Young Women’s Experiences as Consumers of Maternity Care in Queensland

Maggie Redshaw, BA, PhD, C Psychol, Yvette D Miller, PhD, and Julie Hennegan, BPsySc

ABSTRACT: Background: Young motherhood is commonly associated with vulnerabilities, stereotyping of young women’s behavior, and poor outcomes for them and their children. The objective was to understand how maternity care is experienced by this group in the transition to parenthood. Methods: Data from a large-scale 2010 survey of women’s experience of maternity care were analyzed using qualitative methods with open text responses. Results: Overall, 7,193 women responded to the survey: 237 were aged 20 years or less. Most (83%) of these young women provided open text responses. The main themes were: “being a consumer,” “the quality of care,” “needing support,” and “pride in parenthood” whereas subthemes included “being young” and “how staff made me feel,” “testimonials for staff,” “not being left,” and “it is all worthwhile.” Conclusion: Many young women responding described a positive experience. For many first-time mothers this feeling marked a change in their identity. Nevertheless, staff perceptions and attitudes affected how they saw themselves and what they took away from their experience of maternity care. A key message for other women is offered, supporting and reinforcing their role as active and involved consumers who, in engaging with services, have to stand up for themselves and make their needs and wishes known. (BIRTH 41:1 March 2014)

Key words: young mothers, maternity services, perceptions of care

Background

There is a view that for young women, particularly teenagers, pregnancy is a social problem, fraught with difficulties and outside what is expected or desirable (1,2). A study of health professionals’ constructions of adolescence and motherhood described how care practitioners drew on discourses positioning young mothers as problematic (3), constructing them as immature, self-obsessed, likely to be distracted, and having a lack of foresight.

Despite a steady decline in rates of teenage pregnancy, women younger than 20 years of age represent 4 percent of women giving birth in Australia (4). Being a young mother in Australia is associated with vulnerabilities: limited education, low socioeconomic status, living in rural areas, less well-established partnerships, poorer access to economic and emotional resources, and identification as Aboriginal (5–8). Higher rates of lifestyle risk factors (5), later and less frequent access to antenatal services (7,9), and a higher risk of adverse outcomes, including antepartum hemorrhage, pregnancy-induced hypertension, postpartum depression (5,10–12), preterm birth, and neonatal death, have been reported (5,7,13–16).

Stigmatization of young childbearing women has been described (17) with pregnancy and birth commonly framed as deviant, poorly timed, associated with...
immaturity, thoughtlessness, and not being a “good” mother (3). However, qualitative studies have documented incongruence between societal perceptions and young women’s own views (17–19). A strong maternal identity may provide a buffer against threats to self-esteem (20); nevertheless, material hardship and institutional marginalization remain salient features of young motherhood, disconnecting young women from health service support that can mitigate the effects of risk factors on clinical and psychosocial outcomes (21). Recent studies confirm the importance of enhancing communication with young mothers (22). Provision of tailored nonstandard maternity care appears to improve antenatal contact with health care practitioners and outcomes (23).

Understanding the needs of young women is central to improving services for this population. Their views do not figure prominently in research to define areas of need in maternity care reform. We know that first-time mothers’ maternity experiences are characterized by self-perceptions of being a “novice” and that feelings of being valued are influenced by how well services address their needs (24). The aim of this study was to investigate young women’s recent experiences of maternity care and explore key issues by examining the themes identified and the language used.

Methods

Data Collection

This study used data collected in a statewide survey of all women who had given birth in Queensland between February and May 2010 (25). The state registry of Births, Deaths, and Marriages identified women, sending out survey packages between 4 and 5 months after the birth with a reminder after 2 weeks. Women who experienced a stillbirth or neonatal death were excluded from this analysis.

The survey covered details about the baby, maternity care, and sociodemographic characteristics, with a limited number of open-ended questions and could be completed on paper, online, or over the phone.

Data Analysis

This study utilized responses to two open questions: 1) “What would you like to tell other women about having a baby in this hospital or birth center?” and 2) “Is there anything else you would like to tell us about having your baby?” Neither is a leading question in terms of encouraging positive or negative responses. Data from young women aged 20 years or less were extracted. Descriptive analysis was undertaken to compare characteristics such as age and parity of the women answering and not responding to these questions using the Chi-square test ($p < 0.05$).

Individual responses consisted of handwritten text, ranging from a few words to several paragraphs, transcribed for analysis or typed online. The use of existing data did not facilitate a theoretically driven methodology and thus the responses were analyzed using qualitative thematic analysis to explore and identify themes reflecting a collective experience (26). Initially, the responses were categorized as “positive,” “critical,” “mixed,” “other,” or some combination, providing a broad view of how participants answered. The responses were not grouped using these categories. The text from both questions were then read together to gain a detailed sense of women’s accounts and of the patterns emerging from the data after initial coding was refined in an iterative process (26–28). One coder led the analysis, and agreement on themes involved all three authors. Themes that had been anticipated (based on the literature) and emerging themes (not anticipated) were identified (29,30). Further reading resulted in re-arrangement of themes and subthemes (31). Quotations are used for illustration. No changes were made to the text quoted other than corrections to spelling.

Results

The characteristics of the young women responding with open text are summarized (Table 1). Most gave birth for the first time (74%), in a public facility (95%), and had a vaginal birth (78%). Approximately half lived in a major city (49%) and around 1 in 20 lived in a remote or very remote location. First-time mothers were more likely to respond than women who had previously given birth; Aboriginal and Torres Strait Islander women were slightly less likely to respond than women not identifying in this way. There were no significant differences in geographic location, language spoken at home, type of birth, or having a low-birthweight or preterm infant between respondents and nonrespondents.

Most respondents answered the question about what they would say to other women (80%) and a third (32%) the more general “Anything else?” question. More than half the young women responding to the first question were positive in some respect (61%), whereas women replying to the second question were more likely to be critical (57%) (data not shown). Qualitative analysis gave rise to the core theme of “young women as consumers of maternity care” and to the specific themes and subthemes listed in Table 2.
**Being a Consumer**

Responses took different forms: in “being a consumer” these could be about themselves or their experience, with some giving direct advice, recognizing “a need for empowerment,” and of “having a choice” in a real sense.

**Being young**

Some young women felt they were treated differently, their views discounted, and they had fewer rights in interacting with the health care system. They were not always spoken to or listened to respectfully by health care professionals:

> They treat young mothers unkind and don’t listen… (age 17).

If you’re young you won’t get any say or make decisions about your baby (age 20).

Other young women contrasted their recent experience with previous care:

**Table 1. Summary of Maternal and Infant Characteristics for Young Women Responding to Open Questions (n = 237)**

<table>
<thead>
<tr>
<th>Mothers</th>
<th>Women responding to “What would you tell other women?” (n = 190)</th>
<th>Women responding to “Is there anything else?” (n = 77)</th>
<th>Women not responding to either question (n = 40)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parity</td>
<td>Primiparous 165 (87.3)*</td>
<td>64 (83.1)</td>
<td>29 (74.4)</td>
</tr>
<tr>
<td></td>
<td>Multiparous 24 (12.7)</td>
<td>13 (16.9)</td>
<td>10 (25.6)</td>
</tr>
<tr>
<td>Place of birth</td>
<td>Public facility 183 (96.3)</td>
<td>76 (98.7)</td>
<td>36 (94.7)</td>
</tr>
<tr>
<td></td>
<td>Private facility 7 (3.7)</td>
<td>1 (1.3)</td>
<td>2 (5.3)</td>
</tr>
<tr>
<td>Education</td>
<td>No education after year 10 78 (41.5)</td>
<td>28 (36.4)</td>
<td>19 (48.7)</td>
</tr>
<tr>
<td></td>
<td>Education after year 10 110 (58.5)</td>
<td>49 (63.6)</td>
<td>20 (51.3)</td>
</tr>
<tr>
<td>SEIFAa</td>
<td>Quintile 1 (least resources) 23 (12.4)</td>
<td>10 (13.0)</td>
<td>4 (10.0)</td>
</tr>
<tr>
<td>Economic resources</td>
<td>Quintile 2 55 (29.7)</td>
<td>24 (31.2)</td>
<td>11 (27.5)</td>
</tr>
<tr>
<td></td>
<td>Quintile 3 41 (22.2)</td>
<td>17 (22.1)</td>
<td>15 (37.5)</td>
</tr>
<tr>
<td></td>
<td>Quintile 4 39 (21.1)</td>
<td>14 (18.2)</td>
<td>7 (17.5)</td>
</tr>
<tr>
<td></td>
<td>Quintile 5 (most resources) 27 (14.6)</td>
<td>12 (15.6)</td>
<td>3 (7.5)</td>
</tr>
<tr>
<td>Language other than English at home</td>
<td>8 (4.2)</td>
<td>4 (5.2)</td>
<td>1 (2.6)</td>
</tr>
<tr>
<td>Geographic location</td>
<td>Major City 93 (50.3)</td>
<td>42 (55.3)</td>
<td>19 (48.7)</td>
</tr>
<tr>
<td></td>
<td>Inner Regional 65 (35.1)</td>
<td>23 (30.3)</td>
<td>15 (38.5)</td>
</tr>
<tr>
<td></td>
<td>Outer Regional 17 (9.2)</td>
<td>7 (9.2)</td>
<td>3 (7.7)</td>
</tr>
<tr>
<td></td>
<td>Remote/Very Remote 10 (5.4)</td>
<td>4 (5.3)</td>
<td>2 (5.1)</td>
</tr>
<tr>
<td>ATSI Status</td>
<td>Aboriginal/Torres Strait Islander 9 (4.8)*</td>
<td>6 (7.8)</td>
<td>6 (15.4)*</td>
</tr>
<tr>
<td></td>
<td>Non-Indigenous 180 (95.2)</td>
<td>71 (92.2)</td>
<td>33 (84.6)</td>
</tr>
<tr>
<td>Mode of birth</td>
<td>Vaginal birth 157 (82.6)</td>
<td>68 (88.3)</td>
<td>31 (77.5)</td>
</tr>
<tr>
<td></td>
<td>Cesarean section 33 (17.4)</td>
<td>9 (11.7)</td>
<td>9 (22.5)</td>
</tr>
<tr>
<td>Infants</td>
<td>Low-birthweight (&lt; 2500 g)</td>
<td>6 (3.3)</td>
<td>1 (1.3)</td>
</tr>
<tr>
<td></td>
<td>Preterm (&lt; 37 weeks’ gestation)</td>
<td>4 (5.3)</td>
<td>4 (10.0)</td>
</tr>
</tbody>
</table>

Note: Seventy women responded to both open questions. Numbers indicate women providing information on the characteristics listed, excluding missing values, and thus vary. *p < 0.05.

SEIFA = SocioEconomic Indexes for Areas; Economic Resources are derived from Australian Census variables related to economic resources such as income, housing expenditure, and assets of households in a geographic area of residence (41).

**Table 2. The core, main, and subthemes identified in the qualitative analysis of the open text responses of young women**

<table>
<thead>
<tr>
<th>Young women as consumers of maternity care</th>
<th>The quality of care</th>
<th>Needing support</th>
<th>Pride in parenthood</th>
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<tbody>
<tr>
<td><strong>Being a consumer</strong></td>
<td></td>
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<tr>
<td>Being young</td>
<td>How staff behaved and made me feel</td>
<td>Not being left</td>
<td>Joys and pleasures</td>
</tr>
<tr>
<td>A need for empowerment</td>
<td>Testimonials for staff</td>
<td>Not allowed</td>
<td>It is all worthwhile</td>
</tr>
<tr>
<td>Having a choice</td>
<td>The environment of care</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
The midwife I had with my second child was AMAZING! I had her throughout my pregnancy… With my first child … I had a different midwife every visit and because I was a young mother I was looked down on and not treated with respect at all (age 18).

A need for empowerment

Many reflected on the power relationships implicit in maternity care where health professionals have greater knowledge, skills, and clinical experience. Responses in which this theme dominated focused on young women speaking out and standing up for themselves. The language is directive, taking the form of advice about being assertive:

- Stick to your guns, bring supportive people who will make sure you don’t get bossed around (age 18).
- Make sure you say what you want and need (age 18).

They advise others to “make sure they give you what you want,” taking up a strong position, centering on the individual and identifying with them, reinforced by instructions not to be “afraid.” Others are encouraged to make their views known, even against opposition from maternity staff, advising women to “speak up if you don’t agree and stand your ground” (age 20) and “know what you want and don’t be afraid to tell them” (age 19).

In concentrating on individual needs, some really wanted to inspire, emphasizing the benefits of preparation, knowledge, and information:

- Make sure you ask as many questions as you can think of before you say YES to anything (age 19).
- Make sure you always are informed with each new step needed for your labour (age 20).

The value of personal knowledge is emphasized. A passive voice was rarely used, as reflected in the adversarial stance adopted in giving advice, encouraging others to stand their ground and not to be cowed by lack of experience.

Having a choice

A salient theme in young women’s construction of themselves as consumers of maternity services is choice:

- I felt pressured to induce labour at 40 weeks, even though gestation is 38–42 weeks (age 18).
- Overall, I wanted a home birth, but was scared and coerced into going to the hospital (age 18).

Some felt manipulated and were aware that their choice of place of birth and how birthing was managed had been limited or absent:

- The midwife completely violated my personal space probing the entrance to my vagina with her finger apparently to see whether I had torn or not …. She told me what she was doing just as she touched me so I couldn’t say no (age 18).
- They made decisions alone, without consulting me or telling me what they were going to do. They just did it (age 18).
- Others were conscious that their voices had been heard and information needs addressed:
  - The midwives are very good at handling you and your labour and birth. They ask you what you want to do, they don’t do anything without you knowing (age 20).

Exercising choice was framed as a critical element for women as consumers:

- The midwifery group at the [name of hospital] is great! … You can choose to have a water birth and not just have to wait to see if there are enough staff available…. Every woman should have the right to choose what kind of birth they want (age 20).

The Quality of Care

Another theme contributing to the consumerist perspective is the “quality of care” as evidenced by young women positioning themselves with regard to the care received. It included subthemes of “how staff behaved and made me feel,” “testimonials for staff,” and “the environment of care.”

How staff behaved and made me feel

The behavior of staff can influence how women feel and how they see themselves. Some midwives were described as “pushy,” “demanding,” or “nasty” and young women did not understand this behavior, were surprised at the lack of empathy, and puzzled about some of the midwives’ attitudes:

- The midwife that cared for me during the first stages of labour was rude and uncaring. She told me that I was only using gas because I wanted to get high when I was in pain, clearly, and to stop sucking because it wouldn’t help and all women go through it and there’s nothing to help (age 16).
- Once I had my son most of the midwives that I got treated me in an unexpected way. I was in tears constantly every day because they spoke to me so rudely. They made me feel unwelcome, all I wanted to do was go home…. They are not
there to make me feel how they made me feel … They always had me in tears (age 17).

Whereas some felt misunderstood, unwelcome, or an inconvenience, others felt lost or merely part of a mechanized organizational process:

Before choosing the birthing center, the public hospital just moved me to whatever midwife group they decided. I felt lost and unimportant …. The hospital midwives would just shufﬂe you like a herd of cows (age 20).

Health professionals are in a powerful position, able to help young women to feel positive about themselves and parenthood. Some respondents recognized this feeling and worked to have a balanced view:

I was treated by the nurses and midwives unfairly and with no respect. I was upset, I didn’t really want to stay in hospital because the nurses made me feel upset and emotional …. They did care for me but attitudes were off the charts. Some of the midwives treat you as a hassle but a handful treat you well and do as much as they can to help you (age 20).

Many reported on how staff behavior was supportive of their self-esteem, making them feel positive about managing labor and birth:

During my pregnancy I had a really great training midwife … who went to my antenatal appointments with me and was there during my birth. She was wonderful, really made me feel good about myself and conﬁdent about the birth of my son (age 18).

Feeling “safe” in relation to the unknown was a critical aspect of care and was framed positively in terms of the care provided and the absence of fear:

The midwives make you feel very welcomed and safe. They make sure you are comfortable and well looked after (age 17).

The staff are friendly, they make me comfortable staying in there. It’s a good hospital, I felt safe when I was in labour, I didn’t feel scared at all (age 19).

Some were very aware of clinical skill being integral to their feelings of safety and comfort as birthing women:

They are very well practiced, they have a conﬁdence about their job which made me feel safe (age 20).

They were conscious that staff can give different verbal and nonverbal messages affecting women’s self-image and competence during labor, birth, and afterward.

Testimonials for staff

The adjectives and phrasing describing the staff and quality of care function as endorsements for particular maternity services and individual staff, with clear positive messages:

Midwives were fabulous. They respected me and understood my needs. Very patient, willing to help and comforting (age 19).

The nurse, midwife, doctor and student doctor were the most amazing people (age 16).

In wishing to tell others about their care women used extreme terms. The choice of adjectives such as “fabulous,” “excellent,” and “fantastic” may have been heightened by the significance of the event, but the attributions nevertheless reflect their view of the care received.

The environment of care

Quality of care for many respondents was embodied in the physical environment, and women provided useful facts for future consumers:

Lovely home environment…. Beautiful birthing rooms. Very welcoming and modern (age 20).

The [name] is a very well organised and well-staffed hospital. Has a homely feeling …. Food is delicious, rooms very clean (age 18).

Practical aspects were repeatedly mentioned as markers for care quality, with the environment described as “modern,” “comfortable,” and like “home.”

Needing Support

A recognized need for support was discernible. Women referenced the help provided and their expectations. Many were aware of their own needs, valuing the help provided by health professionals, and their own partners, and families.

Not being left

Both presence and absence of staff support were salient in the language women used to describe care, with continued staff presence and availability being critical:

They never left my side during my entire labour, at first I was scared because I was still waiting for family arrive, but they made me feel fine and never left me (age 20).
Being a new parent, I had no confidence ... and my midwife I had during my labour and birth ... was amazing, everything she did for us during the labour/birth was so helpful. The entire time I felt so welcome and unpressured (age 17).

Women explicitly referred to continuity of care and not being left alone. Others identified individual staff who had left them feeling abandoned in the process of care, coloring their whole experience:

Having my baby in this hospital was a horrible experience. During my delivery the midwife was very rude to my support people, left me for about 15 minutes with no pain relief but the shower and an empty gas bottle. I had a type 2 tear and was about to tear to my bottom when my mum asked for me to have an episiotomy, the midwife snapped “It’s not up to you! Your daughter needs to ask!” It wasn’t very nice at all. After I gave birth I was left alone for an hour in the delivery room until the man came to stitch up my tears (age 20).

References to partners and family were common and young women made links between facility rules and their own emotional well-being:

After birth my family was not allowed to see me because visiting hours were over; luckily one nurse understood I needed my family at this time (age 17).

One young respondent with great clarity made a general plea for partner presence and argued cogently on behalf of new mothers:

I am a first-time mother who didn’t really know what I was doing and not having my partner with me through the first few nights was very stressful.... There are 11 extra hours that a father could also bond with their child rather than being chased out at 9 PM and only let back in at 8 AM (age 19).

Pride in Parenthood

The pride of new young parents, particularly first-time mothers, was striking in some responses: “joys and pleasures” and “it is all worthwhile” reflect this pridefulness.

Joys and pleasures

A subtheme concerned the intense pleasure and impact of becoming a parent, framed by pregnancy, birth, and the present. In representing themselves as new parents, women chose to write about their own reactions to this life-changing event, giving affirming messages to other women and health professionals:

My pregnancy felt like I was pregnant forever, but when it was time to give birth, it felt like it was too soon. I was in labour for 16 hours and my baby girl finally arrived. As soon as I saw her all the pain just vanished and I was a proud mum, still are (age 17).

I will always remember the day he was born. He just made my life different and he has taught me how to be an adult and a good mum (age 18).

It is all worthwhile

A related subtheme involved helping other women to face up to the realities of pain and exhaustion and simultaneously value what is achieved in giving birth:

It’s an experience you will never forget! I love being a mum and the pain was so worth every hour and minute of that (age 19).

Great labour and baby, really lucky, being single and young is hard but with the beautiful girl I have, I am lucky (age 19).

Speaking directly, young women wanted to reassure others.

Discussion

Based on other qualitative studies the anticipated themes identified included “needing support” and “having a choice” (17,32,33). The overarching theme of “young women as consumers of maternity care” and the strong position that many adopted in relation to “a need for empowerment” were not anticipated. That so many young women were willing and felt able to advise others suggests that this life-changing event had given them authority to speak. From a postbirth position, they were no longer novices (24,34), affirming their position as consumers and critics of maternity care.

The themes associated with negative staff attitudes and empowerment issues reinforced the view that stereotyping and judgmental attitudes worked to deny some women’s voices and choices. Staff behavior contributed to feelings of inadequacy and positive feelings of self-worth. The women were aware of psychological and social inequalities embodied in the differential status of themselves and staff and “a need for empowerment” included directives about speaking out. Individualism is important for young women in working to frame themselves as “good mothers” (20). Critical elements of care explicitly described being informed, having the appropriate knowledge, and an ability to exercise choice.

“Quality of care” was represented in several ways including “testimonials for staff” and in environmental
characteristics that women saw as markers for high quality care. Favorable evaluations of particular staff, especially those who were understanding and took more time, reflect both individuals and systems of care. Criticism and disapproval can affect confidence and contribute to disengagement. However, targeted programs have the potential to avoid this negative effect and improve experience (22,23).

“Needing support” was recognized as integral to the relationship with health professionals reflected in “not being left” and “not allowed” and young women argued strongly for what they saw as their own and their family’s rights in this regard.

“Pride in parenthood” and the subthemes of “joys and pleasures” and “it is all worthwhile” reflect new motherhood and the associated transitions and responsibilities. Young women wished to give positive and life-enhancing messages to others tempered by realism about labor, birth, and early parenting. Parallels are to be found in other studies of young and teenage women in terms of identity, self-efficacy, and positive self-concept (35–37).

A limitation of the study was that it relied on written responses to a survey. In interviews probes can be used; however, women may give more honest answers to a survey, not needing to convey a positive image to an interviewer. Young women were underrepresented among the respondents; nevertheless, it was possible to explore the perceptions of a greater number of women from a wider range of backgrounds than could have been achieved using other methods. It is acknowledged that asking about what they would like to tell other women may have contributed to the critical position adopted by some young women. However, with the same population of women responding to different, more structured survey questions in a quantitative analysis it is clear that young women aged 20 years or less were also more critical about their care (38).

The responses of young women recently birthing in Queensland, particularly that of disadvantaged groups, find echoes in the literature (39,40). There is a clear wish to be heard, to be informed, and to be treated with respect by health professionals. Many women experienced this kind of care from some, if not all, of their care practitioners and wholeheartedly felt able to recommend the hospital or birth center where they gave birth. Others contrasted care in different parts of the service or between care and practitioners. What was striking was the language used and the way in which the young women positioned themselves as consumers questioning, commenting on, and endorsing particular services or aspects of care. They felt able to be critical and were prepared to pass on unambiguous messages to other consumers. Involving such experienced young mothers more in antenatal and postnatal groups could be one way of using their experience as consumers to good effect.

Conclusions

Most of the young women did not simply express their feelings, but presented their thoughts in a way that was directly relevant to other women as consumers. The study findings reinforce the need to listen to women’s voices, focusing on the experiences and needs of specific groups like younger women. For health professionals and other young consumers it is essential to better understand how young women experience the care provided, what they take away from their encounters with the health care system during pregnancy and birth, and how it impacts their feelings about themselves and their ongoing relationship with health services.

Acknowledgments

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References

6. Quinnivan JA, Tan LH, Steele A, Black K. Impact of demographic factors, early family relationships and depressive symp-