

## Chapter 9 Summary

This thesis contributes to our knowledge of the organization and women's views of maternity care in the Netherlands.

**Chapter 1** provides a general introduction to the thesis, which focuses on the organization and women's views of maternity care in the Netherlands, explores women's suggestions for improving and preserving (primary) midwifery care in the Netherlands and identifies factors associated with less positive experiences of maternity care during childbirth and the postnatal period.

Both positive and negative experiences of pregnancy and childbirth can have immediate and long-lasting effects on a woman's well-being and her relationship with her child. The involvement of patients and clients as active participants in health care instead of passive care recipients has increased over the past few decades, and is visible in the growing literature about informed and shared decision making and patient engagement. In recent years, in the Netherlands, there has been a lot of discussion among professionals and in the public media concerning reports that reductions in perinatal mortality were lagging, compared to other European states. A commonly aired suggestion was that the unique Dutch maternity care system with independent primary care midwives might contribute to higher than expected perinatal mortality – a suggestion that has not been substantiated. A major focus of attention in discussions among the professional groups, and in national media outlets, has been on the need for a more integrated healthcare system with fewer barriers between echelons of care.

This thesis contains the reports of studies which are built on the DELIVER study (DELIVER stands for Data Eerste Lijns VERloskunde, data on primary midwifery care), which is a large prospective cohort study in the Netherlands set up to investigate the organization, accessibility and quality of primary midwifery care. Data were collected between 2009 and 2011.

In more detail, the aims of this thesis are:

1. To understand the relation between client related factors and the experience of intrapartum midwifery care in order to give midwives insight into how they might improve the care they provide during childbirth.
2. To explore the opinion of maternity care assistants about providing continuous support during childbirth and performing additional medical tasks.
3. To explore women's perspective on support during and after childbirth including who provided the support, and the type and timing of supportive activities.
4. To develop an understanding of the uptake of maternity care assistance during the postpartum period in the Netherlands and examine which factors affected the women's rating of postpartum maternity care by maternity care assistants.
5. To explore women's ideas and suggestions about maternity care within the current maternity care model.
6. To explore what women have valued in the care they received and what they think their midwives should continue doing.

**Chapter 2** describes client related factors associated with a 'less than good' experience of midwifery care during childbirth in the Netherlands.

This study was part of the 'DELIVER study' where mothers report on the care they received. We used Generalized Estimating Equations (GEE) to control for correlations within midwife practices. Forward multivariate logistic regression analyses were conducted to model the client related factors associated with the experienced midwifery care during childbirth.

We included the responses of 2377 women. In the multivariable logistic regression model, odds of reporting 'less than good care' were significantly higher for women who experienced an unplanned caesarean birth (OR 2.21 CI 1.19-4.09), an instrumental birth (OR 1.55, CI 1.08-2.23), less control during the dilation phase (OR 0.98, CI 0.97-0.99) and pushing phase (OR 0.98, CI 0.97-0.99).

We found that birth related factors were more likely than maternal characteristics to be associated with the experience of midwifery care during childbirth. We concluded that there is room for midwives to improve their care for women during childbirth particularly in improving the patient centeredness of the care provider, using strategies to enhance sense of control and focussing on the particular needs of those who experience instrumental vaginal or unplanned caesarean births.

**Chapter 3** explores the opinions of maternity care assistants (MCAs) about continuous support during childbirth by MCAs. To explore the opinions of MCAs, four semi-structured group discussions took place and 190 questionnaires were sent out to MCAs nationally.

We found that, in both the group discussions and questionnaires, MCAs displayed positive attitudes towards providing continuous support during childbirth. Generally MCAs were not keen on adding medical tasks. The importance of a clear distribution of responsibilities between midwives and MCAs was reported. The majority of MCAs, 60%, thought midwives would appreciate MCAs providing continuous support, although 40.5% disagreed with dividing the profession into child birth care and postpartum care teams. Two thirds mentioned the need for extra training in childbirth assistance.

We concluded that, in general, MCAs were positive about providing continuous support during childbirth. The majority of MCAs think that it is unwise to give MCAs additional medical responsibilities. The opinions differ concerning issues of practical organization. MCAs generally thought extra schooling was important to be and feel competent to assist during childbirth.

**Chapter 4** aims to quantify women's preferences and preparations for support during labour and the first hours after childbirth and to quantify the specific preference for continuous support. Also the association with parity and the intended place of birth is studied. We used a cross-sectional survey. Twelve midwifery practices in the northern Netherlands recruited pregnant women. Measurements of the structured questionnaire were preparation for childbirth and preference for support (timing, including continuous support, provider and type of support). Of the 247 eligible women 205 women participated.

We found that nulliparae, significantly more often than multiparae, aimed to prepare themselves by attending prenatal classes (63% versus 21%) and by writing a birth plan (59% versus 40%). Women preferred to receive various types of support during childbirth from their partner (100%), midwife (95%), maternity care assistant (29%) and nurse (15%). The women preferred the midwife to be present from the moment the midwife (48%) or the woman herself (22%) indicates. 10% of the women preferred continuous support from 4 cm dilatation onwards.

We considered the best approach to continuous support that it should be available on request rather than being not available or being the standard care.

**Chapter 5** concerns the experiences with and amount of postpartum maternity care: Comparing women who rated the care they received from the maternity care assistant as 'good' or 'less than good care'. Our research questions are; among postpartum women in the Netherlands, what is the uptake of MCA care and what factors are significantly associated with women's rating of care provided by the MCA.

We used data from the 'DELIVER study', a dynamic cohort study, which was set up to investigate the organization, accessibility and quality of primary midwifery care in the Netherlands. In the DELIVER population 95.6% of the women indicated that they had received postpartum maternity care by an MCA in their home. We included the responses of 3170 women. To assess the factors that were significantly associated with reporting 'less than good (postpartum) care' by the MCA, a full cases backward logistic regression model was built using the multilevel approach in Generalized Linear Mixed Models.

We found that the mean rating of the postpartum care by the MCA was 8.8 (on a scale from 1-10), and 444 women (14%) rated the postpartum maternity care by the MCA as 'less than good care'. In the full cases multivariable analysis model odds of reporting 'less than good care' by the MCA were significantly higher for women who were younger (women 25–35 years had an OR 1.32, CI 0.96–1.81 and women < 25 years had an OR 1.90, CI 1.14–3.16) compared to women who were > 35 years, multiparous (OR 1.27, CI 1.01–1.60) and had a higher level of education (women with a middle level had an OR 1.84, CI 1.22–2.79 and women with a high level of education had an OR 2.11, CI 1.40–3.18) compared to women with a low level of education. With regards to the care, odds of reporting 'less than good care' were higher for women who received the minimal amount of hours (OR 1.86, CI 1.45–2.38), in their opinion received not enough or too much hours maternity care assistance (OR 1.47, CI 1.01–2.15 and OR 5.15, CI 3.25–8.15 respectively), received care from more different MCAs (2 MCAs OR 1.61, CI 1.24–2.08),  $\geq 3$  MCAs OR 3.01, CI 1.98–4.56 compared to 1 MCA) and rated the care of the midwife as less than good care (OR 4.03, CI 3.10–5.25). The odds were lower for women whose reason for choosing maternity care assistance was to get information and advice (OR 0.52, CI 0.41–0.65).

We concluded that (the postpartum) MCA care is well utilized, and highly rated by most women. We implicated that the approach to care in the Netherlands addresses the needs as outlined by NICE and WHO. Although no data exist around the impact of use on maternal infant outcomes, this approach might be useful in other jurisdictions. MCA care might be improved if the hours of MCA care were tailored, and care by multiple MCAs minimized.

**Chapter 6 and chapter 7** examined women's suggestions for improving the midwifery care in the Netherlands and their comments about what aspects of midwifery care they value in the maternity care system in the Netherlands. These qualitative studies were part of the "DELIVER" study. Clients were recruited from 20 midwifery practices. Purposive sampling was used to select the practices. The clients received up to three questionnaires, in which they could respond to the question; "Do you have any suggestions on how your midwife could improve his/her provision of care?" and "What should your midwife definitely keep doing?" The answers were analysed with a qualitative thematic content analysis, using the software program MAXQDA. We were able to derive codes, themes, main themes and an overarching concept.

In **chapter 6** 3499 answers were analysed and one overarching concept emerged: clients' desire for individualized care. Within this concept, suggestions could be clustered around 1) provider characteristics: interpersonal skills, communication, and competence, and 2) service characteristics: content and quantity of care, guidance and support, continuity of care provider, continuity of care, information, and coordination of care.

In **chapter 7**, 11437 answers, given by 6715 women, were analysed. We found that the findings from this study strengthened the thematic map developed in our earlier research that examined women's recommendations for changes to their midwifery care.

Many of the items that women value (chapter 7) were very similar to items that women identified as missing in their care (chapter 6). The finding that the results from both studies are corresponding, confirms that women have a clear ideas about what they want in their care.

We discussed that all themes derived were direct and indirect elements of person(women)-centred care. We conclude that women and their families should be served by a women-centred approach which includes; a friendly and kind attitude, client-centred communication, really listening, personal attention, taken seriously and reassuring, more information and information tailored to the person, accessibility and approachability, continuity of care and care provider and with enough time spent with the woman. These elements of value which women mentioned in our study are also shown to be important to women internationally.

We concluded that women centeredness and women's perspectives should play a crucial role in defining the current development of maternity care in the Netherlands. As policy changes are made to incorporate integrated care, efforts must be made to ensure that care continues to be individualized in keeping with the wishes of Dutch women. Discussions and research around the organization of care are still ongoing and women should be involved more prominently as well as their suggestions and perceptions.

## **Chapter 8 General discussion**

The vast majority of women were satisfied with the antenatal, intrapartum and postpartum care they received from midwives and maternity care assistants. Women's good assessments of the postpartum care by maternity care assistants is noteworthy in particular because internationally postpartum care is generally given a lower rating than other periods of maternity care.

Women in the Netherlands would benefit from an improvement of care focusing on: woman (person)-centeredness and woman (person)-centred communication; individualized maternity care; extra time spent per person; continuity of care and maternity care provider; and experienced control.

We conclude that a woman-centred approach should include: a friendly, kind, involved approach, client-centred communication, really listening, personal attention, being taken seriously and reassuring, more information and information tailored to the person, accessibility and approachability, continuity of care and care provider and with enough time spent with the woman.

We consider the best approach to continuous support is that it should be made available on request by the labouring woman. Women favour their midwife (and partner) for support. Additional training could be offered for maternity care assistants in order to be and feel competent to assist in childbirth (although not to provide continuous support).

In order to achieve the improvements of care as described above the current maternity care model could be reconsidered and the midwifery caseload might have to be adjusted downwards.

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