An investigation of routine antenatal care in Europe

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An investigation of routine antenatal care in Europe

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Introduction

The concept of antenatal care in Western Europe has existed now for just over 100 years with the main aim being to reduce the high rate of infant mortality. (*Oakley 1982; Hall et al. 1985; Heringa 1998)* . The programme in its present format was first institutionalised in Britain in 1929 through a report from the Ministry of Health (*Hall et al. 1985, Heringa 1998).* Little has changed since this time, with the exception of the introduction of more sophisticated diagnostic techniques.

Until the late 1970s little was done to evaluate systematically the effectiveness of the antenatal care programmes *(Hall et al. 1985; Heringa 1998).* A reduction in maternal and perinatal morbidity and mortality was seen by service providers, as well as researchers, as evidence of value of these programmes *(Oakley 1982; Hall et al. 1985).*

Following the call for evaluation of effectiveness of health care services by consumers and health care providers, the antenatal care programmes and their content were subjected to much research in the 1980s and 1990s *(Enkin & Chalmers 1982; Hall et al. 1985; WHO, 1987; Chalmers et al 1989; Heringa 1998; Haertsch et al 1999; Langer et al 1999; Villar et al 2001; Villar & Khan- Neelofur 2002)* . These evaluations also included women's experiences and satisfaction with antenatal care and childbirth in the United Kingdom. The women were mainly less satisfied with organisational aspects, the information they were receiving, discontinuity of care and the impersonal treatment at the antenatal care clinics *(Hall et al 1985; Reid & Garcia 1989; Jacoby & Cartwright 1990).*

During the 1990s research in antenatal care addressed the number of antenatal care visits, the person of the care provider, organisational aspects and screening procedures *(Heringa 1998; Villar et al. 2001; Bigirimana & Fraser 2002; Villar & Khan- Neelofur 2002).* Although currently some researchers are convinced about the value of the antenatal programmes in Western Europe in reducing maternal and perinatal mortality and morbidity, others still express doubts about the evidence of effectiveness of the model and its content *(Heringa 1998; Langer et al. 1999; Haertsch et al, 1999; Villar et al, 2001)* .

As antenatal care is a service focused on women, a search in Medline combing both " experience" and " expectations" with " antenatal care" was undertaken. It revealed no results for routine antenatal care programmes from 1996 to 2001. Women's views were studied mainly on the subject of antenatal classes and antenatal screening *(Gregg 1995, Gagnon 2002).*

In the WHO antenatal care randomised trial*(Villar et al 2001)* evaluating a new model of routine antenatal care, women's and care providers' perceptions were also assessed. Women were generally satisfied with the new model, but expressed anxieties about the change of the standard pattern of care, the need to improve the attitude of staff and the need to obtain better information about issues such as nutrition and personal health. The providers were also satisfied with the new model, but wanted to make sure that the changes in the model did not limit their clinical control. Despite the fact that *Villar et al. (2001)* state that "Antenatal care is perhaps the most common routine medical activity", *Heringa (1998)* suggests that antenatal care is more than just medical care and doctors and midwives might not always be the most adequate care providers

This study aims to evaluate the content of the programmes and its effectiveness, through analysing routine antenatal care in Europe. In the first stage of the study important aspects of antenatal care from the women's point of view were determined in order to develop a woman- constructed conceptual model of antenatal care. The preliminary results are presented in this paper.

Method

Approach

A grounded theory approach was chosen to attain the objectives of this study, because it uses a bottom up approach through inductively developing a theory grounded in everyday reality *(Strauss and Corbin, 1990)*. In this way it takes into account the many factors possibly influencing antenatal care. Although grounded theory was introduced by *Glaser* and *Strauss (1967)* collaboratively, the later years are distinguished by their controversial views about the methodological content of the approach *(Strauss & Corbin 1990, Glaser 1992, Babchuck 1997).*

Setting

Women for the interviews were recruited in three European countries; Scotland, Switzerland and the Netherlands. The localities involved were west of Scotland, the German speaking part of Switzerland and the eastern and western part of the Netherlands.

Sample

The participants were healthy women at different stages of uncomplicated pregnancies or within 6 months after giving birth. Routine antenatal care was defined as attending the normal frequency of visits as set by the health system of the country involved. The sample was thus as open as possible, so providing the largest opportunity for discovery.

The sample comprised twenty- three interviews with twenty- one women. The first sample of interviews included five women in Scotland, five women in Switzerland and seven women in the

Netherlands. The theoretical sample included three women in Scotland and three women in Switzerland. In each of these countries one of these women had been interviewed before.

Access and ethical considerations

The major ethical issues of this study are informed consent, anonymity and confidentiality. Ethical approval was obtained from the Ethics Committee of the Glasgow Caledonian University. The access to the participants in the first stage did not need additional ethical approval in any of the countries involved. All of the women gave their written consent to the researcher before the interviews took place. All papers concerning the study were translated by the researcher in the three languages used; English, German and Dutch. The translations were checked by persons living in each of the countries involved. As the researcher herself is not actively involved in maternity care, women were recruited through third persons. They were provided with an information paper about the study and asked to contact the researcher if interested.

Data collection

Data were collected through semi- structured interviews using an interview guideline as a reference. The leading interview question was " If you can determine the content of care during pregnancy yourself based on your needs and expectations, what would be important to you ?" Following this question the women were encouraged to tell their stories, during which some of the topics such as expectations at the beginning of pregnancy were introduced by the interviewer.
The data were collected in one- to- one audio- taped interviews by the researcher at a convenient place for the women in either English, Dutch or German. No woman refused the interview to be taped. Interviews lasted from 20 to 108 minutes.

Data analysis

Field notes were made after each interview describing the interview situation and the main topics of the interview. The interviews were transcribed verbatim. Identifying data were removed.
Open coding was done by line-by-line analysis*(Strauss & Corbin 1990).* The components which resulted from this analysis were examined and coded. These codes were grouped together in order to create categories. A number of different categories were identified and given a name which fitted the meaning given by the women in the interviews. Open coding was followed by axial coding with the results of the interviews of the theoretical sample in Scotland and in Switzerland, during which the existing concepts were rearranged, categories renamed and linked together.

Theoretical sampling

Based on the emerging categories from the first interviews three more interviews in both Scotland and Switzerland were carried out.

- one in-depth interview with a woman, who already had been interviewed in the first sample. The interview included including checking on the emerging categories.
- two interviews with "new" women. The first question of the interview, the leading question as described for the first sample of interviews, was put forward. During the interview the categories from the first analysis were introduced by the interviewer to see whether they fitted the experience of the women. Thus categories could be checked while new concepts still could emerge.

The role of literature

As creativity and sensitising to the emergent concepts was striven for during the time of data collection and analysis, no professional literature on the subject was consulted in order to prevent interference with the developing concepts from the interviews (*Strauss & Corbin 1990)* . Thus the professional literature described in this paper is more selective than systematically searched for.

Findings

In this section the provisional findings of the study to date are presented.
The term used for the participants of the study in this paper is "women". To ascertain anonymity a list with culturally appropriate first names was made and one was assigned to each woman. These pseudonyms have been used in this paper. In accordance with the philosophy of the grounded theory used, the translation of Dutch and German are based on the meaning of the texts (*Strauss & Corbin 1998).*

Following the first interviews four major categories emerged from all countries involved. These categories as well as the subcategories for each of the countries involved are presented in Appendix I.

Although similar categories emerged, the emphasis on each one of them was different in each of the countries. Theoretical sampling was based on these emphasised categories. In Scotland this category was "Being in control" and in Switzerland the "Relationship with the care provider", which was described as "Someone who is always there" for me. The Dutch women emphasised the social side of the care provider through "Listening" and the "Options of choice" within the health care system.

A shift in the categories occurred through the sixth and seventh interview of the theoretical sample. The emerged categories from the first interviews were connected to "Feeling responsible". In the sixth Scottish interview "Feeling in control" was mentioned as a condition of "Feeling responsible". As a condition of "Feeling in control", "Feeling sure" and "confident" were described. This was confirmed in the seventh interview. In the seventh Swiss interview "Getting certainty/ security" arose as a condition for "Feeling responsible".

As a consequence of these shifts new categories emerged for both Scotland and Switzerland:

1. Responsibility
2. Establishing a sharing trust relationship
3. Support me feeling responsible

These categories and their interdependencies are shown in Appendix II.

In the Scottish data another category emerged called “Awareness of time”. This category indicates that the first category, Feeling responsible, is a dynamic process reflecting physical and mental changes in the women as pregnancy proceeds.

The categories derived from the data analyses of the all three countries involved included similarities as well as differences. To present the all the categories for each of the countries would appear to exceed the format of this paper, so in discussion with my supervisors it was agreed on to present one main category in detail.

Responsibility

“Responsibility” as a category contains 3 subcategories: “Feeling sure” and “Feeling in control”. In order not to break the story each of the subcategories is discussed in accordance with the numbers in Appendix III.

1.1 Feeling sure

The most important concepts of Feeling sure were “ Feelings” (1.1.1) and “Knowledge” (1.1.2).
In general “Feelings” were seen by the women as the central concept in pregnancy. Most women experienced a different feeling of health in pregnancy than usual. These included feelings of physical health and mental health.

“I am less patient, and eh, I will react much more emotional concerning certain issues, that means that I think a lot more with my feelings, than I would with my head. “ (Ariane/ the Netherlands)

“That is, when I was pregnant, that was different. So now and then I did not recognise myself. You.., you should not write this down. You know, when they played the hymn of the country, I cried. I mean, when ever do I during this hymn, when this hymn, no.. really. You are different. You are just different. They are different emotions.“ (Paola/ Switzerland)

As women did not recognise themselves, because this did not seem normal to them, they felt “unsure”.

"On a certain moment I actually had a strange feeling in my belly, that was with 10 weeks, look there is so much happening with your body, that, you, you don't know, what all is happening. Then I thought, well, I don't know if everything is right, I go to the doctor, and so he helped me on my way. " (Marianne/ the Netherlands)

The women had an urge to feel sure and at ease, thus they tried to restore the balance (1.1.6). The feeling of uncertainty induced a process called "thinking", which meant going through all the subcategories of aspects that the women had available at that moment within their world (1.1.1-1.1.5), trying to make them fit together. The "thinking" process was stopped, when women perceived that they "Feel sure" (1.1.6).

"Hm, you know, sort of high blood pressure, I'm desperately going through all the possible reasons as to why I have a high blood pressure." (Jan/ Scotland)

If the women remained unsure, the "thinking process" went on. This was called "worrying" by the women. Some women tried to avoid this by consciously reducing the information they were receiving.

"Why should we worry for 2 weeks, if you tell us the results, and we get a few days, then, this is enough time to worry, why should we worry if there is maybe no increased risk." (Megan/ Scotland)

"I, for me I think, that it is best being pregnant, when you don't know anything about it. Just like.... yes, I do think so. Just no, totally no medical, totally no medical knowledge. (..) I think, it is more unburdened *(less worriesome*), that way." (Yvonne/ Switzerland)

One of these subcategories was the existential knowledge women had (1.1.2). This knowledge included cognitive knowledge, knowledge about their daily life and the family, personal experiences about pregnancy and childbirth and values, opinions, views and beliefs. Women also got knowledge through comparing their situation with stories from other women, family members and friends.

"Eh, it's a, eh, I mean, I am a farmer's daughter. Birth is a natural thing, you just.. it just happens.. You, and you just do it. And it is no.. You're not ill. You're just healthy. You're just doing what comes naturally." (Lynn/ Scotland)

"That I liked it, that my mother had the same kind of story and my elder sister, that the first birth was more difficult and the second one was easier. I noticed, that I could do something with that information." (Hannah/ the Netherlands)

Knowledge about the health and the condition of the baby was also part of this category.

"Just, I know now, that it is okay, at least that it has everything it should have." (Marianne/ the Netherlands)

New knowledge and information received through antenatal care came into "Feeling sure" again through "understanding" (1.1.2). It was knowledge that was transformed in order to transfer it to their own world and their own situation.

"Well, well, I suppose knowledge is, part of the process isn't it. You got to have knowledge. But to be able to do anything with knowledge you got to have understanding. I suppose, that is the seam to your thinking." (Jan/ Scotland)

The process of thinking also included checking on wishes the women had (1.1.3).

"Well, I wanted to hear, that my sugar level was okay. And because my sugar levels were already determined before, not during my pregnancy. " (Joelle/ the Netherlands)

In order to feel sure in her own environment relationships played a role (1.1.4) The interaction between the woman and the persons she was involved with in her world was called "sharing" of the experience.

"And also involving the husband a bit more, I think, in the pregnancy, yes. And also, the experience that certain things certainly are caused by pregnancy....yes... Something that one would not notice otherwise, or did not know, yes, and blame it on a bad mood, or that it might cause tensions. That you can laugh about it together, and say, yes, we've gone through that, or so.." (Sarah/ Switzerland)

The women wanted to feel sure in order to "make sure" or "ensure" that the baby was okay and reduce all possible risks. Thus the relationship to the child played a very important role for the women (1.1.5). They emphasised the influence of their physical and mental health on the health of the baby.

" Right, because, when it is just about my own health I can take some medicine. Then it is only about me. But now it is also about someone else. (...) Or like eating, I think, when I eat something unhealthy, it is just about me, that is, well... But now there is someone else. Responsibility. " (Rosemary/ Switzerland)

"And I myself also think that if you, being a mother, eh, worry about something, then a bit of it goes on to your child. That, that, it is within you and it nurtures your frame of mind. So.. That is the reason that I think it is important to be at ease." (Ariane/ the Netherlands)

The data showed that the relationship to the baby was established through feelings at the "perception" level of "Feeling sure", where knowledge and feelings were combined (1.1.6). Often a certain knowledge about the baby was already there.

"Well, it is also very nice to hear the heart sound, especially in the beginning, when you do not yet feel it moving, then it is really nice.„ (Barbara/ Switzerland)

"He was moving an awful lot in my stomache. I think, well, is this normal ? The first one was very quiet and this one, he was half eh.. kicking in my ribs apart." (Joelle/ the Netherlands)

The “thinking process” came full circle as this knowledge was combined again with the feelings (1.1. 6). The desired state of health reached was “ Feeling sure”, which was expressed in other terms as “Feeling relaxed” or “Feeling confident”. This was a state in which the thinking stopped. Most Swiss women called this “It is right for me”. The Dutch women “Feel at ease/ Be in peace”.

“And it if everything is working fine, or eh the heart beats etcetera. Then I have the feeling of, yeah, then I have peace. “ (Saskia/ the Netherlands)

“I suppose, again your feelings reinforce, that yes, knowledge is there, this is what happens, because of this. So... th...Or this happening, because of this and that is fine. So relax about this.” (Jan/ Scotland)

If the result of combining “Feelings” with “Knowledge” was “Feeling unsure”, often the women experienced a need; they were lacking something (1.1.7). These needs were reassurance, information about certain issues, which were important to them, sharing their experience, especially the emotional side, or empowering their attitude to get what they want. With these needs they went to antenatal care in order to feel sure afterwards (1.1.8).

“Well, that the pregnancy is kept an eye on. And if I’d like to have an ultrasound scan that that is perhaps possible. And yes, I just want them to keep an eye on it. “ (Saskia/ the Netherlands)

“I have always been looking forward to it. That, when I get home, I am a little bit further, I know exactly, what is till then, what is there, and... yes, one goes also with the expectation, that everything is in order, one is also hoping for that, and yes, I have always been happy, and thought, well, everything is fine, and, yes... “ (Verena/ Switzerland)

The results of the thinking process in “ Feeling sure” were also expectations, wants and wishes (1.1.7). These were things the women were certain about.

“I think I was really looking for, a lot of reassurance from the people looking after me. Hm, you know, and I, I think ideally, you would want to see one, or two people, throughout the pregnancy. So that, so that you feel that you don’t have to explain it all over again with every visit.” (Vanessa/ Scotland)

When women did not feel sure after antenatal care, they tried to empower themselves through searching for information on their own (1.1.9).

“I went to look for information from somebody else to get recognised or get an answer to what I felt or about what I thought I had to organise or... So I went insearch to solve it in a different way. But actually not with her. “ (Erin/ the Netherlands)

1.2 Feeling in control

"Feeling in Control" consisted of "Making your own decisions" (1.2.2) and "Being able to do what you want or perform what you have chosen for" (1.2.4). Issues which resulted from the thinking process in "Feeling sure" (1.1.6) were subjected to a decision making process. Most often the issues for these decisions in routine antenatal care were antenatal screening and the options for birth or postnatal care.

"Hmm, It is also caused by the media, one gets older herself, so it is going to play a role for you, and then I think it is also important, that it is possible to get some specific advice on it."
"And I want to choose for that, I'd like to have it in my hand, I think. Maybe it is also a bit a phenomenon of this time, but... I'd like to make a conscious choice about it. " (Hannah/ the Netherlands)

The decision making process included "thinking over" all the subcategories (1.1- 1.1.5) in Feeling sure again (1.2.1). Therefore all knowledge on the issue and the possible options are needed.

"I suppose the pregnancy, I don't know, cause it is so much slower, if you like keeping , you know, sort of, I suppose mentally sort of think problems over and eh you know, how you would like them resolved." (Jan/ Scotland)

During thinking the subcategories over, risks are determined. These risks are then weighted against each other in order to set priorities and make a decision.

"I thought, well, if there is no risk of dying, what is everyone worrying about, you know. Hm, because all the same, I didn't want to be in a situation, where I was going to put my own life at risk, cause that would be worse for Robin, than, than a bit of jealousy about this new baby. Hm, yeah. So, yeah, I think, you know, all sorts of different things, come in, come in to play." (Vanessa/ Scotland)

Some of the Scottish women describe the necessary state of mind needed to feel in control (1.2.3).

"Hm, I know what I feel, and until I see it reflected in print, hm, I can't be totally confident enough.(..)
Hm, not just in print, but with someone, other peoples' shared experience. You know, people who have seen it, done it. " (Lynn/ Scotland)

Expectations, wants and wishes, which resulted from the subcategory "Feeling sure", and issues on which decisions were made, were the topics of the subcategory "Being in control as much as possible" (1.2.4).

" So now I resolved, if it is, if it really stays in a breech position, I will no have a version, eh then it just will be a caesarean section, likely with an epidural, then my husband can also be there. And then I can have my child with me, that is what I want, that is what I think is important. " (Ariane/ the Netherlands)

Not all the women wanted to have all the control themselves. There are dimensions in the amount of control women. These are especially visible through a comparison of the countries.

"I think emotionally, eh, you know, you have to be in control of it as well. You have to be in control of your environment. And that is what is to be a pregnant mom, you just want to be in control." (Heather/ Scotland)

"Although, that was decided on by the midwife.(..) But that was actually alright. Cause, cause I had the confidence, that it would be okay." (Sarah/ Switzerland)

"I don't, I don't want the responsibility of all this being in control. Hm.."
(Nora/ Scotland)

Basically the women expressed the wish that they were supported in doing what they wanted to do. The women managed and organised the pregnancy themselves as much as possible (1.2.5).

"Well, a bit like my isle, which I am organising myself. Or something like at this moment I am having a constipation. Well, that is really difficult. And now I am considering, whether I should have a couple of meetings of, like foot reflex zone massage to stimulate the digestive system." (Lilian/ Switzerland)

As they acknowledged that there would always be unexpected situations, the women searched for someone who helped them, speak up for them, providing them with information and options and supported them feeling in control through antenatal care, (1.2.6).

"Being there to do what was necessary. Hm, if I asked. Mmmm, to be, to, to intervene if they felt I was loosing my lean, but to back off if I was doing fine." (Lynn/ Scotland)

" I think, if there, if we, if we had someone like that, a reference person, who, indeed a midwife, who maybe had said, maybe it is better that she is goes home and walk around a bit. Hm, maybe we could try it this way. At that moment I can imagine, maybe that she had be able to... Although she said he is quite stubborn and old fashioned. Yes, exactly. (...) Because she knows more about it, yes, she is stronger concerning knowledge, I think, concerning information, again. "
(Yvonne/ Switzerland)

The experience of being able to make one's own decision and being able to do what one wants are combined with the feelings again in the subcategory of " Feeling in Control" (1.2.7)

"And... there is the care again. They also give me there, the feeling that I, I can determine it myself. I like that very much. That just gives me a bit of peace." (Ariane/ the Netherlands)

If women did not feel in control of her own experience, three strategies were described (1.2.8) "balancing your wishes" or "lie down with it",

"I think as well you have to balance your wishes, your perception of how it is going to go, about the reality of how it did go and kind of come to an understanding between the two." (Heather/ Scotland)

" Also said to myself, give yourself time because eh, well, you don't have another choice. You also have to think about, the work pressure, that they have. It just can't be different, you have to lie down with it *(give up*). " (Ariane/ the Netherlands)

"empower yourself through information" or

"I'd rather be informed. I mean, I think it is like a patient, that is dying, you know, and do you tell them or not. And I, you know, most people would want to know, and, I think, better hm prepared and armed than not."
(Jan/ Scotland)

"empower yourself through person"; this could be the partner or another care provider.

" Hm, hm, which is one of Frances' role as an advocate. Hm, to speak for you. So that your wishes are known beforehand. And eh, she would discuss them with you. And you'd get it transferred over to the hospital, whatever that, and you'd still get as far as possible what you'd like." (Lynn/ Scotland)

1.3 Feeling responsible

"Feeling responsible" can be regarded as a result of collapsing of both "Feeling sure" and "Feeling in Control". Some women talked about physical and emotional ownership of the experience (1.3.1).

"And I think people need to make choices for themselves to have ownership of.. of the problem, yo, the grief whatever."
(Lynn/ Scotland)

The women talked about the responsibility they had for their themselves, their child and their environment during the pregnancy until childbirth and afterwards (1.3.2/ 1.3.3).

"Ultimately, if, if, if I have made the decisions and things go wrong, the bus stops here. Yeah.. If they have made the decision and things go wrong, how, how do you deal with that ?" (Lynn/ Scotland)

"So, just having to take the responsibility, when she would abort, because the amniocentesis."
(Lilian/ Switzerland).

Immediately after the childbirth the women were happy, that everything is physically well with the baby and themselves (1.3.4).

"Eh, the baby was fine, eh, and, well, apart from jaundice, and the suturing done at the hospital.. And.. even that wasn't a problem. And I didn't realise that was an issue until afterwards. And it kind of worked out later, you're euphoric for the birth of a new baby. Hm, and eh that was fine for about 6 months." (Lynn/ Scotland)

After a while they reflected on the experience (1.3.4). This process was part of antenatal care, as it included preparing for birth and postpartum period. Thus expectations were raised.

"So I don't know if this is quite a common thing, you go in, and you think you are going to have an epidural and I was quite hm disappointed, Ann, not to receive an epidural. Hm, so that is one thing you know, where I had to have maybe another third child, I would maybe think about going private, because an epidural was very important to me."
(Susan/ Scotland)

A lot of women expressed the need to talk the experience over postpartum (1.3.5). The possibility to do this would give them the lacking information on the experience, but also the possibility to share the experience again.

"Or also, it is not just about the burden, it is also about memories, about which, I had a feeling like, did this happen, or what did really happen there. Or, yes...." (Sarah/ Switzerland)

The results of this process of reflection were going to be a content of "Feeling sure" again, in the subcategory of "Knowledge" (1.1.2). A good experience empowered, a bad experience created more anxieties. A bad experience also empowered though (1.3.6).

"And that is why I decided now, I am now, I am going to do this quite different, now I am going to ask questions, now I will really, not thinking that I am a burden, now I am really going to demand time for me. " (Ariane/ the Netherlands)

Discussion/ Transfer to PhD stage

Current progress and limitations

This exploratory study addressed antenatal care in Europe though using a grounded theory approach in order to develop a woman- constructed model in the first stage. Twenty- three interviews were carried out in three European countries. The emergence of similar categories from each country from the first interviews seemed to indicate that one overall European model of antenatal care could be found. Theoretical sampling however not only emphasised the similar but also the divergent data for each of the countries through which the saturation of the categories could not be obtained. A bias on behalf of the researcher could be excluded as the new interviews from the theoretical sample were started with the leading interview question, which left the women an opportunity to emphasise their own topic. On the other hand a cross- cultural checking of the concepts was included in the interviews.

The main limitations of the study were organisational aspects, such as the part time mode of the study and obligations the researcher had in the remainder of time.

New knowledge

New knowledge will be created through the cross- cultural character of this study, which enriched both the study as well as opened new perspectives on women's views about care in pregnancy during this first stage of the study. An enrichment of the study was the use of different terms for describing experiences and phenomena by the women in the different countries. This was an input to think again about the meaning of a concept. Upon this the meaning of words were checked in a dictionary and a thesaurus in each one of the languages used. Thus it was discovered that for instance "feel" had different meanings in the way these expressions were used by the women. In the Swiss data "it is right" was used to make a balance between feelings and knowledge resulting in "feelings" again, the Scottish terms used did not make this clear. Thus the processes in the Scottish stories were checked again to see what actually happened. This resulted in 2 subcategories in Feeling sure (1.1.1 and 1.1.6). In this way the research itself is providing new views on the phenomena.

Although similar main categories emerged in the first stage, the Swiss women viewed the category of the "Relationship with the care provider" (Appendix II, 2) as very important , whereas the Scottish women emphasised "Knowledge" and "Information" and "Feeling in control" (Appendix III, 1.1.2). The Dutch women emphasised both the "Attitude of the care provider" in the relationship as well as the "Options" given by the system. The importance of the relationship with the care provider and decision making is marginally mentioned in the English speaking literature on evaluating women's views, the emphasis however is reassurance and providing information *(Hall et al. 1985; Reid & Garcia 1989; Jacoby & Cartwright 1990).* These preliminary results suggest an extension of knowledge about women's views and thus opening new perspectives for both the United Kingdom as well as internationally.

Future work: the theoretical framework of the second stage of the study

The findings of the first stage have identified a depth, that needs to be explored. The divergence of the data leads to the fact that women- constructed models of antenatal care have to be developed for each one of the countries involved. To attain this objective the framework of a multiple case study design will guide the second stage of the study based upon *Yin (1994)*.

As grounded theory grounds itself in the everyday reality of the subjects, it accounts for the realities experienced by the women in each of the countries involved. Within each of these cases symbolic interactionist theory will underpin data collection and analysis. Theoretical sampling will continue to drive future data sources, including interview and literature reviewing.

Further axial coding and selective coding should complete the process of developing a model of antenatal care for each of the countries involved. Through comparing and contrasting these models a theory on antenatal care in Europe can be derived.

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APPENDIX II. Categories after the theoretical sample of interviews