



Vulnerable pregnant women in antenatal practice: Caregiver's perception of workload, associated burden and agreement with objective caseload, and the influence of a structured organisation of antenatal risk management

Nynke de Groot, MSc (Researcher)^{a,*}, Angélica A. Venekamp, MSc (Research Associate)^b,
 Hanneke W. Torij, MSc (Associate Professor Midwifery & Childbirth)^b,
 Mijke P. Lambregtse-Van den Berg, MD, PhD (Psychiatrist and Child- and Youth
 Psychiatrist)^c,
 Gouke J. Bonssel, MD, PhD, MPH (Professor in Perinatal Care and Public Health)^a

^a Department of Obstetrics and Gynecology, Division of Obstetrics & Prenatal Medicine, University Medical Centre Rotterdam, P.O. Box 2040, 3000 CA Rotterdam, The Netherlands

^b Rotterdam University of Applied Science, Center of Expertise Innovations in Care, P.O. Box 25035, 3001 HA Rotterdam, The Netherlands

^c Department of Psychiatry, University Medical Centre Rotterdam, P.O. Box 2040, 3000 CA Rotterdam, The Netherlands

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ABSTRACT

Introduction: pregnancy care for vulnerable women is often perceived as a burden by caregivers as vulnerable clients require complex case management, additional time, and more often show adverse perinatal outcomes. Vulnerable clients bring about additional work strain for the caregiver, especially when the workload is high. We define client vulnerability as coexistence of psychopathology, psychosocial problems or substance use, together with features of deprivation. We investigated, as part of a national programme, whether the subjective caregiver's perception of workload and the objective registry-based caseload of vulnerable clients are in agreement, and whether a structured organisation of antenatal risk management reduces the burden associated with the perceived workload, in particular if the objective caseload is high.

Methods: we combined three data sources: (1) at the unit level (i.e. midwifery practice, obstetric unit) interview data from caregivers, from which we derived a) the (subjective) caregiver's perception of workload, b) the associated burden and c) organisational structure of antenatal risk management, (2) at the unit level perinatal registry data, from which we derived a) unit characteristics and b) (objective) unit specific caseload, and (3) at the individual client level survey data collected during the first antenatal visit, from which the prevalence of vulnerable clients was derived. The study area was the South-West Netherlands (2.5 million inhabitants), containing areas with varying degrees of urbanisation and deprivation.

Findings: sixteen units had complete data on all measures. Generally, subjective workload and objective caseload were only weakly related, the relation being modified by the organisation of antenatal risk management. If the organisational structure of antenatal risk management was low, the experienced burden was high, even if the objective caseload was low. Highly structured antenatal risk management was associated with a medium to low burden.

Discussion: our observational study suggests that even a high caseload can be dealt with by structured antenatal risk management. A change from the current individual case-finding policies towards a more universal screen-like approach may thus benefit both the client and the caregiver.

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* Corresponding author.

E-mail addresses: n.degroot@erasmusmc.nl (N. de Groot),
a.a.venekamp@hr.nl (A.A. Venekamp), h.w.torij@hr.nl (H.W. Torij),
mijke.vandenberg@erasmusmc.nl (M.P. Lambregtse-Van den Berg),
g.bonsel@erasmusmc.nl (G.J. Bonssel).

Introduction

Vulnerability is increasingly recognised as key determinant of care processes and outcome (Grabovschi et al., 2013). We define

vulnerability as a dynamic concept; it reflects the personal susceptibility to adverse outcomes, in particular health and health-related outcomes, due to the presence of a reinforcing set of personal and environmental risks often related to deprivation. According to the World Health Organization (WHO), the decrease of vulnerability may be the foremost means to achieve Universal Health Coverage (UHC) in health care systems of developed and underdeveloped countries; this justifies prioritisation of health policies in charge of this decrease (Sridhar et al., 2015). This particularly applies to the care for pregnant women and newborns (UN Secretary-General, 2010; World Health Organization, 2008, 2015).

In perinatal care, vulnerability is a major factor in the development of inequalities in maternal and perinatal health (De Graaf et al., 2013a; National Institute of Clinical Excellence, 2014; Quispel et al., 2014). This is also true in developed countries such as the Netherlands. A 2010 report of the Dutch perinatal system showed unexpected high levels of mortality and morbidity as compared to European standards (EURO-PERISTAT Project et al., 2008). Additionally, impressive health inequalities exist between deprived and non-deprived areas, in particular in large cities (De Graaf et al., 2013b). Detailed analysis showed a considerable contribution of professional performance factors in this context (Bonsel et al., 2010; Stuurgroep Zwangerschap en Geboorte, 2011; Poeran et al., 2015). These findings were unexpected in view of the national prosperity and the well-developed care system, claimed to be equitable (Flood, 2010).

Several initiatives, among which national and regional programmes, were launched to improve outcomes in specific parts of The Netherlands. Professional organisations accepted co-responsibility in this regard (Denktaş et al., 2012). They emphasised a high workload and associated burden is involved in providing due care to vulnerable clients, in particular during the antenatal stage. Current reimbursement schemes do not provide incentives for extra preventive efforts nor addressing non-medical factors, both of which are experienced as barriers towards improvement (Poeran et al., 2012).

A nation-wide research programme instituted so-called regional consortia of professionals, academia and others, where each consortium defined its specific regional target. The Regional Perinatal Consortium South-West Netherlands (RPCSWN) in 2013 defined as its target the improvement of perinatal outcomes among the most vulnerable women (ZonMw, 2014). This regional prioritisation rested on the high regional prevalence of vulnerability-related adverse outcomes and the high experienced burden of care for vulnerable clients (Bonsel et al., 2010; De Graaf et al., 2013b; Quispel et al., 2012, 2014; Vos et al., 2014). This high prevalence relates to the presence of two adjacent, highly urbanised areas (the Rotterdam region, and Dordrecht city area). Frequently more consulting time was reported to be required, as were interventions by other medical specialists, social workers and preventive services: comorbidity treatment, household support regarding finance and occasionally domestic violence (Mejdoubi et al., 2015), educational arrangements in teenage pregnancies, STD treatment, and the reduction of tobacco, drug, and/or alcohol addiction.

The RPCSWN project empirically compared the subjective workload and the associated burden of care provision induced by vulnerable pregnant women. The perspective was the experience of the caregivers (midwifery practices, obstetric units in hospitals), while the caseload defined by objective client-derived criteria. With interview information from the caregivers we established the degree to which antenatal risk management was structured, e.g. by the routine use of checklists and standardized risk-protocols.

We hypothesised that a) higher urbanisation would be associated with a higher proportion of vulnerable clients. We further

hypothesised that b) the subjective caregiver's perception of workload as emerging from formal interview data with midwives and gynaecologists is in agreement with objective count data on vulnerable clients ('caseload'; medical record information) attending their practices; and c) that a highly structured organisation of antenatal risk-management reduces the experienced burden, in particular if the caseload is high. Standard checklist screening plus follow-up is a defining feature of a structured organisation.

Except for about 15% of women with high initial risk attending the gynaecologist, midwives are responsible for initial antenatal care in the Netherlands. Apart from some tests (early ultrasound, blood group typing, STD), history taking and risk assessment is not standardized and does not include routine consultation of a gynaecologist. This situation is at the core of the current debate on Dutch maternity care reform. If our hypothesis on burden reduction appeared true, this would add support to current experimental programmes, which introduce highly structured care right at the start of prenatal care (Vos et al., 2015a, 2015b).

Methods

General

This study is part of a large, governmentally funded regional study introducing structured care for vulnerable pregnant women within the region of the South-West Netherlands (about 80 midwifery practices and obstetric units). Part of the study design is the foundation of an intermediary organisation (RPCSWN, see below). The paper here combines, at the unit level, data from three sources: interview data from regional caregivers (2013–2015; for this paper restricted to caregivers from midwifery practices and obstetric units), perinatal registry data from Perined (The Netherlands Perinatal Registry) which is complete at the national level (The Netherlands Perinatal Registry, 2014), and survey data from a cohort of clients from each unit (2014–2015). Consequently we speak about units (midwifery practices and obstetric units) and clients as participants.

Vulnerability

Vulnerability is a concept used in the public domain and research, in the social, economic and medical sciences (Aday, 1994; Rogers, 1997; Gobbens et al., 2010; Poeran et al., 2013). In sociological and economic research traditions, the concept is typically defined at the aggregate (group, area) level; in the clinical and psychological domain, vulnerability is defined at the individual level ('risk factor'). Both levels contribute to adverse outcomes such as intra-uterine growth retardation (postnatally reflected as small-for-gestational-age) and stillbirth. Growth retardation (measured as SGA) is a strong co-factor in the occurrence of stillbirth and mortality during birth. For this reason both SGA and stillbirth have their own merits in perinatal inequality analysis.

To obtain an operational definition of vulnerability, we distinguish between two pathways to adverse outcome (say, illness): the pathway to becoming ill and the pathway of recovery once being ill.

Both pathways encompass aggregate and individual level factors such as living in a deprived neighbourhood, local availability of health care services, educational level, manifest problems (such as substance use) and uptake of preventive or curative health care services.

However, where vulnerability is usually based on the concept of risk accumulation (Timmermans et al., 2011), we emphasise the circularity and reinforcement of risk factors. Vulnerability then

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