that were measuring pregnant women's satisfaction with antenatal services.

- Regarding the validity, I was aware of the danger that I was one of the midwives that some of the pregnant women were seeing during their antenatal visits. I tried to guarantee as much as I could, that this would not influence the women, by explaining that she had a real choice whether to take part in the study or not, when I gave her the introduction letter. I also took care not to go into the waiting room when they were or were not answering the questionnaire.
- My tutor, Ólöf Ásta Ólafsdóttir criticised the questionnaire for me, and gave me some good advice. I also contacted one of the survey specialists in Iceland, Friðrik H. Jónsson who is a sociologist and has done a large amount of studies using questionnaires. He criticised the questionnaire and gave me some advice regarding the questionnaire.
- Other people such as Sía Jónsdóttir, a MSc. nurse and a midwife, assistant professor at the University of Akureyri, Dr. Sigríður Halldórsdóttir, the Dean in the Faculty of Health Sciences at the University of Akureyri, also criticised the questionnaire,. Bragi Guðmundsson, linguist read the questionnaire over for me regarding the wording and Hjörtur Jónsson, statistician criticised the questionnaire regarding the data analysis.
- I also did a pilot study where ten women answered the questionnaire and no disadvantages came through in the pilot study.
- I collected data at three places. They varied in the number of pregnant women who visit them each year, and they are also at various places in the country.

5. Presentation of findings

The purpose of this study was to find out the characteristics of antenatal service that women were satisfied or unsatisfied with. As this was a descriptive survey the purpose was also to be able to describe the relationship among variables.

5.1. Introduction

Altogether 256 questionnaires were distributed at the three places where data collection took place, and 232 were returned completed.

That means that the average respondent rate was 91,3%.

The respondent rate according to the three different places is shown in figure 1.

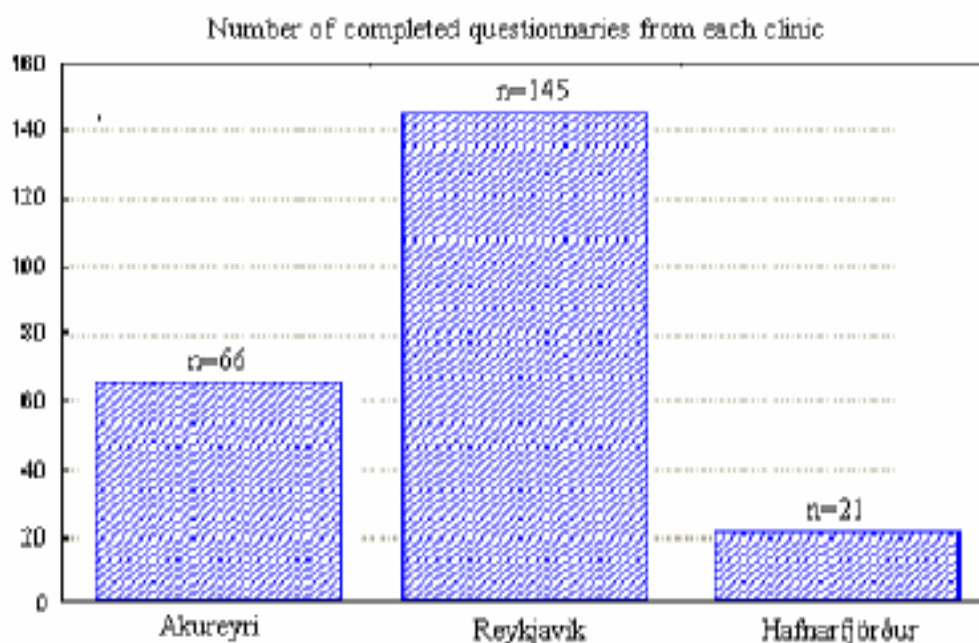


Figure 1.

5.2. Sample characteristics

The first seven questions in the questionnaire had the purpose of identifying the sample characteristics. The questions were all closed questions and the women were asked to tick only one item in each question.

The first question was regarding women's age. The age band of the respondents was from 15 to 44. Five point six percent were aged between 15 and 19, nineteen percent were aged between 20 and 24, fifty-eight point two percent were aged between 25 and 34. Furthermore 12,9% were aged between 35 and 39 and 4,3% were aged between 40 and 44, as shown in figure 2.

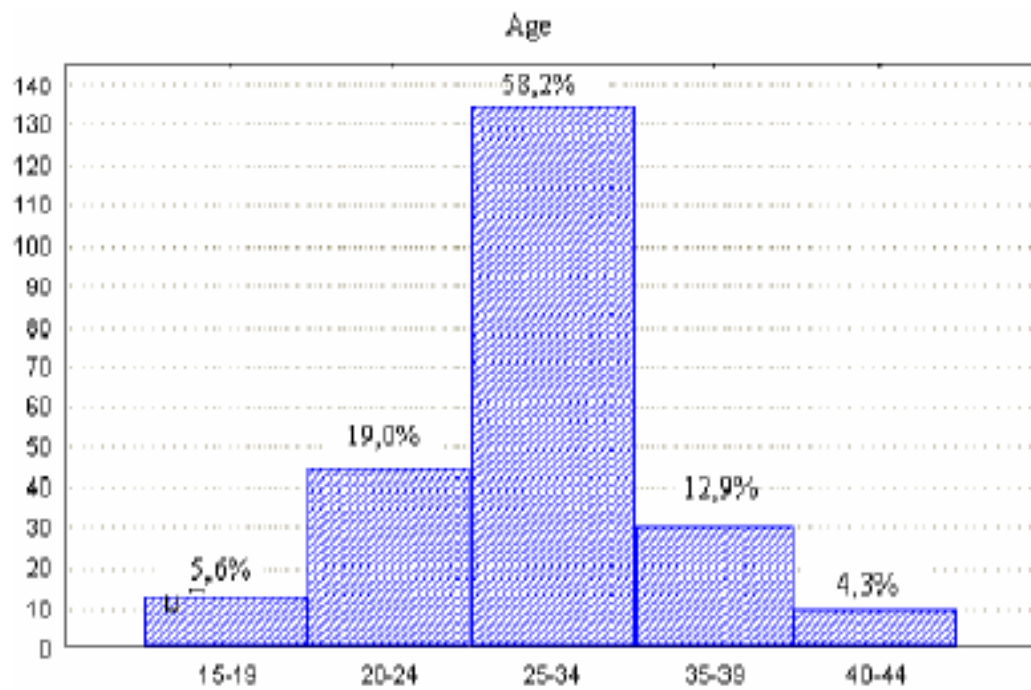


Figure 2.

Question two was regarding the marital status. Thirty-three point six percent were married, 58,2% lived with the father of their child, 3,9% had a relationship with the father of their child, but 4,3% did not live with or have a relationship with the father of their child. As shown in figure 3.

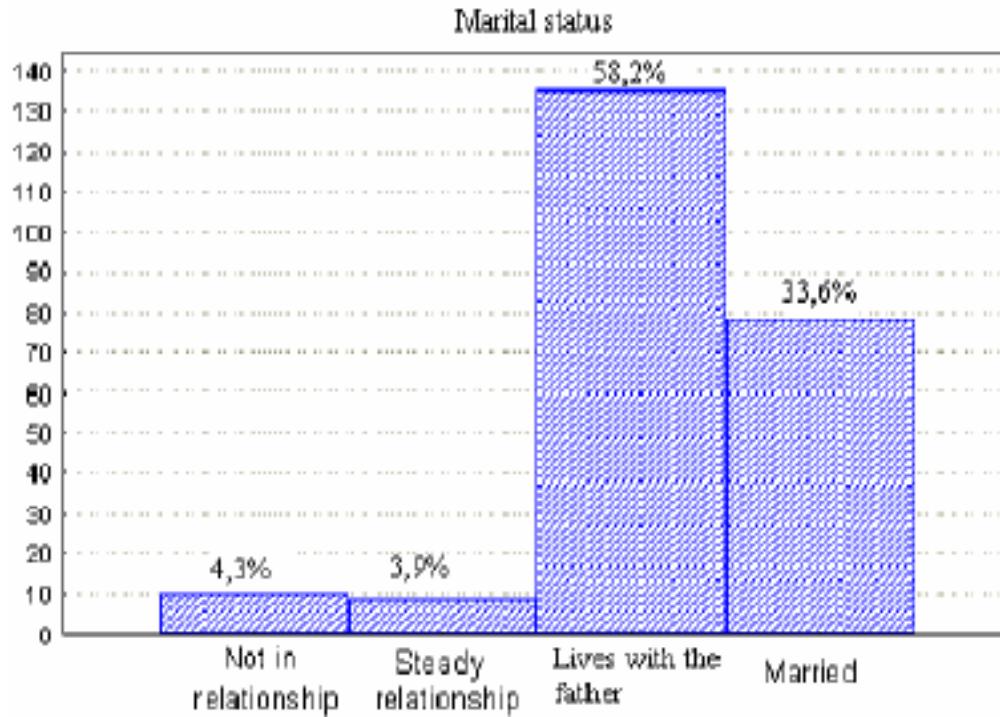


Figure 3.

Question number three was about the level of education they received. The educational standard of the sample was divided up into: less than secondary school, secondary school, college of further education, apprenticeship, university and other education. The results are shown in figure 4.

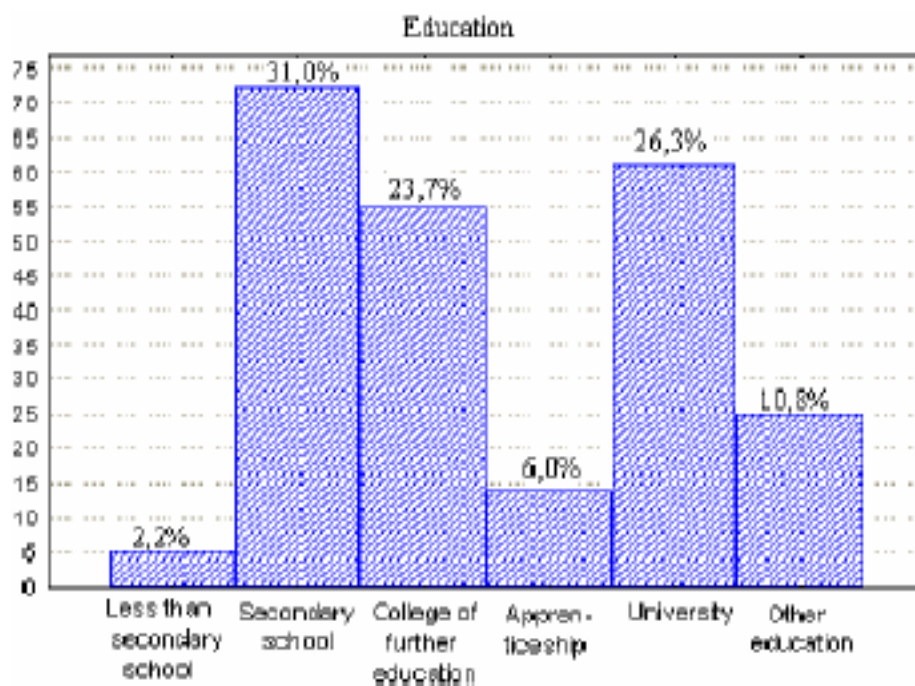


Figure 4.

Question number four was about the number of children they had had before. Forty one point eight percent were having their first child, 28% were having their second child, 19,8% were having their third child, 6,9% were having their fourth child, and 3,4% were having their fifth child as shown in figure 5.

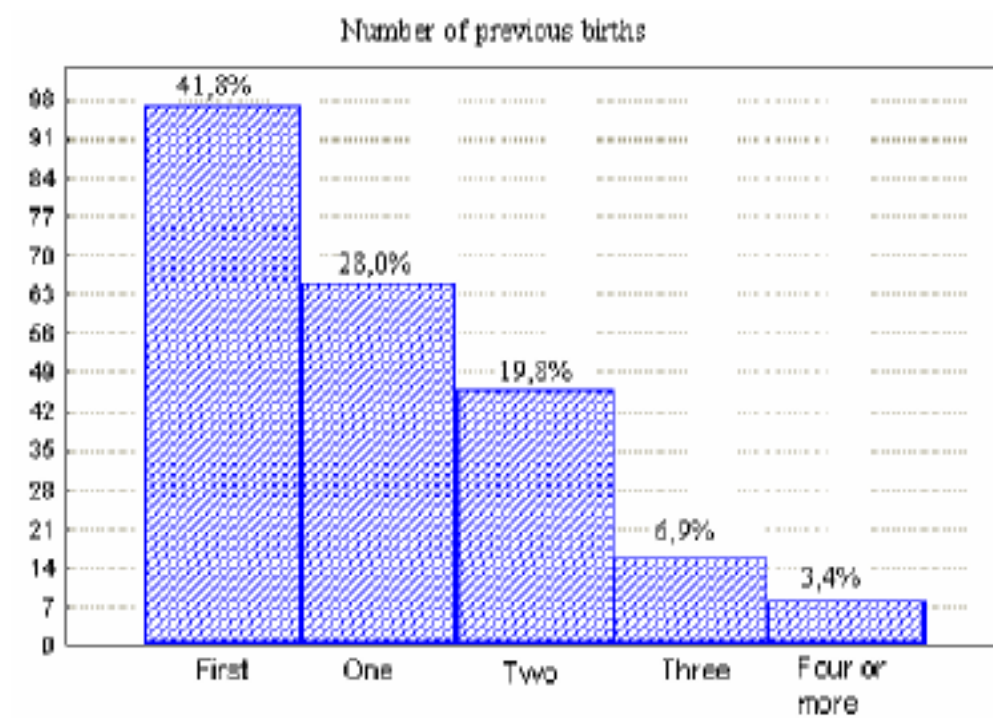


Figure 5.

Question number five was regarding the age of their youngest child. The ages of their youngest child was divided into; I have no other 42,2%, zero to four 34,9%, five to nine 19%, ten to fourteen 2,6%, and fifteen years or older 1,3% (n=3). The results are as shown in figure 6.

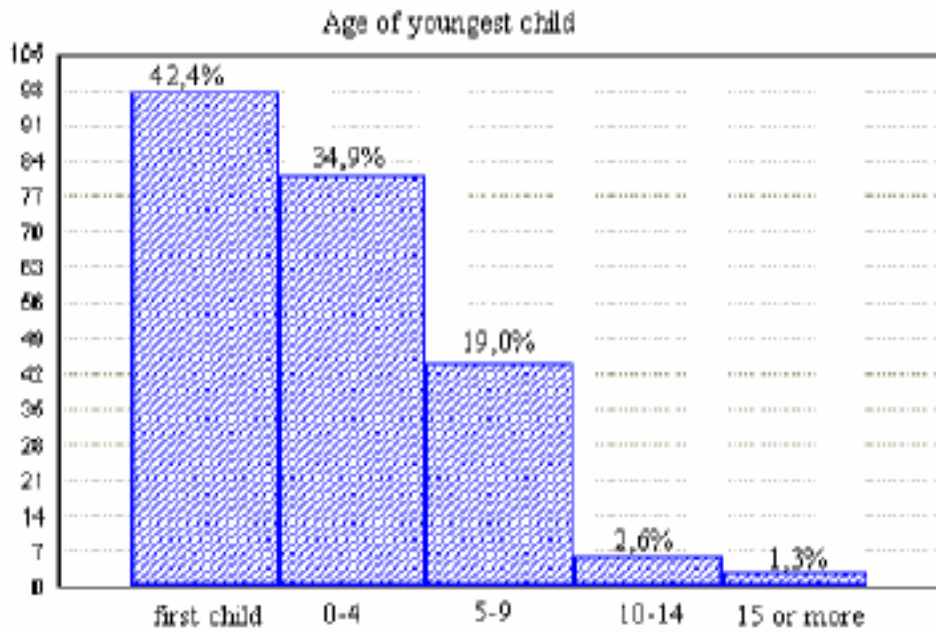


Figure 6.

Question number six was regarding miscarriage. If the women had never, once, twice or three times or more had a miscarriage. The results were that 71,1% had never had miscarriage, 18,9% had miscarried once, 5,7 % had had a miscarriage twice and 4,4% had had a miscarriage three times or more, as shown in figure 7.

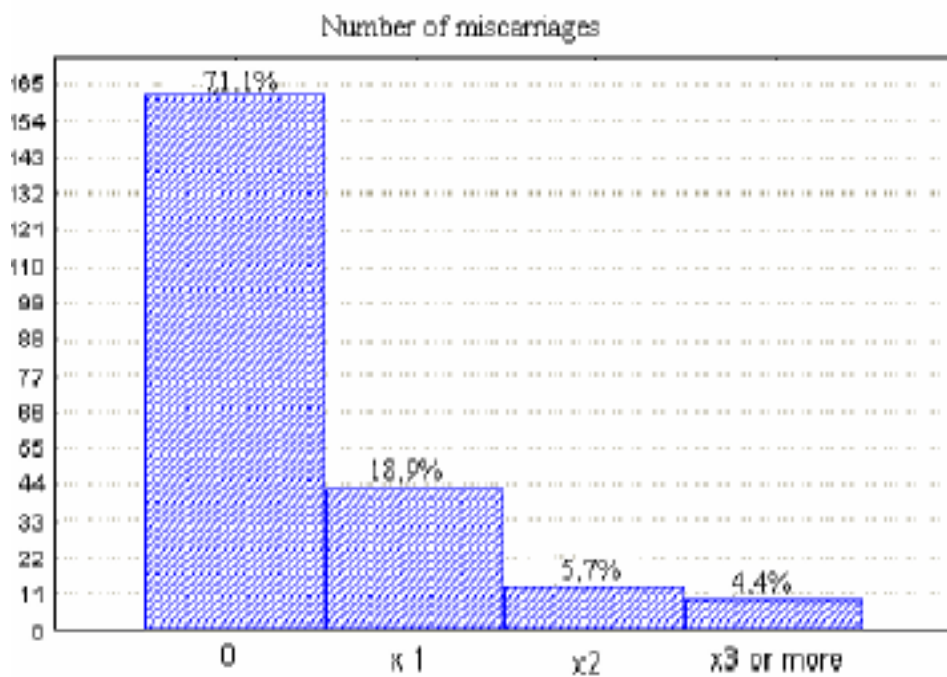


Figure 7.

Question number seven was regarding whether the women had lost a child or not and if they had lost a child, how old was the child. The results show that 2,3% had lost a child and 97,7% had not lost a child, as shown in figure 8.

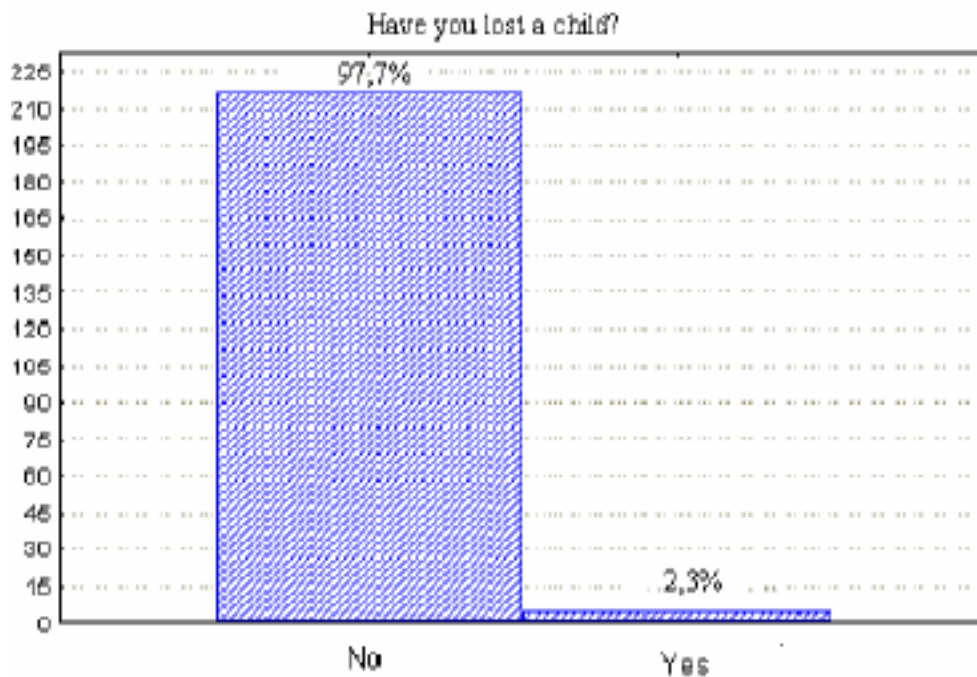


Figure 8.

5.3. Findings in the closed questions

The next fourteen questions were all closed questions about the women's perceptions and wishes during their antenatal visits. Questions about time between visits to the clinic, time spent with midwife during each visit, waiting time, continuity of care, information given and support they got from the midwife. Also regarding their perception of the midwives skills, the presence of the midwives and the relationship with the midwives. Furthermore, questions regarding women's wishes that the same midwife took care of them during pregnancy and birth and finally women's satisfaction with the antenatal care which they got from the midwives as a whole.

Question number eight was about the time between the visits to the clinics. The results portray that 93,9% thought the time was adequate, 0% thought it much too short, 3% thought it was too short, 0% thought it was much too long and 3,1% thought it was too long as shown in figure 9.

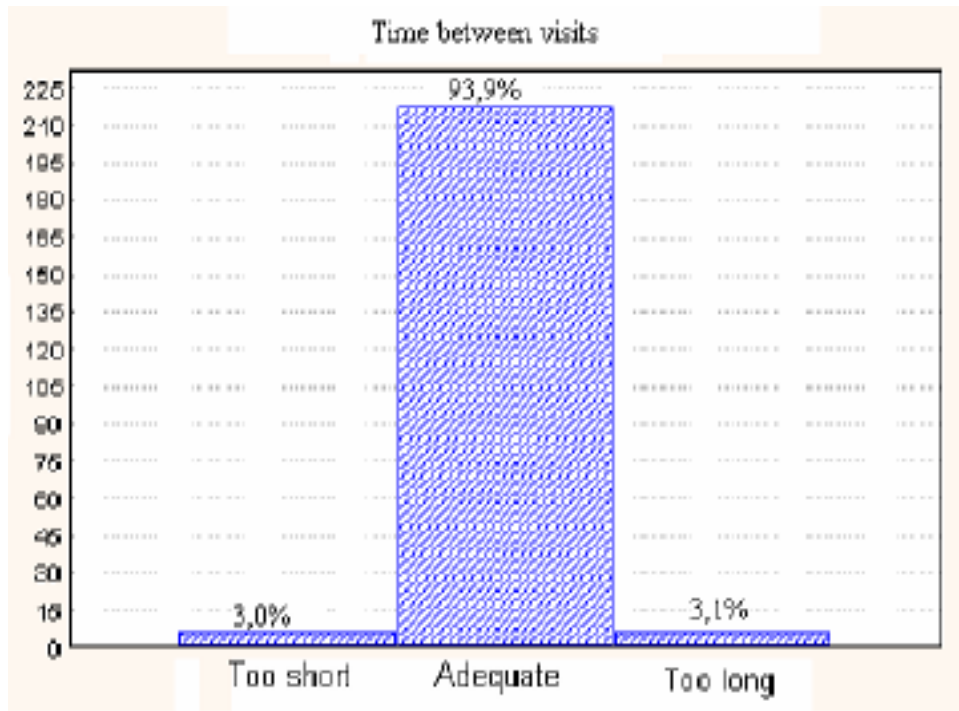


Figure 9.

Question number nine was regarding the time the women had to talk to her midwife during the antenatal visits. The results shows that 1,3% of the women thought it was much too short, 9,9% thought it was too short, 88,4% thought the time was adequate, 0,4% thought the time was too long and no one thought it was much too long. The results are shown in figure 10.

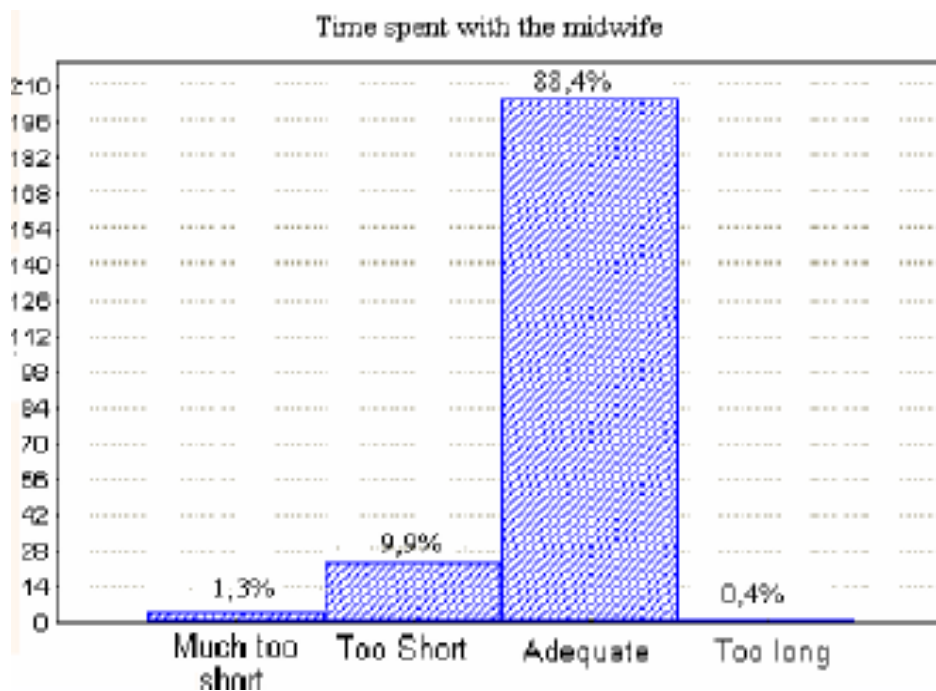


Figure 10.

Question number ten was regarding the time they spent waiting for the midwife. Thirty-five point five percent said they were very satisfied, 24,2% were rather satisfied, 24,2% were neither satisfied or unsatisfied, 13,9% were rather unsatisfied and 2,2% were very unsatisfied as shown in figure 11.

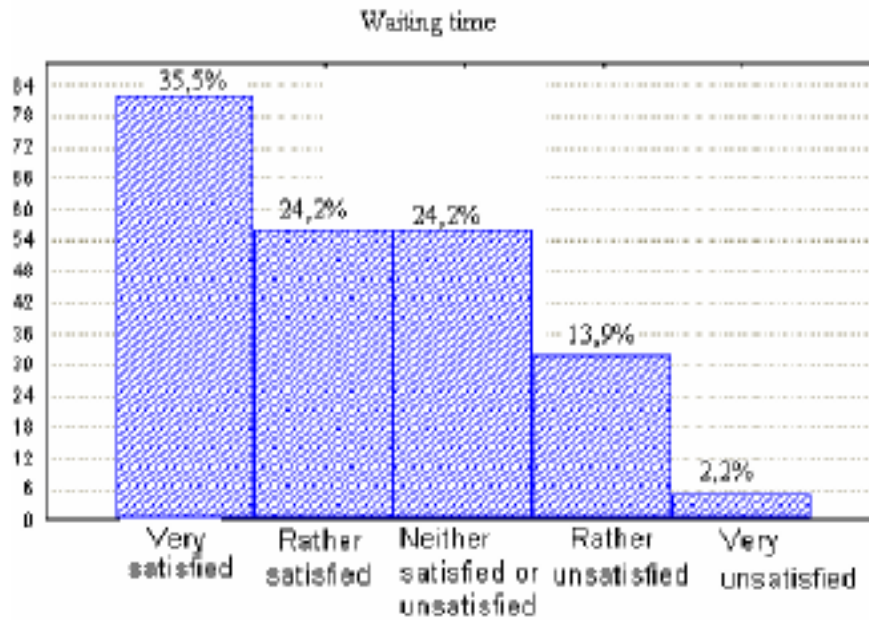


Figure 11.

The next question was regarding the satisfaction or dissatisfaction with meeting nearly always the same midwife instead of a new one every time they came to the clinic. Seventy-nine point six percent were very satisfied, 15,2% were rather satisfied, 2,2% were neither satisfied or unsatisfied, 2,2% were rather unsatisfied and 0,9% were very unsatisfied as shown in figure 12.

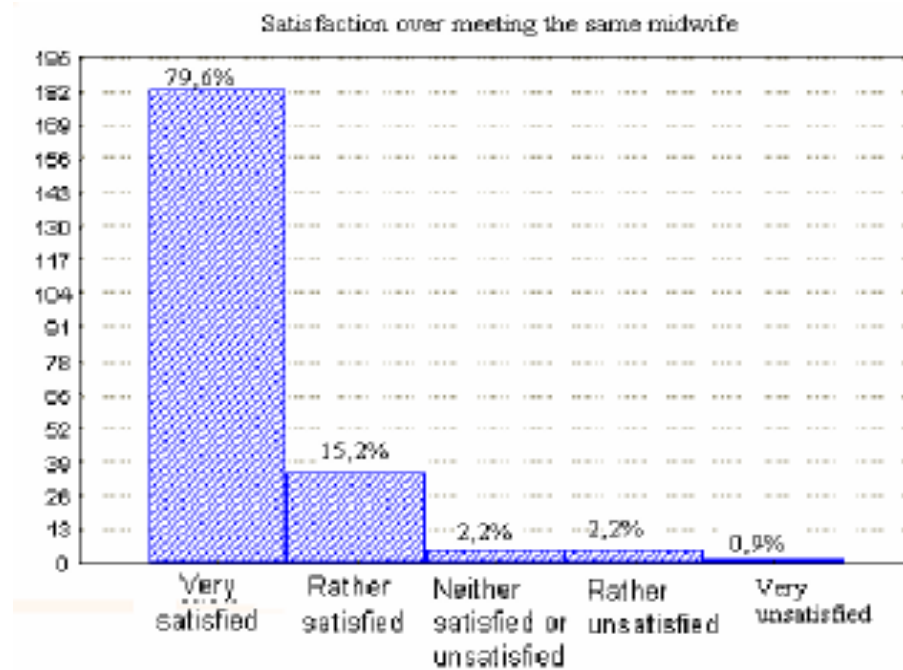


Figure 12.

Question number 12 was about the satisfaction or dissatisfaction regarding the education (for example education about nutrition) they received during the visits to the clinics. Sixty-six point five percent were very satisfied, 26,5% were rather satisfied, 5,7% were neither satisfied or unsatisfied, 1,3% were rather unsatisfied and no women was very unsatisfied, as shown in figure 13.

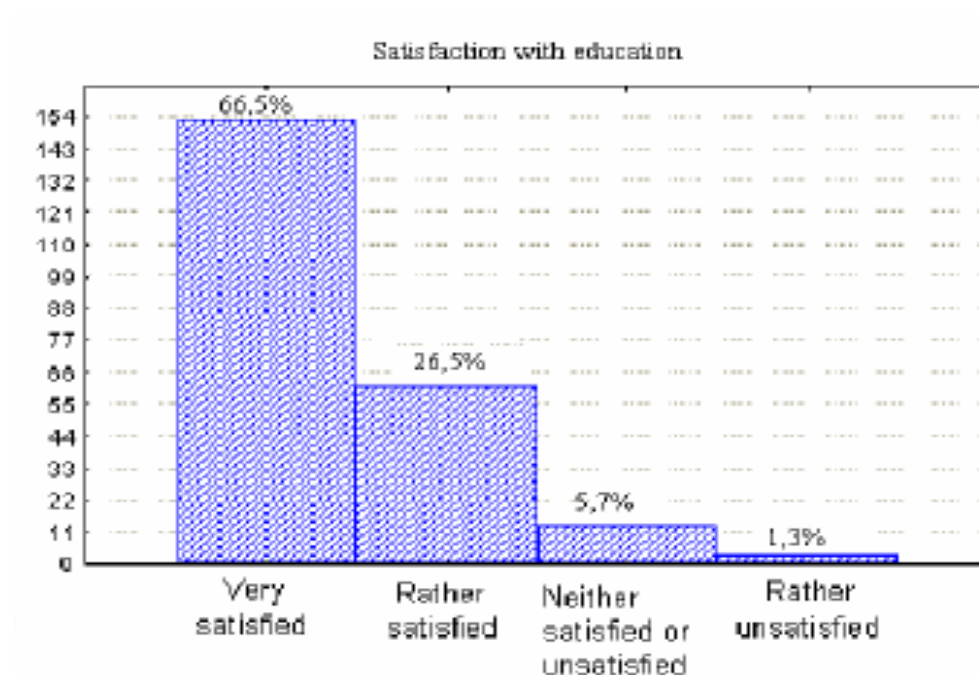


Figure 13.

The next question was regarding whether the women were satisfied or not with the information (like what number they should call if they needed to contact the midwife) they received about the service. Forty-five point seven were very satisfied, 32,6% were rather satisfied, 17,8% were neither satisfied or unsatisfied, 3,5% were rather unsatisfied and 0,4% were very unsatisfied, as shown in figure 14.

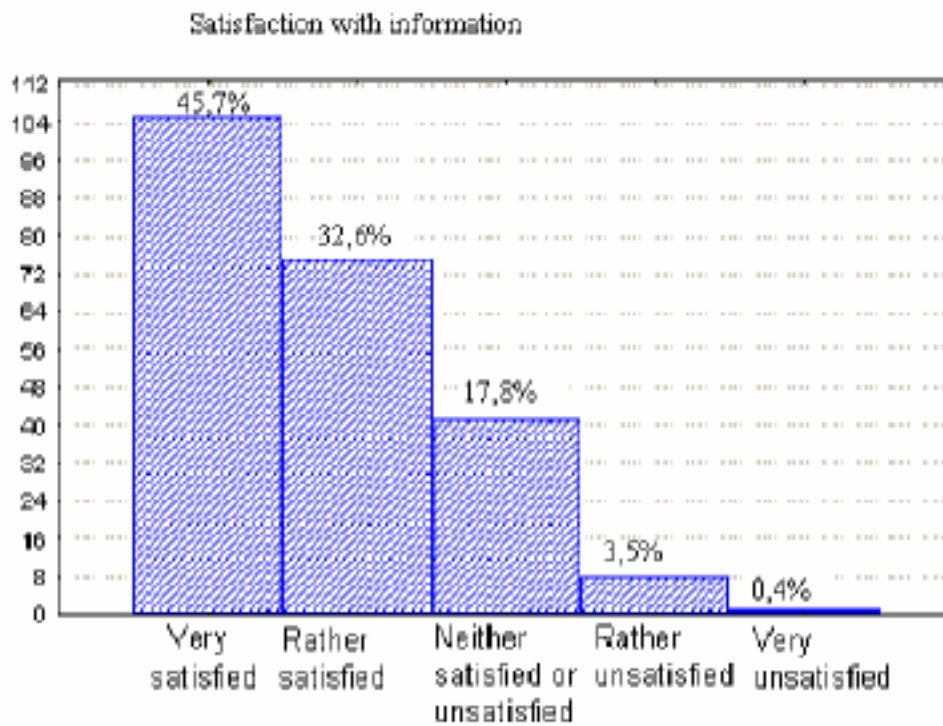


Figure 14.

Question 14 was regarding the women's satisfaction or dissatisfaction with the support that they got from their midwife. Sixty-four point eight percent were very satisfied, 30,4% were rather satisfied, 3,9% were neither satisfied or unsatisfied, 0,9% were rather unsatisfied and no woman was very unsatisfied as shown in figure 15.

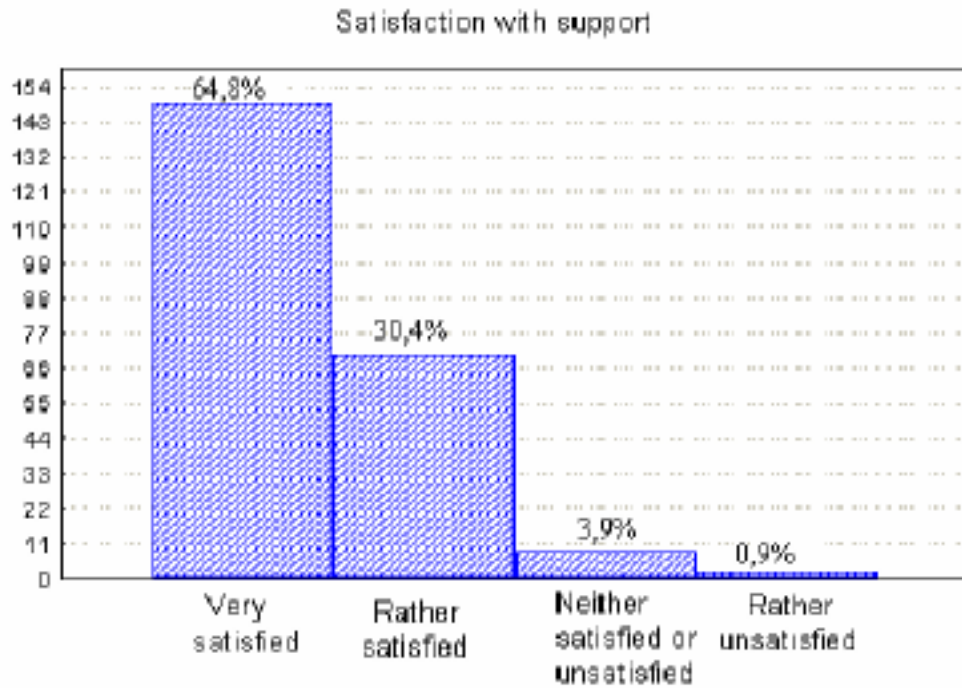


Figure 15.

Question 15 was regarding the woman's perception of the midwives' skill. The results shows that 74,9% were very satisfied, 20,3% were rather satisfied, 3,9% were neither satisfied or unsatisfied, 0,9% were rather unsatisfied and no woman was very unsatisfied,as shown in figure 16.

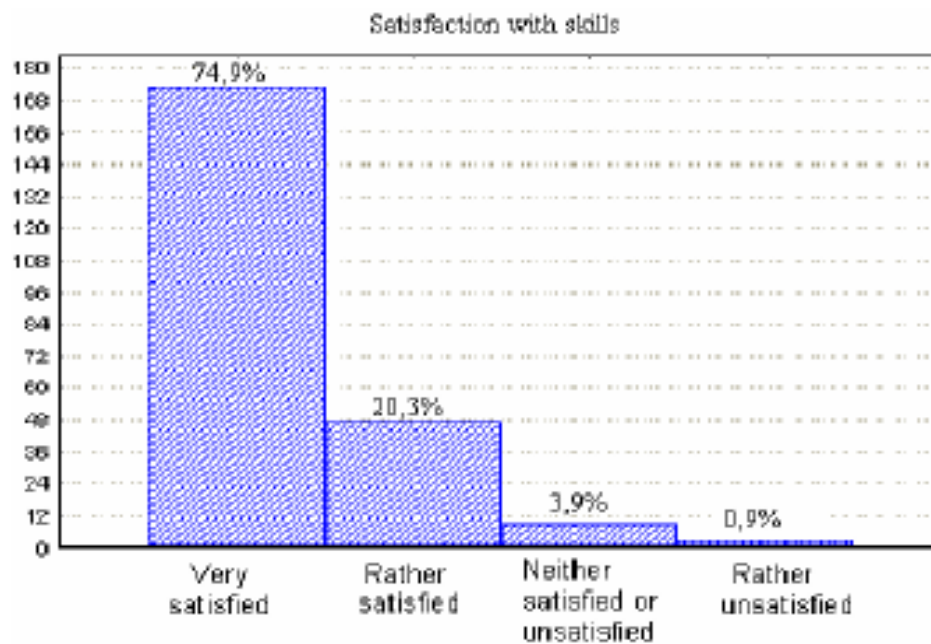


Figure 16.

Question 16 was regarding the woman's satisfaction or dissatisfaction regarding the presence of the midwives towards them. Eighty-nine point two percent were very satisfied, 10% were rather satisfied, 0,4% were neither satisfied or unsatisfied, 0,4% were rather unsatisfied and no woman was very unsatisfied, as shown in figure 17.

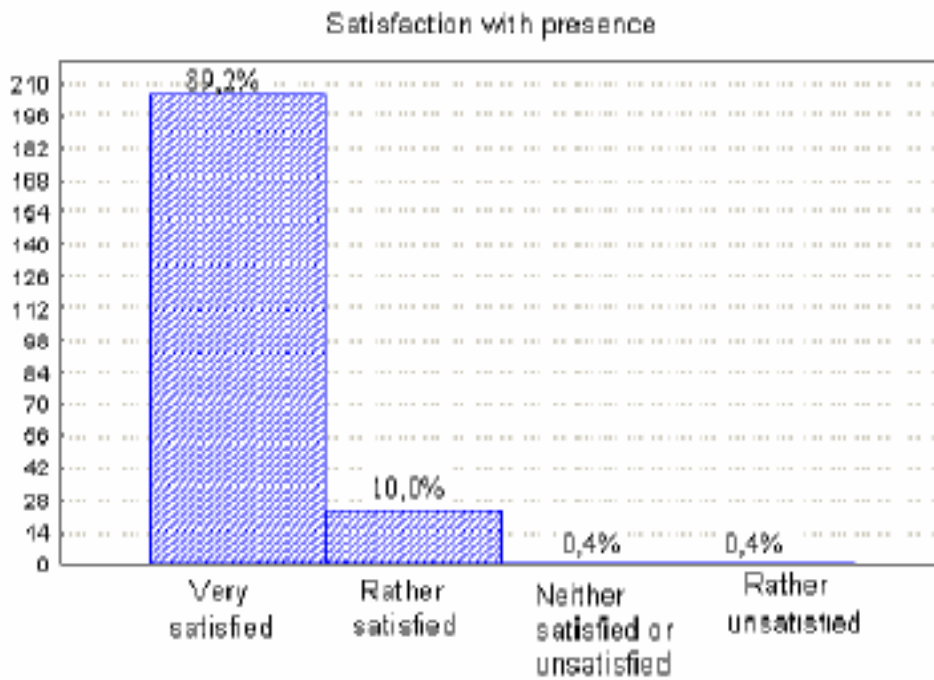


Figure 17.

The next question was regarding the women's perception of whether the midwives showed interest in their work or not. Eighty-one point eight percent were very satisfied, 16,9% were rather satisfied, 0,4% were neither satisfied or unsatisfied, 0,9% were rather unsatisfied and no woman was very unsatisfied, as shown in figure 18.

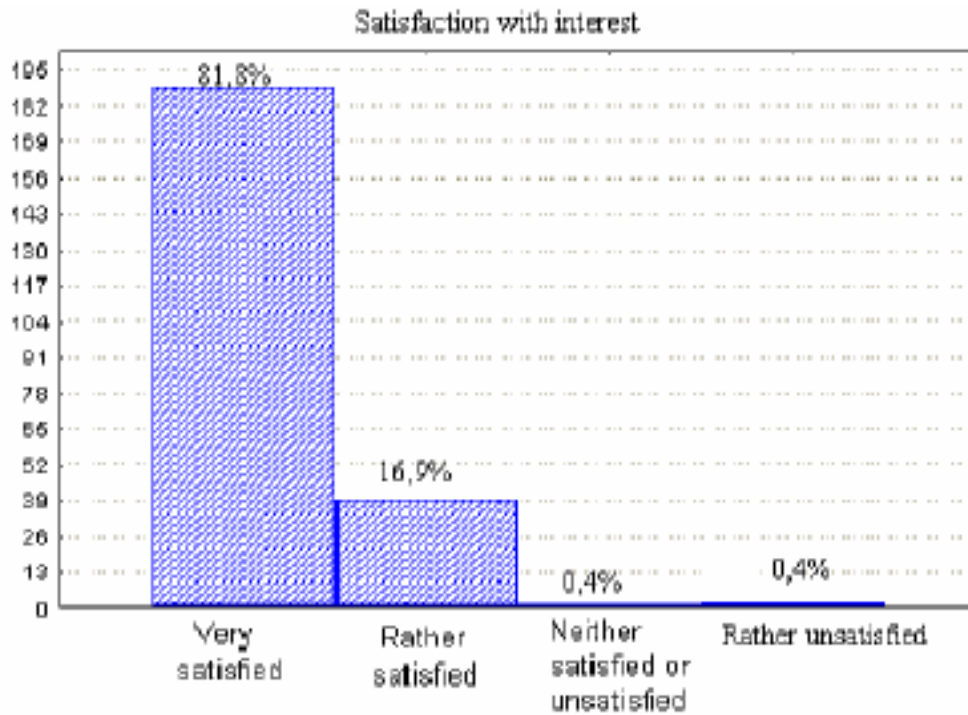


Figure 18.

Question number eighteen was about the women's perception regarding her relationship with the midwives. Sixty-nine point one percent were very satisfied, 22,6% were rather satisfied, 7,4% were neither satisfied or unsatisfied, 0,9% were rather unsatisfied and no woman was very unsatisfied, as shown in figure 19.

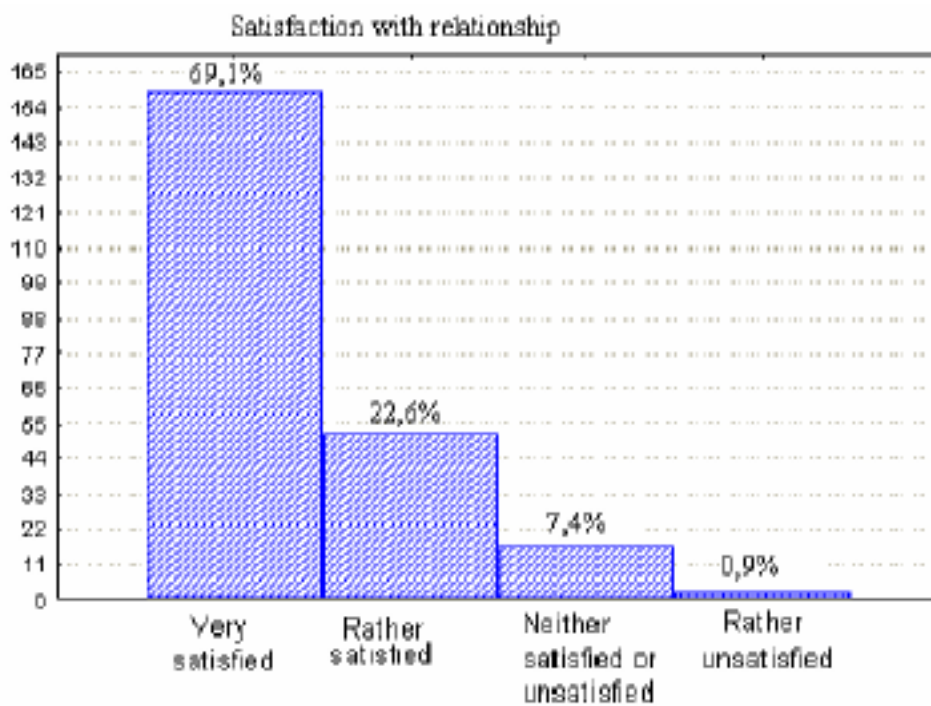


Figure 19.

The results of question 19 shows what the women think about if the midwife that they met during their pregnancy would also be with them when their child is born. If they would be satisfied with that or not. Seventy-seven point one percent would be very satisfied, 11,3% would be rather satisfied, 10,4% would be neither satisfied or unsatisfied, 0,4% would be rather unsatisfied and 0,9% would be very unsatisfied, as shown in figure 20.

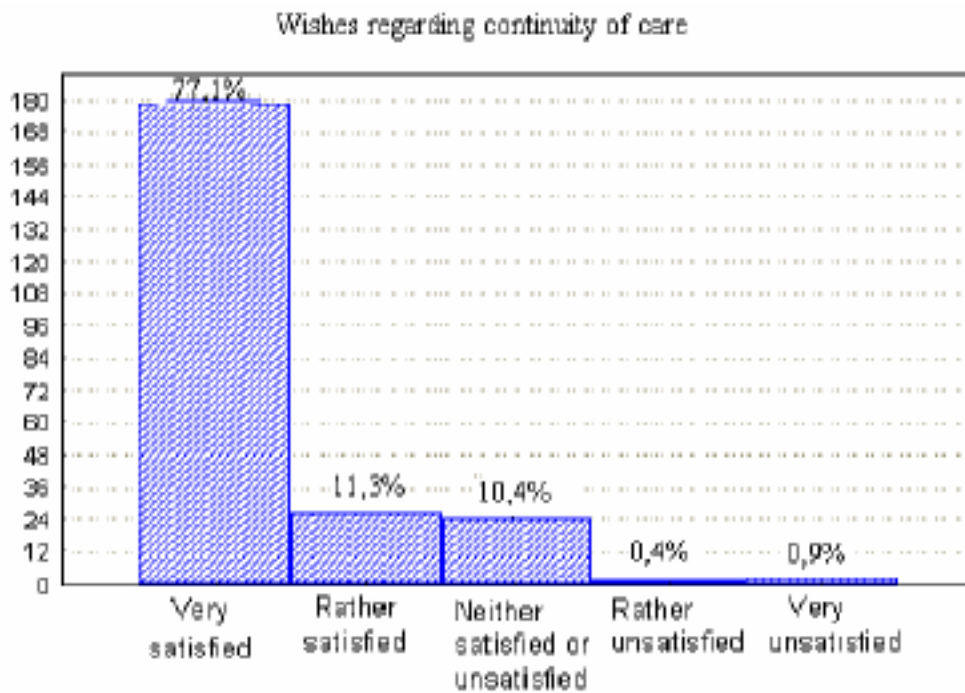


Figure 20.

Question number twenty was regarding what the women thought about the opportunity for them to contact their midwife by telephone. Twenty five point four percent were very satisfied, 9,2% were rather satisfied, 11,0% were neither satisfied or unsatisfied, 0,9% were rather unsatisfied and no woman was very unsatisfied and 53,5% said they never needed to contact their midwives through telephone, as shown in figure 21.

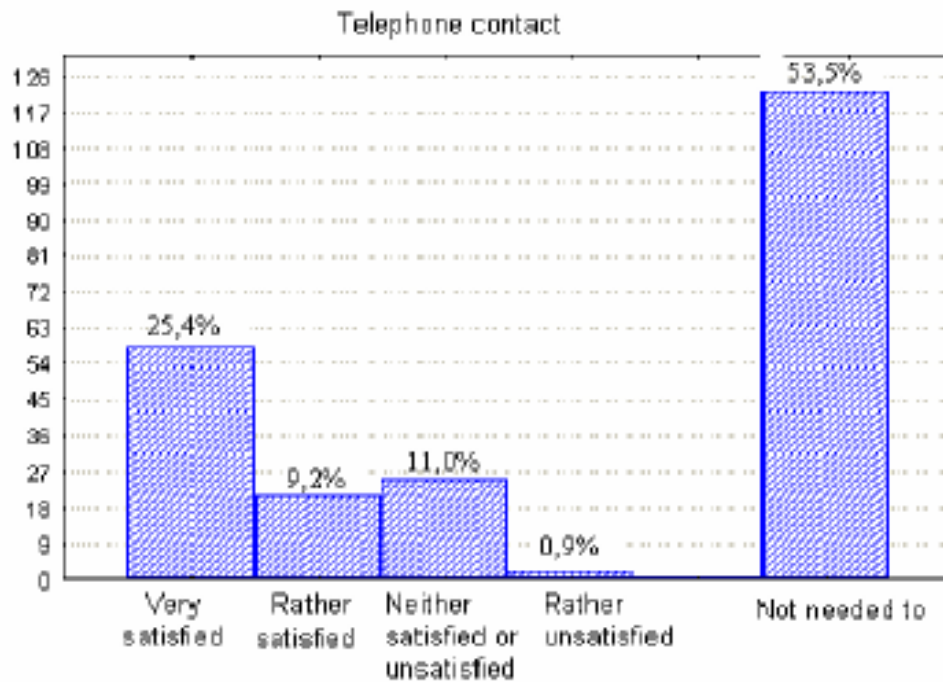


Figure 21.

The next question was regarding all the fields of the service, if the women were satisfied or not with the care they got during their pregnancy from their midwives. Sixty-eight point six percent were very satisfied, 29,7% were rather satisfied, 1,3% were neither satisfied or unsatisfied, and no woman was rather unsatisfied and 0,4% were very unsatisfied, as shown in figure 22.

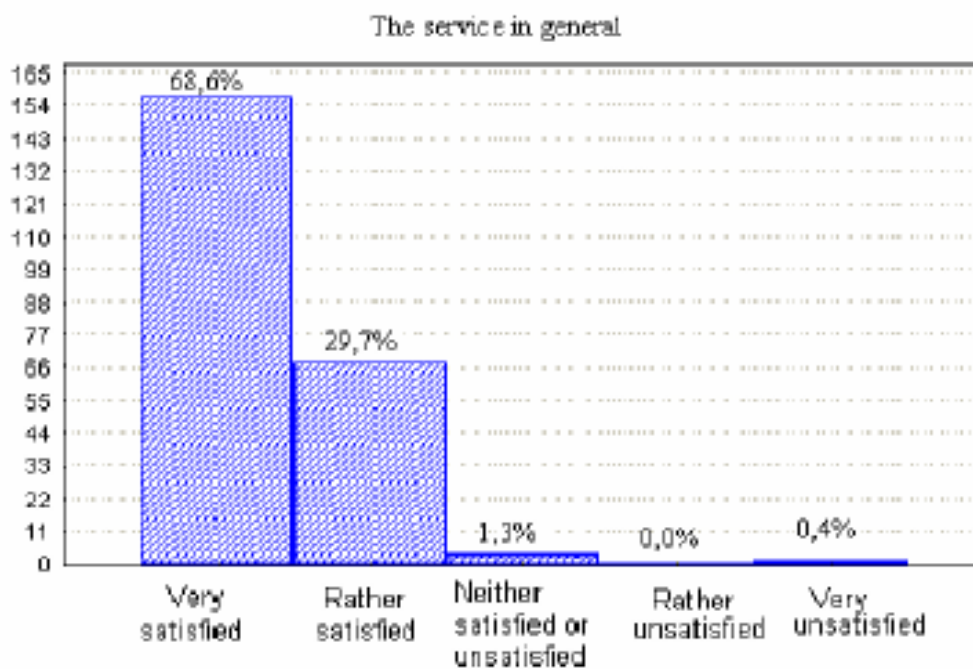


Figure 22.

5.4. Findings in the open-ended questions

The four last questions in the questionnaire were open and women were free to write what ever they felt important to them.

Question twenty-two was: What do you think was the most important aspect regarding the midwife's service?

Two hundred and nine women of the 232 that took part in the study, answered that question, either with one comment or many

Item	Number
Always meet the same midwife	144
Her abilities	73
The information she gave	71
Her interest	75
Her presence	14
Our relationship	36
Her politeness	55
It was easy to contact her	20
She is so warm	5
It is good to talk to her	3
Everything	2
She is wonderful	3
She is considerate	2
I feel comfortable with her	2
She is caring	1
She is so smiling	1
She is tender	1
She is good	1
She is frank	1
She is in high spirit	1

She is just great	1
She also takes care of the father	1
She is special	1

Question number twenty three was: What have you been most satisfied with the care that the midwife has given you?

One hundred eighty three women answered that question either with one comment or many.

Item	Number
Her warm presence	41
She was interested.....	34
The information she gave.....	21
Her competence	18
Everything.....	18
Her politeness.....	16
She gives me good time	3
Our relationship	4
She is caring.....	6
I feel comfortable with her.....	4
She is calming.....	3
She gives me support	4
She praises me.....	4
It is good to talk to her	4
She has humour.....	3
She is firm.....	3
She is so tender	3
She is positive	2
She is good.....	2
She is sensitive.....	2
She is fantastic	2
She is trustworthy	2
To know her	2

Her respect	3
She is friendly	2
She is in good spirits	2
She likes her work.....	1
It is just a good service.....	1
She understands	1
She is so human	1
Not much.....	1
How she does what she does.....	1
She is wonderful	1
She is open	1
She is considerate.....	1

Question number twenty-four was: What have you been most unsatisfied with regarding the care you got from your midwife? One hundred and thirty-eight answered that question either with one comment or many.

Item	Number
Nothing that I am unsatisfied with	92
Too little time that we had	13
Not to meet the same again and again	7
Too much waiting time	5
Too little information given	5
She was not interested in my pregnancy	3
She did not have the skills	1
She was out of touch	1
Difficult to get appointment	1
Too little notice taken of problems	1

The last question was about if they wanted to comment on something at the end. Ninety-two women commented on that question, some with one comment but some with many.

Item	Number
Wanted to say thanks	21
Nothing special	18
To have the same midwife during labour and birth	9
To always meet the same during pregnancy	4
Wonderful service	7
Wanted to have more time with the midwife	4
Shorter waiting time	4
The doctors are always in a hurry	3
To go more often to ultrasound	2
Want to have the midwife more personal	1
Better facility	1
Continuity of care for everyone	1
To take care of the fathers needs	1
To recommend more books	1
More car parks	1
Good to have the doctor	1
Not enough listened to complaints	1
Parent's classes are too short	1
I always look forward to visits	1

Every woman that took part in the study answered every question, except the four last questions in the questionnaire. In those questions it varied how many women wrote a comment on the questions.

6. Discussion, implications, limitations, strengths and recommendations

6.1. Introduction

The purpose of this study was to find out the characteristics of the antenatal service that women were satisfied or unsatisfied with. As this was a descriptive survey the purpose was also to be able to describe the relationship among variables.

I decided to choose three different places in Iceland where antenatal service is offered, one in Akureyri one in Hafnarfjörður and one in Reykjavik, the capital city. The purpose of my choice to have three different antenatal services, was to be able to generalise to some extent about the antenatal services in Iceland. My purpose was not to compare those three different places, but rather to explore items that characterised the service that women were satisfied or unsatisfied with.

In this chapter I will discuss the findings in every question and look at the relationship with the last question in the questionnaire, which was about the women's satisfaction with the antenatal service in general.

It was found that 68,6% (n=157) of the women were very satisfied, 29% (n=68) said they very rather satisfied, 1,3% (n=3) said they were neither satisfied nor unsatisfied, no one was rather unsatisfied and 0,4% (n=1) said they were very unsatisfied.

In this chapter I will also look at the women's comments in the open-ended questions and discuss the results.

Furthermore, I will examine the sample characteristics and look at the relationship between results of some of the questions in the questionnaire.

6.2. Sample characteristics

The first questions were to identify sample characteristics and to get information about the background of the women taking part in this study.

Altogether 232 questionnaires were completed, out of 256, which were handed over to the women. That means that the response rate was 91,3%, which was agreeable and is one of the strengths of the study. There was slight difference in response rate between the three places, from 89% to 95%.

6.2.1. Age

The majority of the women, 135 were aged between 25 and 34 years (58,2%). Forty-four were aged between 20 and 24 (19,0%). Thirteen were between 15 and 19 years (5,6%) thirty were between 35 and 39 (12,9%) and ten women were between the age of 40 and 44 years (4,3%).

According to the Statistics of Iceland (1997), 4073 women had children in the year of 1997. Fifty seven point three percent of these women were aged between 25 and 34. Twenty-two point one percent were aged between 20 and 24; five point one percent were between 15 and 19 years of age. Thirteen point five percent were between thirty-five and thirty-nine.

Those statistics indicate that my sample has very similar characteristics regarding the age of the mothers.

6.2.2. Marital status

Regarding the marital status, 33,6% were married (n=78), 58,2% lived with the father of their child (n=135), nearly 3,9% had relationship with the father of their child (n=9) and 4,3% did not live with or have a relationship with the father of their child (n=10).

In the booklet "Women and men in Iceland" that was published 1997, (Statistics of Iceland, 1997) it is recorded that 100% of women between the age of 16 and 19 are unmarried. On the other hand, in the age band of 20 to 24 years, 5% of them were married, 38% of the women were married who were aged between 25 and 34 and 63% of women between the age of 34 and 44 were married.

It is also stated that between the ages of 16 and 19, zero percent of the women are divorced, in those aged between 20 and 24, one percent of the women are divorced. At the age of 25 to 34, six percent of the women are divorced and at the age of 34 to 44, thirteen percent of the women are divorced.

Furthermore, if we look at the figures regarding the nuclear family in the year 1996, we can see that 31% of the women were with spouse and had children and 8% were single with children. Finally, if we look at the percentage of children aged between 0 and 16 years of age, that lived with two adults, (here is no information if it is their mother and father or some other adult person like grandmother and grandfather) 83% percent were living with two adults, and 17% were living with only one adult in the home.

Although figures about the marital status of women when they are having their children are not available, the figures I have quoted are important. They indicate that my sample has similar characteristics to Icelandic women in general, who are having children. For example, if we look at the group aged between 25 and 34, which is 58,2% of women that came to the three antenatal clinics, I can see that 38% of the Icelandic women are married compared to 33,6% in the sample. Furthermore, 56% in the same age group of Icelandic women were unmarried, compared to fifty-eight point two percent in the sample. No information was available regarding the percentage of women that were having children and did not live with the father, but had steady relationship. Neither was there information about the percentage of women that were not in a relationship with the father of their child available.

Regarding some matters, I can say that my sample is rather similar to the population of Icelandic women that are having children, but regarding other matters, I can not say that. For example I know nothing about the percentage of women that are or are not in a steady relationship with the expectant father, who are not living together.

6.2.3. Education

The educational standard of the women is one of the variables that is often measured. Two point two percent had less education than secondary school (n=5). Thirty-one percent had secondary school education (n=72), 23,7% had studied at a college of further education (n=55) and 6% had apprenticeship education (n=14). Twenty-six point three had university education (n=61) and 10,8% (n=25) had other education.

Information from the Statistics of Iceland (1997) shows that 59% of people passing college of further education are women, 21% of people that finish apprenticeship are women and 59% of people graduated from university are women.

Available information about the education of women who are having children is very limited, and I can not compare my sample to other Icelandic women regarding education.

6.2.4. Number of births

How the sample divides in different groups regarding the number of children they have had before. Forty-one point eight percent (n=97) were having their first child, 28% (n=65) were having their second child, 19,8% (n=46) were having their third child, 6,9% (n=16) were having their fourth child and finally 3,4% (n=8) women were having their fifth or more.

Figures from the Statistics of Iceland (1997) shows that 39,1% of the women that had a child in the year 1996 were having their first child, compared to 41,8% in the sample.

Five percent of the women that were having their first child in Iceland in 1996 were aged between 15 and 19 and 22% were aged between 20 and 24. The majority, or 57%, was aged between 25 and 34, 13% aged between 35 and 39, and finally 2% were aged between 40 and 44.

According to the Statistics of Iceland (1997) thirty-five percent of women that had a child in 1996, were having their first child, compared to 41,8% in the sample. Thirty-four percent were having their second child, compared to 28% in the sample, and 20% were having their third child compared to 19,8% in the sample. Furthermore, 7% were having their fourth child compared to 6,9% in the sample, 1% were having their fifth child or more, compared to 3,4% in the sample.

From that, I can say that according to some figures the populations of Icelandic women are similar to my sample, but to according to others, not.

6.2.5. Age of the women's youngest child

The next question was regarding how old their youngest child was, if they had a child. The findings shows that 42,2% (n=98) were having their first child, 34,9% had a child aged 0 to 4, nineteen percent (n=44) had a child aged between 5 and 9, two point six percent (n=6) had child between 10 and 14 and finally, 1,3% (n=3) had a child aged 15 or older.

6.2.6. Number of miscarriages

Looking at the results regarding the number of pregnant women that had had a miscarriage earlier in their life, 71,1% (n=162) of the women had never had miscarriage, 18,9% (n=43) had had a miscarriage once, 5,7% (n=13) had miscarried twice and 4,4% (n=10) had miscarried three times or more.

According to Geirsson, (1998) 15 to 20% of all pregnancies end with a miscarriage, but further information was not found in the literature.

In my sample, 28,9% of the women had had a miscarriage, so that is a little higher. This can maybe be explained by the fact that the women that had miscarried earlier in their lives chose to come for their antenatal check-ups at the National Hospital in Reykjavik rather than at their health care clinics in their own neighbourhood.

The largest numbers of the women in the sample had their antenatal service at the national hospital and that is probably the reason why the percents of women that had had miscarriage are so high.

6.2.7. Number of children that you have lost

One of the variables that I wanted to look at, was if the women had lost a child in the past or not. The results shows that 2,3% (n=5) of the women had lost a child, but 97,7% (n=217) had not lost a child. The age of their children when they died was from 0 to 3 years. As there were only 5 women in the sample that had lost a child earlier in their life, I cannot compare them with statistics from the Statistics of Iceland.

To some extent my sample has similar characteristics to the population of Icelandic women that are having children. There is no information available on some of the characteristics, and some characteristics are not similar to the characteristics of the population of Icelandic women.

6.3. Different variables and satisfaction with the antenatal services

In the next thirteen questions, which were all close-ended, women were asked about their satisfaction with various items that the literature have found to be related to women's satisfaction with care.

6.3.1. Time between visits

Question eight was regarding what the women thought about the time between the visits to the antenatal clinic, if it was much too short, too short, adequate, too long or much too long. No woman thought the time between visits much too long or too long. Ninety-three point nine (n=217) percent thought the time was adequate, and it was interesting to discover that nearly 94% are pleased about the time between visits. Three percent (n=7) thought the time as too short and 3% (n=7) thought the time was too long.

The results shows significant difference between women's satisfaction regarding their satisfaction with the time between visits and their satisfaction with the antenatal services in general (p=0.001).

As the research illustrates that 6% (n=14) of the women were not pleased about the time between visits, the question can be raised, why they are not pleased. Is it because they were not given a choice about when they would like to come next, or was there some other reason, like lack of information about why the midwife wanted them to come at a certain time?

As Waldenström (1996) illustrates, the medical model has too much influence in the antenatal service.

That could be one of the reasons why so many women are not very satisfied with the time between visits. Midwives and doctors have been creating the system in the antenatal services, under too much influence of the medical model and too little with the feminine values in mind. That could also be the reason for, why 32% of the women in this study, were rather satisfied or unsatisfied in general, with the antenatal services.

6.3.2. The time to talk to the midwife during the visit

Results regarding the question about the time they spent with the midwife during the visits showed that 88,4% (n=205) thought the time was adequate, 9,9% (n=23) thought it was too short, 1,3% (n=3) percent thought that the time was much too short and 0,4% (n=1) thought the time that they spent with their midwives was too long.

Significant difference was found between answers regarding women's satisfaction with the length of time spent with their midwives during the visits to the antenatal visits and their general satisfaction with the antenatal service (p=0.001).

Looking at the results in the study and the fact that 88,4% (205) of the women thought the length of time spent with the midwife was adequate, but 11,6% (n=27) were not completely satisfied, it can be stated that our system is not good enough. We should be able to give every woman the time she needs, because as Frossel (1996) states pregnant women are all special individual beings and their needs are different. It should be reasonable to expect a service where all women are satisfied with the time spent with her midwife. Because 11,2% consider the time too short, or much too short, it is possible that this could be one of the major variables in increasing women's satisfaction with the service in general. By increasing the time, the women should receive more information, education, support and an improved relationship with the midwife.

Comparing the results in my study to another study by Williamson and Thomson, (1996) 46% of the women thought the length of time excellent, 34% thought the length of time very good, 2% thought the length of time poor and 6% did not answer. From that it can be stated that nine 11,2% of the women in my study claim that they need more time with their midwife during antenatal visits compared to two percent in the study by Williamson and Thomson (1996).

For the last few decades, a reduction in the health care system in Iceland has occurred. It is my experience that the time that midwives have to spend with each woman has been decreasing, and that is something that we have to consider in the near future.

The time spent with women in each visit is usually 15 minutes and it seems that, it does not meet the needs of all the women.

6.3.3. The time spent in the waiting room

Question ten was regarding the time spent in the waiting room. Only 35,5% (n=82) of the woman were very satisfied with the time they had to wait, 24,2% (n=56) were rather satisfied, 24,2% (n=56) were neither satisfied or unsatisfied, 13,9% (n=32) were rather unsatisfied and 2,2% (n=5) were very unsatisfied with the time they had to wait in the waiting room.

Women's satisfaction with the waiting time was highly significant with their general satisfaction with the service (p=0.0000001).

As Harper (1994) states, women have had too little control in their antenatal services, they have too little choice regarding their care, and they are suppose to come to the clinics when it is adequate for the health providers. However, as the time that the midwife has to spend with the woman during each visit has been decreased, many women perceive that they have to wait too long in the waiting room, and according to this study that affects their satisfaction in general.

As satisfaction with the waiting time in this study, was one of the variables that was highly significant in the study with their satisfaction in general, it can be wondered if decreased waiting time would be one of the improvements that would increase women's satisfaction with the antenatal service in general.

In a survey conducted by Williamson and Thomson (1996), one of the variables that was measured was the women's satisfaction or dissatisfaction with the time they had to wait in the waiting room. The majority, 78% of the women in the study, felt they had to wait too long.

Comparing those results with the results in my study, the perception of waiting time was very different. In this study 59% percent of the women were very or rather satisfied, compared to 22% in the study conducted by Williamson and Thomson.

6.3.4. Always seeing the same midwife

Women's satisfaction with seeing always the same midwife was one of the variables that were measured in the study.

Seventy-nine point six (n=183) percent were very satisfied regarding always seeing the same midwife. Fifteen point two percent (n=35) were rather satisfied, 2,2% (n=5) were neither satisfied nor unsatisfied, 2,2% (n=5) percent were rather unsatisfied, and 0,9% (n=2) were very unsatisfied.

These results are strange, when compared with the results in question number 22 where the majority of the women stated that always seeing the same midwife was the thing that was for them the most important about their antenatal care. It comes to mind that maybe this question did not measure the thing that it was suppose to measure, when reading those results, and that could be one of the limitation of the study.

No significant difference was found between women's satisfaction in general and women's satisfaction with always seeing the same midwife ($p=0,402$).

Although those results are similar to the results which Waldenström (1998) portrays in her study, this is the opposite of many other studies, (Olafsdottir, 1992, Karlsdottir and Halldorsdottir, 1996, Williamson and Thomson, 1996) which all claims, that always seeing the same midwife, was one of the major factors in women's satisfaction with antenatal services in general.

Shields et al. (1998) conducted a study comparing women's satisfaction with continuity of care, which was midwife led, and women's satisfaction with continuity of care that had shared care between midwives. Twenty-eight point nine percent of the midwife-managed care group commented that they were satisfied with the continuity of care they were offered, compared to 7,3% in the shared care group.

Comparing those results with this study, where 79,6% of the women said that they were very satisfied with the continuity of care, indicates that women in the three clinics are very satisfied with the continuity of care which they received.

6.3.5. The education received from the midwife

Many authors have implied that the education the women received during their antenatal visits as one of the variables in women's satisfaction. In my study, 66,5% ($n=153$) were very satisfied with the education they received, 26,5% ($n=61$) were rather satisfied, 5,7% ($n=13$) were neither satisfied or unsatisfied, and 1,3% ($n=3$) were rather unsatisfied with the education they received during the visits to the clinics. No woman answered that she was very unsatisfied.

No significant difference were found between general satisfaction with the antenatal service, and the satisfaction regarding education they received during the antenatal visits ($p=0.058$).

In the literature review, it seems that information and education is written about at the same time and no difference is made between those two words. In this study information was defined as practical information about where to go, when to come, what choices they had and so on. On the other hand, education was defined as information such as about nutrition, preparation for birth and the birth process it self.

Tew (1990) claims that as the medical model has had so much influence for the past few years, the system has not been created with the individual needs in mind or with that in mind that women need education during their pregnancy. They do not just need a time to be weighed, taken blood tests and the foetal heart beat to be listened to.

Furthermore, Waldentstöm (1996) claims that the Health care service has forgotten how the process through childbirth has different perspectives, and some health care providers have stated that the aim of the antenatal service was just to provide medically safe care. That the service has been built up just with medical issues in mind and not with feminine values in mind.

That could be one of the reasons why 26,5% of the women in that study said that they were rather satisfied with the education they received from their midwives, 5,7% were neither satisfied or unsatisfied and 1,3% were rather unsatisfied. That fact is noteworthy and something which the health care providers have to improve in the future and needs further research.

6.3.6. Information about the service

Practical information about the system, such as where to go, at what time the women could come, when they should go to parents classes, information regarding place of birth and etc., was another of the variables.

Forty-five point seven (n=105) percent were very satisfied with the information they received, 32,6% (n=75) were rather satisfied, 17,8% (n=41) were neither satisfied or unsatisfied, 3,5% (n=8) were rather unsatisfied, and 0,4% (n=1) were very unsatisfied. General satisfaction with the antenatal service has a strong relationship with women's satisfaction with information they receive during their visits in the antenatal clinics (p=0,0000001).

This result illustrates that only 45,7% (N=105) of the women are very satisfied with the information they receive, meaning that 54,3% (N=125) think we could do better regarding the information we give them about the maternity services. That must be noteworthy, considering, that in that question, women that said they were very satisfied had the second lowest score of all the questions in the questionnaire.

Furthermore, the satisfaction with information given had a highly significant relationship with satisfaction with care in general.

These results imply that having information about choices in the maternity services, affects women's satisfaction with antenatal services in general

According to McKay (1997) lack of effective oral communication is sometimes the fact between health care providers and their clients, and sometimes clear and meaningful language is not used.

Effective communication could increase the information that women receive from their midwives, and maybe increase women's satisfaction with antenatal services in general.

Looking at the fact that 32,6% of the women were rather satisfied, I think that is very important and something we have to try to improve in the future. Our goal should be that every woman is very satisfied with the antenatal services.

6.3.7. Support from the midwife

Support from the midwife is one of the issues that has been emphasised very much, and Flint, (1986) has stressed the importance of the perception of satisfaction with the support they got from the midwife. She states that to be emotionally close to the midwife is something that women need very much during their pregnancy, birth and puerperium.

In this study, 64,8% (n=149) were very satisfied with the support, 30,4% (n=70) were rather satisfied, 3,9% (n=9) were neither satisfied or unsatisfied and 0,9% (n=2) percent were rather unsatisfied. No woman answered that she was very unsatisfied.

Looking at these findings, it can be portrayed that 34,2% (n=81) were expecting more support than they received.

Women's perceptions of the support they get from their midwives during the antenatal visits seems to be related to their satisfaction with the service in general (p=0,028).

Flint (1986) and McKay (1977) have illustrated how important support from the midwife is for pregnant women. Kitzinger (1994) states that this support is a special

kind of support, that she needs during a time of big changes in her life. Looking at that, it is not satisfactory that 64% of the women were very satisfied and the rest of the women hoped to receive more support from their midwives during their antenatal services, but did not receive it. That is one of the things which the health care providers have to improve in the future and needs further research.

6.3.8. Midwife's skills

The women's perceptions of the midwife's skills were also measured.

The results show that the women's perceptions of the midwives' skills were varied. Seventy-four point nine percent (n=173) said that they were very satisfied with the midwives' skills, 20,3% (n=47) were rather satisfied, 3,9% (n=9) percent were neither satisfied or unsatisfied, 0,9 % (n=2) were rather unsatisfied, and no woman was very unsatisfied with the skills that they perceived that the midwife had.

No significant difference was found between women's perception of the skills their midwife had and their general satisfaction with the antenatal service (p=0,346).

These results are interesting, because they do not agree with what many authors, such as Halldorsdottir and Karlsdottir (1996b). Although their study was not about satisfaction and perception of the midwives skills, in their study it was found that women's perception of the midwives skills were one of the major factors in their perception of caring or uncaring encounters.

Olafsdottir (1992) conducted a qualitative study, where hermeneutic phenomenology, was used. Women described two different kinds of competence. One with a caring approach and another more technical competence, without caring behaviour. The results in that study portray that competence without caring is not enough and although, the midwife was technically competent it was not perceived as an effective intervention. The reason they claimed was that the interaction with the midwife had caused negative feelings and emotional tension.

Those results are noteworthy and are not in agreement with the results in this study, however it can be difficult to compare those results as one of them uses qualitative research approach and the other one quantitative one.

6.3.9. Midwife's presence

Results regarding the women's satisfaction with the presence of their midwives are interesting and very decisive.

Eighty-nine point two (n=206) were very satisfied with the presence of the midwives, 10% (n=23) were rather satisfied, 0,4% (n=1) were neither satisfied nor unsatisfied, 0,4% (n=1) were rather unsatisfied, and no women were very unsatisfied.

Women's perception of the presence of their midwives was highly significant with their general satisfaction with antenatal services (p=0,000001).

Halldorsdottir (1996) has defined the caring concept. In her definition it is explained how important the presence of the health care provider is so the client can receive good care. The health providers' attitude and their presence towards their clients affect the relationship that must be built up between them.

Maybe the women's satisfaction with the midwives' presence affects many other variables that are measured in this study, such as information given, midwife's interest in her work and many other variables.

In the Williamson and Thomson (1996) study, 64% of the women perceived the midwives' presence as excellent, 27% said that it was very good and 10% of the women said it was good.

Although the words that are used to measure women's satisfaction in those two studies are not the same, they are rather similar, as are the results regarding that issue.

In this study 10,8% (n=25) of the women said they were not very satisfied and as the p-value was 0,00001 it would be one of the goals in the future to improve midwives presence towards the women.

6.3.10. Midwife's interest in her work

The results showing women's perceptions on whether they felt that their midwife showed an interest in her work are very interesting. Eighty-one point eight (n=189) were very satisfied with the interest that the midwife showed in her work, 16,9% (n=39) were rather satisfied, 0,4% (n=1) were neither satisfied nor unsatisfied, 0,9% (n=2) were rather unsatisfied and no one was very unsatisfied.

As 16,9% (n=42) of the women were rather satisfied with their the midwives interest in their work, it indicates that that they would have expected more of their midwives. This raise a question if we are just supposed to provide medically safe care or are we supposed to provide a care where we show interest in our clients as special individual beings with different kind of needs. As the feminine and masculine debate has been about what matters should be taken notice of, regarding the care of our clients, this is one of the issues that the health care providers need to take notice of in the future.

According to Waldenström, (1996) as has been emphasized earlier, the medical model has too much influence in the antenatal services today and she claims that just providing medically safe care has been the goal in antenatal services in many countries.

Looking at the relationship between women's satisfaction with the midwives interest and their satisfaction in general ($p=0.00001$), it illustrates that all women do not just want medically safe care, they also want care where the midwives show that they are interested in their work.

6.3.11. The relationship with the midwife

Question eighteen was regarding whether the women were pleased or not with their relationship with the midwives. Sixty-nine point one percent (n=159) said that they were very satisfied, 22,6% (n=52) said that they were rather satisfied, 7,4% (n=17) said they were neither satisfied or unsatisfied, 0,9% (n=2) said they were rather unsatisfied and no woman said she was very unsatisfied.

Significant difference was found between satisfaction with the antenatal service in general and their satisfaction with their relationship with their midwives ($p=0,0080$).

No researches were found that looked especially at the women's perception of their relationship with their midwives. However, some authors such as Halldorsdottir (1996), claim that a feeling of a good relationship with the health care provider is very important and can provide a caring relationship where support and trust can be built up between the health care provider and the client.

Halldorsdottir (1996) describes the relationship that can be built up between the health provider and their clients, as a bridge where connection with a comfortable distance of

respect and compassion is built up. On the other hand she explains lack of connection as a wall that has the characteristics of disconnection.

Looking at the results, where 22,6% (n=52) of the women were rather satisfied 7,4% (n=17) neither satisfied or unsatisfied and 0,9% (n=2) rather unsatisfied it maybe stated that 30,9% (n=71) of the women are not very satisfied with their relationship with their midwives.

As so many women claim that they were not very satisfied, those results should be taken notice of in the future and further research is needed.

6.3.12. The same midwife during pregnancy and birth

Harper (1994) describes the changes, which have been occurring in many countries, as the "gentle revolution". She discussed continuity of care and choice for women regarding the childbirth process. This has received more attention in the health care system during the last few years.

I decided to ask the next question to try to discover what the women's wishes were regarding more continuity of care than they are usually offered today. Especially because of the fact that so few midwives work both in the antenatal clinics, labour and also on the postnatal ward, and offer women continuity of care.

My question was regarding women's satisfaction if the same midwife that they met during their pregnancy would also be with them when their child was born. Seventy-seven point one (n=178) percent said that they would be very satisfied if the same midwife could be with them, 11,3% (n=26) said that they would be rather pleased, 10,4% (n=24) said they would be neither satisfied or unsatisfied, if the same midwife would be with them. Zero point four (n=1) said they would be rather unsatisfied, and 0,9% (n=2) said they would be very unsatisfied.

The fact that 77,1% (n=178) said they would be very satisfied if the same midwife that took care of her during the pregnancy would be with them during the labour is very interesting. Furthermore, 11% (n=26) of the women said that they would be rather satisfied. Altogether 88,4% (n=202) of the women said that they would like to have the same midwife both during pregnancy and birth. Those results imply that continuity of care through pregnancy and birth is something that women would very much like, as so often has been stated.

Although the majority of the women would like the same midwife to take care of them during pregnancy and birth, no significant difference was between the group that was satisfied and the group that was not satisfied with the antenatal service ($p=0,4997$).

In a study conducted by Shields et al. (1998) lack of continuity of care was one of the four issues that women stated were the main reasons for their dissatisfaction during pregnancy, birth and postnatal care.

Looking at the literature review, where the masculine effect in the antenatal services is discussed many authors, (Sampsell, 1990, Robinson, 1990, Kyle, 1995) state that the masculine effect on the system has decreased the continuity of care that women are offered during the childbearing process.

My study illustrates that women want continuity of care, not just during their pregnancy but also through the birth, and as Flint (1993) states, what the women are asking for is only reasonable.

6.3.13. Opportunity to telephone her midwife

Another of the variables that was measured was the women's perception of whether it was difficult or not to contact their midwife by telephone. Fifty-three point five percent ($n=122$) said they never had to contact their midwife by telephone. Twenty-five point four percent ($n=58$) said they were very satisfied with that service, 9,2% ($n=21$) were rather satisfied, 11% ($n=25$) said they were neither satisfied or unsatisfied, and 0,9% ($n=2$) said they were very unsatisfied with that part of the service.

A significant difference was between the women that were satisfied with the antenatal service in general and the women who were satisfied about contacting their midwives by telephone ($p=0.001$).

It is interesting that 46,5% of the women needed sometime during their pregnancy to contact their midwives by telephone. Looking also at the fact that their satisfaction in general had a significant difference with their satisfaction with their opportunities to telephone their midwives, it is noteworthy that 21% ($n=42$) of the women were not very satisfied with the service.

Nolan (1977) claims that society has been changing through the past few years and health care providers have a bigger part in educating their clients than before. Opportunities for women to contact their midwives by telephone should be one way for the pregnant women to receive education and information when they need it.

No studies were found regarding women's perceptions of opportunities to contact their midwives by telephone, but perhaps that is a part of continuity of care, support from the midwife or women's perceptions of their relationship with their midwife.

6.3.14. The midwives' service in general

The next question was regarding the service in general. If the women were satisfied or not with the care they received from their midwives during their pregnancy. The conclusions were noteworthy. Sixty-eight point six percent (n=157) said they were very satisfied with the care they received, 29,7% (n=68) said they very rather satisfied, 1,3% (n=3) said they were neither satisfied nor unsatisfied, no one was rather unsatisfied and 0,4% (n=1) said they were very unsatisfied.

As 29,7% (n=68) of the women stated that they were rather satisfied, they must have expected or hoped for something better. That is one of the things that we can take notice of when we are planing our antenatal service in the future, but further research is needed..

6.4. Findings in the open-ended questions

The last four questions were open-ended and women were able to write in their own words their perception of the midwives' care. Discussing the results I will just look at the most common comments here, but in chapter five all the comments are listed.

6.4.1. The most important aspects of the midwives' service

Question twenty-two was:

What do you think was the most important aspect thing regarding the midwife's service?

Two hundred and nine women answered that question, either with one comment or more.

Item	Number
To always see the same midwife	144
Her abilities	73
The information she gave	71
Her interest	75
Her politeness	55
Our relationship	36
It was easy to contact her	20
Her presence	14

The comments illustrates that always meeting the same midwife, who has good skills, gives good information, and shows an interest in her work are the issues that women perceive the most important things regarding the service they get from their midwives. Furthermore, having a good relationship with the midwife, her presence, her politeness, and how easy it is to contact her, seem to be factors that women perceive as very important regarding their perception of midwife's service that they are satisfied with. Those results agree with many studies (Olafsdottir, 1992, Omar and Schiffman, 1995, Todd et al., 1998, Williamson and Thomson, 1996).

However, as has been demonstrated earlier, no significant difference was found in the results of the question about general satisfaction and satisfaction with always seeing the same midwife. That supports my feeling that the question earlier in the questionnaire was not clear enough.

6.4.2. The thing I was most satisfied with

Question number twenty three was:

What have you been most satisfied with concerning the care that the midwife has given you?

One hundred and eighty three women answered that question, either with one comment or more.

Item	Number
Her warm presence	41
She was interested.....	34
The information she gave.....	21
Her competence	18
Everything.....	18
Her politeness.....	16

Two of the comments from women that participated in the study were:

"Her interest in my pregnancy and she does not make my pregnancy a disease, but something enjoyable and good"

"Just everything"

Women's comments portray that the midwives presence towards the women, their interest in their work and their competence were the most important things for the women. In the close ended questions in that study, where women were asked about their satisfaction about their midwives presence, the results portray that general satisfaction was highly significant ($p=0,000001$) with women's satisfaction in general. Other variables such as women's perception of the midwives interest in their work was also significant with satisfaction in general ($p=0,0001$). Furthermore, women's satisfaction with the information received also had a highly significant difference ($p=0,0000001$) with their satisfaction in general.

6.4.3. The thing I was most unsatisfied with

Question number twenty-four was: What have you been most unsatisfied with regarding the care you received from your midwife? One hundred and thirty-eight women answered that question, either with one comment, or more.

Item	Number
Nothing that I am unsatisfied with	92

Too little time that we had	13
Not to meet the same person again and again	7
Too much waiting time	5
Too little information given	5
She was not interested in my pregnancy	3

Two of the comments from women that participated in the study were:

"Not seeing always the same midwife"

"Too much waiting time"

It is interesting, as ninety-two of the 138 women that answered that question, commented that there was nothing that they had been unsatisfied with regarding the midwives service.

Thirty-seven women explained in their own words why they had not been satisfied with the care they receive in the antenatal clinics. Their comments were; lack of continuity of care, too short time in each visit, too little information given and lack of the midwives' interest in their work.

This is in accordance with Williamson and Thomson (1996). The major reasons for women's dissatisfaction were, according to their study, the waiting time, lack of explanation, lack of continuity of care, lack of information given and miscellaneous events.

6.4.4. Comments at the end of the questionnaire

The last question was asking if they wanted to comment about something at the end. Ninety-two women made comments, some with one comment and some with many.

Item	Number
Wanted to say thanks	21
Nothing special	18

To have the same midwife during labour and birth	9
Wonderful service	7
To always meet the same midwife	4
Wanted to have more time with the midwife	4
Shorter waiting time	4

Four of the comments from women that participated in the study, which demonstrates the individual experience, were:

"During that pregnancy I have come four times to the clinic and met three midwives and I am not pleased with that".

"I am very unsatisfied that every women should not have opportunity to have continuity of care from booking to post partum, from the same midwife".

"It is good to come to the clinic and I always look forward to it".

"I have been very satisfied with my midwife".

Women used that question both to present their satisfaction and dissatisfaction with the antenatal services although the majority of comments were positive. That gives a message that generally the women were pleased with their service and that they had perceived that they had an opportunity in the questionnaire to express the things they had not been pleased with.

6.5. The relationship between variables

Looking at the relationship between various results of the questions, some interesting results can be illustrated. For example, age and marital status had a strong relationship ($p < 0.001$ in every question) with their satisfaction with the time spent in the waiting room, continuity of care, the education they received from the midwife, the information about the service, and the support they got from the midwives.

The age of the women and their marital status had a significant difference in their perception of midwife's skills, their presence, their interest and also in their relationship with their midwives ($p < 0,001$).

The number of previous births did not have a significant difference with their perception of support, information given nor any of the other variables that were measured ($p > 0,2$ in every question).

There was a significant difference with some of the variables, with women who had younger children, such as women's satisfaction with information given, support, continuity of care, waiting time and also the perception of the relationship with the midwife ($p < 0.001$ in every question)

6.6. Summary

It was found that the variables that seem to characterise the antenatal services that women were satisfied with in general were: satisfaction with the time they had to talk to their midwives, satisfaction with information received and satisfaction with the presence of their midwives. Additional, the characteristics were: satisfaction with their perception of the midwife's interest in her work, satisfaction with their relationship with their midwives, satisfaction with their opportunities to telephone their midwives, satisfaction with the time between visits which also had significant difference with the antenatal service women are satisfied with in general.

It was not possible to identify what characterised the antenatal services which women were unsatisfied with, as few women claimed they were rather or very unsatisfied. However it maybe postulated that these characteristics are the opposite of what characterises the services which women are satisfied with.

The research illustrates that 68% of the women in the three clinics were very satisfied with the service in general, and 32% claimed that they were rather satisfied or unsatisfied. The question that can be raised looking at those results is if it is agreeable that only 68% are very satisfied with the service in general. Those results are noteworthy and important to keep in mind during the "gentle revolution" in Iceland.

6.7. The strengths of the study

- In the study, probability sampling was used to collect data, and as the return rate was 91,3% it can be looked at as one of the strengths of the study.
- The data collection took place in three different places in Iceland, which are three of four of the antenatal clinics that has the highest number of women that come for their antenatal visits every year.
- In the questionnaire, both open-ended and closed questions were used to collect data. The comments where women's perception was written in their own words, supports the results in the study as a whole.

6.8. The limitation of the study

- One of the limitations of the study was that it would have been better if the data collection had taken place in every antenatal clinic in Iceland because the results could have been used more to discuss the satisfaction or dissatisfaction of the population of Icelandic women as a whole. However, the three places where the data collection took place were three of the four places where the highest number of women in Iceland come for their antenatal services.
- Some of the questions were not good enough because of some disadvantages that were not found in the pilot study. For example the question about women's education that was one of variables that was asked about regarding the sample characteristics had some disadvantages, as women were not asked to tick the highest education that they had completed. During the data collection, some of the women asked about that question, so that would be one of the improvements that were necessary to the questionnaire in the future. Other question that was unsatisfactory, was the question about women's satisfaction with always seeing the same midwife. Looking at that question afterwards, one can ask oneself what the women's answers mean. Were they not satisfied with not always meeting the same midwife or did she not want to meet the same midwife. That question needs to be changed to improve the questionnaire in the future.
- It would have been interesting to know the reasons why women were not very satisfied, as so many women were rather satisfied with many of the variables that

were measured. That could both be looked at as a limitation of the study, and also as a recommendation for the future.

- Looking at the results, I began to ask myself what I could have done better, and I began to wonder about some issues, such as if it would have been better to have information about what week of pregnancy the women were in. That may have been a variable that could have been useful to look at and compare to other results.
- Due to the time scale of the study, limited time was to analyse the data and write the final report.

6.9. Implications

As various changes have been occurring in Iceland, regarding the service that pregnant women receive during the childbirth process, it is noteworthy that this study is the first one that measures women's satisfaction with antenatal services in Iceland. It can be stated that this study is a contribution to the discussion that has been going on in Iceland about what changes will be made in the near future in our services. As many of the variables that were measured, did have significant difference with the women's satisfaction with the antenatal services in general, this can be a support in the changing that are occurring in Iceland and be a guide for further research and for changes to be based upon in the future.

6.10. Recommendations

- Looking at the variables that characterise the women's satisfaction with antenatal services and how many are "rather satisfied", it would be interesting to look at the reasons why they were not "very satisfied". That could for example, be done by repeating the study and adding to the questionnaire a further questions to women who are not "very satisfied" asking about why they were not "very satisfied". A study using both quantitative and qualitative research methodology could be used.
- The satisfaction or dissatisfaction of pregnant women, with the antenatal service who have, at some time, had a miscarriage. It would be interesting to explore further the perception and the needs of those women, are we taking good care of those women and does the have some special kinds of needs that other women do not have that never have had had miscarriage. Performing a qualitative study using phenomenology to explore those needs would be interesting.

- The satisfaction or dissatisfaction of pregnant women, with the antenatal service who have, at some time, lost a child. No study have been conducted in Iceland exploring what kind of antenatal service those women need as very few women in that study have lost a child (n=5) it not possible to say anything about their perception of satisfaction and dissatisfaction. A qualitative study using phenomenology would suit well that kind of study where it would give information about what kind of antenatal services those women want.

In spite of the changes that have taken place, there are many things that still need to be changed. Midwives need more information regarding women's wishes and choices regarding the service they receive from their midwives.

As many a variables had significant difference with women's satisfaction with the antenatal services in general, it would be interesting to conduct a study using phenomenology, to explore the women's perception of what affects their satisfaction with regard to:

- the time they had to talk to their midwives
- information received
- the presence of their midwives
- their perception the midwife's interest in her work
- their relationship with their midwives
- their opportunities to telephone their midwives
- the time between visits
- the length of waiting time

Conducting a study that would give information about all those variables that characterise the women's satisfaction with the antenatal service would give more information that would help in the "gentle revolution" that has been taking place in the service in Iceland for the past few years.

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9. Appendixes

- 9.1. Appendix A The introduction letter and the questionnaire
- 9.2. Appendix B. Permissions to conduct the study