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Swedish women's interest in models of midwifery care – Time to consider the system? A prospective longitudinal survey

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ABSTRACT

Background: Sweden has an international reputation for offering high quality maternity care, although models that provide continuity of care are rare. The aim was to explore women's interest in models of care such as continuity with the same midwife, homebirth and birth center care.
Methods: A prospective longitudinal survey where 758 women's interest in models such as having the same midwife throughout antenatal, intrapartum and postpartum care, homebirth with a known midwife, and birth center care were investigated.
Results: Approximately 50% wanted continuity of care with the same midwife throughout pregnancy, birth and the postpartum period. Few participants were interested in birth center care or home birth. Fear of giving birth was associated with a preference for continuity with midwife.
Conclusions: Continuity with the same midwife could be of certain importance to women with childbirth fear. Models that offer continuity of care with one or two midwives are safe, cost-effective and enhance the chance of having a normal birth, a positive birth experience and possibly reduce fear of birth. The evidence is now overwhelming that all women should have maternity care delivered in this way.
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Background

In Sweden there are few alternatives to highly medicalized hospital births. Options such as continuity of midwife caregiver, homebirth and birth center care are not offered by the health services. A previous national survey conducted more than 10 years ago showed that, when asked in early pregnancy, a majority of women (52%) preferred continuity in terms of having a known midwife at birth, 23% were interested in birth center care and 5% in homebirth [1].

Continuity with the same midwife during all episodes of care from pregnancy to labor and birth, and the postpartum period is uncommon in Sweden. In some parts of the Western world such continuity is provided by teams of midwives or in caseload models [2]. A recent Cochrane review comprising 15 studies with more than 17,000 women, with and without increased risk for complications, concluded that most women should be offered midwife-led continuity models of care. The result of the review clearly demonstrated a lower use of interventions, a higher rate of spontaneous vaginal births and higher satisfaction with care [2].

The difference between team midwifery and caseload midwifery is the number of midwives taking care of the woman and the level of continuity of carer the woman can expect to receive Team midwifery usually consists of 6–10 midwives who work on a rostered system to care of larger numbers of women than occurs in case load models. Case load midwifery is usually one midwife being responsible for a small number of women (3 to 4 per fulltime midwife per month) who provides all care during pregnancy, birth and postpartum [3]. The caseload midwife usually has one or two partners who cover the caseload midwife's free time and holiday leave [4,5]. The likelihood for meeting a known midwife at birth is 87–89% in these models [4,5]. Usually such models of care are offered only to women of low risk for complications [4,6], but a recent trial included women of any risk [5].

Homebirths are rare in Sweden. In a national survey of homebirths conducted 1992–2005 only 1 in 1000 births occurred at home [7], although the national survey showed an interest 10 times higher [1]. If a woman wants to have a homebirth in Sweden she has to arrange it herself by finding a midwife willing to assist. The women have to pay for the homebirths themselves, as most midwives work in other places and assisting at homebirth occurs outside

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their regular working schedule. In the capital area of Sweden multiparous women with a previous uncomplicated birth could have a homebirth subsidized from the county council, if they fulfill the criteria and can find two midwives willing to assist [7]. Women who actually gave birth at home in Sweden during the same period were characterized by being older than 35 years, multiparas, born in a European country outside Sweden and were mostly living in the capital area [8].

Birth center care was introduced in the US around 1970 as an alternative to home birth and hospital birth [9]. This trend followed on in many countries such as UK and Australia the following decades [10,11]. In Sweden the first birth center opened in 1989 in Stockholm and was evaluated in a randomized controlled trial showing increased maternal satisfaction [12]. During the same period a modified birth center was opened in Gotenburg, but closed down after some years. In the Stockholm birth center a home like atmosphere was offered, and medical technology usually limited. Parents were actively involved in the care [13]. The birth center has however, been modified due to the increase in perinatal mortality for babies born by first time mothers found in the previous trial [13]. This led to restricted inclusion criteria of women of low medical risk only, electronic fetal monitoring at admission and intermittent during labor, and application of the same guidelines as in standard intrapartum care [14].

Problem area

There is strong evidence that midwifery-led models of care could benefit women in terms of lower rates of interventions and higher satisfaction. Women's interest in such models of care in Sweden is fairly under investigated. The aim of this study was to explore prospective and new mothers' interest in continuity with the same midwife, homebirth and birth center care, in a region where these models are not offered. An additional aim was to explore if the interest in these models of care changed over time.

Methods

Design

A Swedish prospective longitudinal survey in which women were recruited in mid pregnancy and followed up at three points in time (late pregnancy, 2 months, and 1 year after birth). For the purpose of this study, we identified women who completed all three follow up questionnaires. The study was approved by the regional ethical committee (dnr 05–134). The purpose of the regional study was to address questions relevant to the childbearing population in the region, in order to improve the maternity services. A detailed description of the project is found elsewhere [15].

Recruitment

Participants came from a one-year cohort of pregnant women who were booked for routine ultrasound screening offered to all pregnant women in gestational weeks 17–19. The recruitment took place during the whole year 2007 at three hospitals in the mid-north part of Sweden. The region covers both rural parts and middle-sized cities and the annual birth rates in the three regional hospitals were 1600, 550, and 350 respectively. All participants had to be able to communicate in Swedish and were invited by the midwife who carried out the ultrasound examination. Participating women signed a consent form and was given the first questionnaire at the ultrasound ward. These could be filled out on site or taken home and returned in a pre-paid envelope. Two letters of reminder were sent to non-responders after two and four weeks respectively. The follow-up questionnaires were sent to the participants' home address, in gestational weeks 32–34 (questionnaire II), at two months (questionnaire III) and at one year (questionnaire IV) after the birth. Similar reminder procedures were performed on all questionnaires. The two month post birth questionnaire was sent out to all women who completed any of the questionnaires delivered during pregnancy. The one year follow up questionnaire however was only sent to those who had completed all three previous study packages.

Measures

Outcome variables

Questions about women's interest in alternative models of midwifery care were worded "Which of the following models of care would you be interested in?" with the response alternatives:

- The same midwife throughout antenatal, intrapartum and postpartum care
- Homebirth with a known midwife
- Birth center care (which included the description: "antenatal and intrapartum care in a homelike environment with a team of midwives and where natural birth is promoted and medical technology is limited").

There was no rating of the options and the respondents could choose several options by ticking the alternatives of interest. There was also one option labeled "hospital birth". In the analysis the preferred options were coded =1 and if not preferred = 0.

Explanatory variables

Background data were collected in mid-pregnancy and included information about age, number of children, marital status, country of birth, and level of education. In addition, birth preference (vaginal birth or caesarean section) and fear of childbirth, using the cut of point of 60 on the FOBS-scale [16] were used as explanatory variables. Two months and one year after birth the relationship between birth related data (mode of birth, birth complications, birth experience) and care related data (satisfaction with antenatal and intrapartum care) and interest in the alternative models of care were also investigated. The birth experiences as well as the satisfaction variables were assessed on a five point Likert scale ranging from 1 (very positive/very satisfied) to 5 (very negative/very dissatisfied), and for the analysis dichotomized into positive/satisfied (1 + 2) versus less than positive/less than satisfied (3–5).

Analysis

Descriptive statistics were used in presenting the data. To assess changes in interest in models of care over time, Friedman's test was applied [17]. Differences between participants who had an interest in a certain model of care versus those without such interest were calculated by χ^2 test and Risk Ratios (RR) with 95% Confidence Intervals (CI) were estimated using Mantel–Haenszel's method [18],. SPSS version 21 was used for the statistical analysis.

Results

The sample consisted of 758 women who completed all four questionnaires in the longitudinal cohort study. The majority of the women were 25–35 years old, cohabiting, and born in Sweden. Just under half of the sample was expecting the first baby and the majority had at least high school level of education (Table 1).

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