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Experience 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'

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ABSTRACT

Objective: The postpartum period is an important time in the lives of new mothers, their children and their families. The aim of postpartum care is 'to detect health problems of mother and/or baby at an early stage, to encourage breastfeeding and to give families a good start' (Wiegers, 2006). The Netherlands maternity care system aims to enable every new family to receive postpartum care in their home by a maternity care assistant (MCA). In order to better understand this approach, in this study we focus on women who experienced the postpartum care by the MCA as '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. Design and setting This study uses 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. Participants 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.

Measurements and findings: 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.

Findings: 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 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). Odds of reporting 'less than good care' were higher for women who, received the minimum amount of hours (OR 1.86, CI 1.45-2.38), in their opinion received not enough or too many 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 two or more different MCAs (2 MCAs OR 1.61 CI 1.24-2.08, ≥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 of reporting 'less than good care' 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).

Key conclusions: We conclude that (the postpartum) MCA care is well utilised, and highly rated by most

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women. Implications for practice:The approach to care in the Netherlands addresses the needs as outlined by NICE and WHO. Although no data exists 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 minimised.

Introduction

The postpartum period is an important time in the lives of new mothers, their children and their families. It is a time of changes, transitions and emotions (Shaw et al., 2006). The aim of postpartum care is 'to detect health problems of mother and/or baby at an early stage to encourage breastfeeding and to give families a good start' (Wiegers, 2006). Internationally, women's evaluation of postpartum care has consistently been more negative than their rating of other episodes of maternity care. Despite such evaluations postpartum care is often given low priority in research and practice (Rudman and Waldenstrom, 2007; Morrow et al., 2013*)* From the perspective of both postnatal women and care providers increasing concern has been expressed regarding postnatal care provision while at the same time there has been a lack of evidence to guide developments in postpartum care (Rudman and Waldenstrom, 2007; Bick et al. 2011; Morrow et al., 2013). The importance of professional postpartum care is described in the World Health Organisation and United Nations Children's Fund (WHO/UNICEF) standard as well as in the National Institute for Health and Care Excellence (NICE) guideline and the NICE quality standard (WHO/UNICEF 2009; NICE, 2013). In their joint statement WHO/UNICEF recommend home visits by qualified care providers in the baby's first week of life based on studies showing that home-based new born care interventions can prevent 30–60% of new born deaths in high mortality settings under controlled conditions. The NICE guideline is one of the few guidelines that covers routine postpartum care for the mother and infant (Haran et al., 2014). In high-income countries some studies have shown postpartum home visits to be effective in improving breastfeeding rates and parenting skills (Avellar and Supplee, 2013; Shaw et al., 2006). A Cochrane review (2013) concluded that, although postpartum home visits may promote infant health and maternal satisfaction, the evidence was inconsistent and that the frequency, timing, duration and intensity of postpartum care visits should be based upon local needs (Yonemoto et al., 2013).

The care provided in the postpartum period differs across jurisdictions and maternity care models, in terms of duration of postpartum hospital stay, frequency and number of home visits as well as care provider qualification (Bick et al., 2008; Schmied and Bick, 2014).

The Netherlands' maternity care system aims to enable every new family to receive postpartum care in their home (Stuurgroep zwangerschap en geboorte, 2009). In the Netherlands 13% of the women give birth at home and 87% in hospital or a birth centre following which they will usually return home within a few hours (Stichting Perinatale Registratie Nederland, 2015). At home the new family receives care from a team of a midwife and maternity care assistant (MCA). A primary care midwife will visit the family 3–5 times (or more when necessary) in the first 8–10 days after birth. The MCA provides care (3–8 hours per day) up to 8 to 10 days after birth (Wiegers, 2006). Every year nearly 170,000 women give birth in the Netherlands and an estimated 90% of those families receive postpartum maternity care assistance in their home. The MCAs also assist midwives during births at home, and increasingly in hospital and birth centres. The MCA provides the mother, her partner and child with practical care, support, instruction and guidance during and after childbirth (Teijlingen van, 1990; Wiegers, 2006). The MCA has a role in assessing and screening for complications and when a complication occurs or threatens to occur, will contact the midwife who will assess the woman and/ or child and make appropriate referrals to secondary care for a consultation or admission to hospital (Teijlingen van, 1990; Wiegers, 2006). "An MCA, unlike a midwife, will be with the family for an extended period. The advantage of this is that information and education is embedded in the daily activities and therefore more easily understood and accepted, health care and psycho-social care are indissolubly intertwined. The timely detection of symptoms that may lead to health problems later will help reduce readmissions rates and thereby reduce costs (Wiegers, 2006). Another advantage is that with the help of a MCA mothers may have more opportunity to will rest thus ameliorating tiredness and fatigue, which are described as the most common problem affecting new mothers. (Schytt et al., 2005; Badr and Zauszniewski, 2017)."A possible disadvantage is that it increases health care costs. However, the availability of maternity care assistance makes home birth and early discharge after hospital birth possible, thereby reducing health care costs. In the Netherlands the care in the postpartum period is substantially less studied compared to the care in the prenatal and intrapartum period with little research related to women's ratings of the care by MCAs. The approach to care in the Netherlands appears to address the needs as outlined by NICE and WHO, however before other health care systems could consider using an approach that would include an MCA, it is useful to evaluate more carefully the organization of and experience with postpartum care, including the care provided by the maternity care assistants, in the Netherlands. In this study, we focus on women who experienced the postpartum care by the MCA as 'less than good' care.

The purpose of this study was twofold: first, we were interested in getting a better understanding of the uptake of maternity care assistance during the postpartum period in the Netherlands; and second, we investigated which factors affected the women's rating of postpartum maternity care by the MCA. Our research questions were: (1) among postpartum women in the Netherlands what is the uptake of MCA care and (2) what factors are significantly associated with women's ratings of care provided by the MCA? To address the latter, we compared women who rated care they received by the MCA as 'good' and 'less than good care'.

Postpartum care by Maternity Care Assistants (MCAs) in The Netherlands

1. MCA education: 3 year senior secondary vocational education (without experience or previous relevant education)
2. In general, women sign up for MCA at the end of the first trimester of their pregnancy.
3. Every person in the Netherlands is statutorily insured for health care costs and MCA is included in the basic health care package that is available for everyone.
4. A co-payment of 4.15 euro per hour is required (in 2016) for postpartum maternity care assistance, for which people can take out an additional insurance.
5. The standard for postpartum maternity care assistance is 49 hours in 8 consecutive days, beginning at the day of birth. The legally defined minimum is 24 hours in up to 8 days and the maximum is 80 hours, in a period of 10 days.
6. Because MCA is care to be provided at home (or in a home-like environment), for each day spent in hospital after giving birth one eighth is deducted from the agreed upon number of hours, based on the notion that during their hospital stay they also receive postpartum care, not from an MCA, but from an obstetrical nurse. This was meant to encourage women with an