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Caseload midwifery for women with fear of birth is a feasible option

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ABSTRACT

Objective: Continuity with a known midwife might benefit women with fear of birth, but is rare in Sweden. The aim was to test a modified caseload midwifery model of care to provide continuity of caregiver to women with fear of birth.

Methods: A feasibility study where women received antenatal and intrapartum care from a known midwife who focused on women's fear during all antenatal visits. The study was performed in one antenatal clinic in central Sweden and one university hospital labor ward. Data was collected with questionnaires in mid and late pregnancy and two months after birth. The main outcome was fear of childbirth.

Result: Eight out of ten women received all antenatal and intrapartum care from a known midwife. The majority had a normal vaginal birth with non-pharmacological pain relief. Satisfaction was high and most women reported that their fear of birth alleviated or disappeared.

Conclusion: Offering a modified caseload midwifery model of care seems to be a feasible option for women with elevated levels of childbirth fear as well as for midwives working in antenatal clinics as it reduces fear of childbirth for most women. Women were satisfied with the model of care and with the care provided.

Introduction

There is strong evidence that continuity models care, such as caseload midwifery, is beneficial for women and birth outcome and is labelled 'best practice' and should be offered to all pregnant women [1–3]. Working in caseload models has also shown to be safe, satisfying and sustainable [4] as midwives are likely to stay in the profession [5–6]. Research from Sweden shows that more than half of women in population-based studies prefer continuity with a known midwife throughout all episodes of care [7–9]. Women who prefer continuity of a known midwife are often younger than 25 years, first time mothers and have fear of birth [7–8].

Swedish maternity care is funded by taxes and offered to all citizens and asylum seekers. The primary health care in the community serves women during pregnancy with the midwife as the primary caregiver. During a normal pregnancy women usually meet the midwife during 6–9 check-ups. Prenatal education is offered to first-time parents and private antenatal clinics could offer additional birth preparation courses. If any problem occur during a pregnancy the women are referred to an obstetrician for consultation. Intrapartum care usually takes place in hospitals, there are few alternative birth settings and only 1/1000 give birth at home. Hospital based midwives are responsible for normal labor and birth and work in collaboration with obstetricians when needed. Postnatal stay in hospital is usually short with follow up visits for the mother (usually by a midwife working in the postnatal ward) and pediatric examination of the baby in hospital. In some hospitals midwives might rotate between the labor ward and the postnatal ward, but it is unusual that midwives rotate between antenatal care and hospital based care. Women are also offered a follow up visit to their antenatal midwife 6–12 weeks after birth [10].

Hence, the fragmented care during pregnancy and birth in Sweden affects the majority of women. Usually the continuity during pregnancy is good, with 85% meeting only 1–2 midwives during antenatal care [11]. However, continuity of caregiver between pregnancy and birth is uncommon in Sweden. The trend in Sweden has been to close down smaller birthing units, and most of the few alternative models of care offered in large cities have been closed, giving no choice for women rather than large scale, highly medicalized labor wards [9]. One outcome of this change in options is that midwives are leaving the profession due to stress and lack of opportunities to provide high standard care [12–14]. Overcrowded labor wards and lack of midwives calls for alternatives that could bring midwives back to the profession.

Caseload is the model of midwifery care that has high evidence in terms of less medical interventions, high satisfaction [1–3] and a model

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that makes midwives stay in the profession [5,6]. Caseload midwifery usually refers to a model of care when all antenatal, intrapartum and postpartum care is provided by one midwife who work in partnership with a co-midwife [1–6].

The worldwide prevalence of Fear of childbirth has been estimated to around 14% [15]. It is also common in Sweden with 6–10% suffering from severe fear of childbirth, despite the lack of consensus regarding the standard criteria of definition [16]. However, treatment of fear of childbirth consumes a large proportion of the hospital resources available in Sweden [17] in terms of counseling teams for fearful women. The organization of the counseling differs between hospitals [18], and there are only few recommendations for how the counseling should be provided. In 2004, the Swedish Society of Obstetrics and Gynecology published a report that recommended that women with mild fear should be taken care of by the antenatal midwife in primary care, specially trained midwives in hospital should offer women with moderate fear counseling, and women with severe fear/caesarean section request should see an obstetrician [16]. There are no recommendations how to identify or categorize levels of fear and only a few hospitals use screening instruments [18]. Currently the most dominant instruments in research is the Wijma Delivery Expectancy Questionnaire (W-DEQ) consisting of 33 items [19] and the Fear of Birth Scale (FOBS), with two items [20,21]. FOBS was developed to address the critique of W-DEQ regarding length and cultural transferability as well as practical issues when used in clinical practice where there was a call for a simple instrument to use as a screening tool.

Several attempts to treat childbirth fear are available internationally, such as group psycho-education with relaxation [22], cognitive psychotherapy [23], short psychoeducation intervention [24], counseling with midwives [18], internet cognitive behavioral therapy [25] and crisis oriented therapy [26]. One pilot study of 14 women with severe fear of birth evaluated the significance of continuous support by a specially assigned midwife working at the labor ward concluded that fearful women might benefit from continuous support [27]. In addition, a qualitative interview study with 13 women with fear of birth who received team-midwifery care showed the importance of the midwife when it comes to reducing fear of birth. Some women reported the importance of a *known* midwife who knew them and guided them through labor and birth [28].

Based on previous evidence based research, continuity of midwife caregiver could be a means to create security for women with childbirth fear. The aim of this feasibility study was to test a modified caseload midwifery model of care to provide continuity of caregiver to women with childbirth fear and to test whether continuity of care reduced fear of birth. An additional aim was to study women's experiences of birth and the care received.

Methods

Design

A feasibility study of pregnant women with childbirth fear who were offered a modified caseload continuity midwifery model of care by midwives working full-time at an antenatal clinic in Sweden.

Context

The antenatal clinic where the women were enrolled is situated in a large university city with short distance to the hospital. The clinic serves around 700 pregnant women a year, is privately run but has an agreement with the government and is free of charge. In total there are 11 midwives employed at the clinic. The antenatal clinic pays for one midwife position at the labor ward and the midwives take turns on that position, usually two or three midwives are present on the labor ward each week. This initiative came from the private clinic in order to keep the midwifery skills updated and increase the opportunity for women at their clinic to actually have a familiar face at the labor ward. The clinic follows the national guidelines for antenatal care which recommends 7–9 visits during a normal pregnancy. In addition to the antenatal visits the clinic offers courses e.g. psycho-prophylaxis classes, and baby massage. These courses are not part of the standard visiting schedule and paid for by the parents.

Participants

Women with a score of 60 or more on the Fear of Birth Scale (FOBS) [20,21] (indicating fear of birth) during a screening procedure at the booking visit, were invited to participate if they had the expected due date within the selected periods (two weeks in autumn 2016 and two weeks in spring 2017), a normal ultrasound examination and could manage the Swedish language. Oral and written information was provided and women who fulfilled the inclusion criteria signed a consent form.

Procedure

Women who consented to participate followed the standard visiting schedule for antenatal care. In addition, they were offered one extra visit in gestational week 25 and they were invited to join the psychoprophylaxis course free of charge. The women were assigned a named midwife whom they met during most antenatal visits. The midwife had a co-midwife that shared the on-call shifts, and the women had at least one visit to the co-midwife and both midwives were present at the standardized appointment in gestational week 36 when a summary of the pregnancy and a plan for the birth and the postpartum period, based on the women's needs, were performed. The midwives were told by the research team to focus a lot on women's childbirth fear during all visits and to discuss women's feelings, causes of fear and coping strategies. No specific training for counseling was provided as there is a diversity of how to perform the counseling, as was shown in the national survey [18]. If women had specific needs for psychiatric treatment they were referred to the hospital.

During two periods, in November 2016 and April 2017 two midwives in each period were on call between 7 am and 10 pm every day two weeks before and after women's expected due date. The women were informed to contact the midwife on call when labor started (7 am–10 pm). The midwives could make home visits to assess the onset of labor, or they could meet up with the woman at the labor ward. The midwives worked in the antenatal clinic Monday to Friday also when they were on call. They were on call every other day, also during weekends in the selected periods. If a woman got into labor and the midwife on-call had other booked visits, these women were taken care of by another midwife at the antenatal clinic or were re-scheduled to another visit with her primary midwife.

The midwife on call was assisting the woman at the labor ward no longer than 10 h, (due to work hour regulations) thereafter the standard care hospital staff provided the care. If a woman were admitted during nighttime, the antenatal midwife or the co-midwife (depending on who were on call) was called in the morning, came into the labor ward, and provided the care from 7 am.

Data collection

A screening procedure was performed and women who fulfilled the inclusion criteria were, after returning the consent form, sent the first questionnaire in gestational week 25 (baseline) with a prepaid envelope. The remaining questionnaires (in late pregnancy (gw 36) and two months after birth) were sent to the women's home addresses. Two reminders were sent to women after two and four weeks respectively.

The baseline questionnaire included questions about socio-demographic and obstetric background, questions about emotional wellbeing such as anxiety and depression, experiences of previous encounters