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Chapter 7

General discussion



The focus of this thesis has been the current organisation of midwifery care in the Netherlands and perceptions of midwifery care organization in relation to potential changes to the organisation of midwifery care. In this thesis we sought and identified components of care organisation, which are likely to be conditional for successful collaborative midwifery practice in the future. The first part has been concerned with how midwives currently experience their profession and approaches midwifery from a human resource management perspective and has been particularly concerned with job satisfaction among primary care midwives and their potential intention to leave their job in primary care. The second part explored the nature of the work undertaken by Dutch primary care midwives within the contemporary echelon system, including their workload and their collaboration with other maternity care providers. The third part explores perspectives on the organisation of midwifery care from final year midwifery students (soon-to-be professionals).

The following studies were undertaken to address our aim of investigating midwifery care organization in the Netherlands:

1. To gain an understanding of how primary care midwives feel about their work and investigate factors associated with job satisfaction of primary care midwives in the Netherlands (chapter 2).
2. To examine the career plans of primary care midwives and their intentions to leave their current job (chapter 3).
3. To present data about the work and workload of primary care midwives in the Netherlands in 2010 and to compare these with data from 2001 and 2004 from an earlier study (chapter 4).
4. To assess the differences in how primary care midwives experience satisfaction when collaborating with other maternity care providers and the relationship between the primary care midwives' 'satisfaction with collaboration' and midwives' work-related and personal characteristics, attitudes towards their work and collaboration characteristics (chapter 5).
5. To explore student midwives' perceptions regarding the organisation of maternity care and alternative maternity care systems (chapter 6).

Before discussing the findings of this thesis in their broader context, and their implications for practice, policy and education, we will first summarise the main findings again from each of the studies.

Aim 1 (Chapter 2): We found that, in general, most of the participating primary care midwives were satisfied with their job. The factors positively associated with their job satisfaction were their direct contact with clients, the supportive cooperation and teamwork with immediate colleagues, the organisation of and innovation within their practice group and the independence, autonomy,

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freedom, variety and opportunities that they experienced in their work. Regarding improvements, the midwives preferred a reduction in non-client-related activities, such as paperwork and meetings. They wanted a lower level of work pressure, and a reduced case-load in order to have more time to devote to individual clients' needs. Participants identified that cooperation with other partners in the healthcare system could also be improved.

Aim 2 (Chapter 3): We found that, in 2010, three quarters of the primary care midwives in the Netherlands wanted to stay or become self-employed practitioners in their own midwifery practice in five years' time, and practice a full range of primary care tasks. Significant predictors for the primary care midwives' intention to leave included a lower overall score on the job satisfaction scale (OR=0.18; 95% CI= 0.06-0.58) and being between 30 and 45 years old (OR=2.69; 95% CI=1.04-7.0;).

Aim 3 (Chapter 4): We found that, in 2010, primary care midwives actually worked on average 32.6 hours per week and approximately 67% of their working time (almost 22 hours per week) was spent on client-related activities. On average a midwife was on-call for 39 hours a week and almost 13 of the 32.6 hours of work took place during on-call-hours. This means that the total hours that an average midwife was involved in her work (either actually working or being on-call) was almost 59 hours a week. Compared to 2004 the number of hours an average midwife was actually working increased by 4 hours (from 29 to 32.6 hours) while the total number of hours an average midwife was involved with her work decreased by 6 hours (from 65 to 59 hours). In 2010, compared to 2001-2004, the midwives spent proportionally less time on direct client care (67% vs. 73%), although in actual number of hours this did not change much (22 vs. 21). In 2009 the average workload of a midwife was 99 clients at booking, 56 at the start of labour, 33 at childbirth, and 90 clients in postpartum care.

Aim 4 (Chapter 5): Our results indicate that satisfaction experienced by primary care midwives when collaborating with the different maternity care providers varies within and between the primary and secondary/tertiary care. Interactions with non-physicians (clinical midwives, maternity care assistance organisations and maternity care assistants) are ranked consistently higher on satisfaction compared with the interactions with physicians (general practitioners, obstetricians and paediatricians). Midwives with a higher mean of working years were more satisfied with the collaboration with the GPs. Midwives from the southern region of the Netherlands were more satisfied with collaboration with GPs and obstetricians. Compared to the urban areas, in the rural or mixed areas the midwives were more satisfied regarding the collaboration with MCA(O)s and clinical midwives. Midwives from non-Dutch origin are less satisfied with

the collaboration with paediatricians. We found associations of satisfaction with collaboration with reciprocity and problems in accessibility in some interactions. No relations were found between the overall mean satisfaction of collaboration and work-related and personal characteristics and attitude towards work.

Aim 5 (Chapter 6): We found that students felt that inevitably there will be a change in the organisation of maternity care, and they were open to change. Participants indicated that good collaboration between professions, including a shared system of maternity notes and guidelines, and mutual trust and respect were important aspects of any alternative model. The students indicated that client-centered care and the safeguarding of the physiological, normalcy approach to pregnancy and birth should be maintained in any alternative model. Students expressed worries that the role of midwives in intrapartum care could become redundant, and thus they are motivated to take on new roles and competencies, so they can ensure their own role in intrapartum care.

Discussion of the main findings

In the discussion of the main findings of the five studies together, the focus is on themes that have emerged from the research and may constitute essential components conditional for successful midwifery practice in the future.

The **high level of job satisfaction** [chapter 2 and 3] indicates that midwives in the Netherlands generally enjoy their work in the current system: providing midwife-led care as independent, autonomous primary care midwives. This is reflected in a statement from one DELIVER midwife: "*The satisfaction I get from the work!*" [chapter 2]. The factors positively associated with job satisfaction of the midwives were [chapter 2]: their direct contact with clients, the supportive cooperation and teamwork with immediate colleagues, the organisation of and innovation within their practice group and the independence, autonomy, freedom, variety and opportunities that they experienced in their work. Despite the uncertainties about the future of primary midwifery care, the majority of primary care midwives intended to stay in primary care. In a time when midwifery is in flux and when there are so many suggestions for potential structural change regarding how midwifery is organized, job-satisfaction is an important ingredient in the total mix. Job satisfaction plays an important part in any decision to leave the job, and is associated with the health of the care provider and the motivation for self-development, as well as the quality of care [chapter 3]. When changes in the organisation of midwifery care are envisioned in the Netherlands this high current job satisfaction among primary care midwives should be taken into account.

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Going into the future, factors associated with job satisfaction and areas for improvement are important to address.

Although the midwives are shown to be very content and satisfied in their profession, chapter 2 and 4 show that **workload** is high among primary care midwives. The midwives still perceive high work pressure even after the reduction of the number of 'care units' in January 2010 from 120 to 105 per year (NZa, 2009). This feeling corresponds with the results of chapter 4 that midwives worked on average more hours in 2010 compared to 2004 or 2001, and spent an increasing proportion of their time on non-client-related activities. "*I spend much too much time on administrative matters and those related to the practice and further training*" [chapter 2]. So, although non-client related activities such as administrative tasks and consultation with other care providers are an essential part of the midwives' job, the balance between these activities and direct client care appears to have changed and may need to be re-evaluated.

In chapter 2, 5 and 6 potential for **improved collaboration** with secondary care providers, such as obstetricians and paediatricians was emphasised, and a need was expressed for better, **respectful communication**. According to the primary care midwives and student midwives a lack of trust, and 'professional territorialism' between primary and secondary care providers can sometimes be bottlenecks in achieving a closer cooperation or an integrated model of care. One student midwife stated: *Very often I have the feeling that the obstetrician thinks 'you want to be autonomous, well you can just look after yourself then!' And if you want to discuss something with this person, ...they first want to see the client and once they've seen the client, they basically already take over the whole thing.* #fg1 [chapter 6]. The urge for improved collaboration is in line with the call of the steering committee *Pregnancy and Birth* (2009) to improve cooperation and communication between the involved maternity care providers. Problems with communication and collaboration among perinatal caregivers can threaten the quality and safety of care given to mothers and babies (Joint Commission on Accreditation of Healthcare Organizations, 2004; Simpson & Knox, 2003). These themes, highlighted in a variety of Dutch studies, show fragmented collaboration and inadequate communication between the maternity care professionals (de Vries, et al, 2013; Posthumus, et al. 2013; Schölmerich, et al, 2014; van der Lee, 2014).

Collaboration can be seen as particularly important for pregnant women who cross the boundaries of the echelons (Downe, et al, 2010). A **shared maternity note system and shared guidelines** can be important aspects of any new maternity care model, according to the students [chapter 6], but developing more guidelines is discussed among primary care midwives "*This increasing tendency to force us to work according to rigid guidelines should be abolished*" [chapter 2].

Chapter 5 shows that exchanging **contact information**, such as name and phone number of care provider or opportunities for frequent, informal communication with other maternity care providers can be a simple but effective measure in improving the communication.

Client-centred care is key, according to all participants. Primary care midwives want to devote more time to individual clients' needs. Getting to know the clients and putting them at the centre of midwifery care were regarded as important: *"I want to deliver more personal care, and that means more time for my clients", "I wish I had fewer clients so that I could offer each one the full care and attention she needs"* [chapter 2]. Client-centred care should be maintained in any new model according to the student midwives [chapter 6]. This is in line with the call of the steering committee *Pregnancy and Birth* (2009) to improve cooperation and communication with other care providers as well as with the pregnant woman and her relatives and put mother and child in the lead.

In chapter 2 and 6 it also became clear that **safeguarding of the physiological, normalcy approach to pregnancy and birth** is important. The primary care midwives made a plea for home births: *"Research has shown that home birth is safe. Please let us maintain this beautiful Dutch tradition"* [chapter 2]. A student midwife stated: *"... if you're pregnant, then you're not ill! You're quite simply healthy and so why should you have to go into hospital?"*#3 [chapter 6].

Regarding **the organisation of maternity care** in the Netherlands, the suggested shared care between primary and secondary care (Schippers, 2016) is not supported fully by our participants. A student stated: *"progress is always good of course... I just wonder whether it's worth radically changing the whole system right now"*. #1 [chapter 6]. According to the primary care midwives, more can be done in favour of integration within primary care and improvement of the collaboration with general practitioners (GPs) [chapter 6] and youth healthcare in order *"to join forces in primary care"* [chapter 2]. According to the student midwives, possible changes in the current maternity care model can be envisioned such as CenteringPregnancy™ (group antenatal care instead of one-to-one antenatal care), maternity care professionals (such as midwives, GPs and obstetricians) active in the community as well as in the hospital, or expanding primary care midwives' responsibilities and competencies to supervising medium-risk pregnancies and births [chapter 6]. From an international perspective, one might say the current Dutch maternity system is not just any old system. Other countries, such as Canada, the United Kingdom and New Zealand had set the current maternity care system of the Netherlands as a good example for changing their maternity care systems. In these countries, midwives increasingly work autonomously now and the homebirth rate is rising (Davis-Floyd, et al. 2009; de Vries, et al. 2009; Malott, et al., 2009). For many women, the Dutch

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maternity system works well. Women are most satisfied if they give birth at home (Christiaens & Bracke, 2009). In addition, low-risk women who start labour under supervision of a midwife ("midwife-led care") and especially if they start at home are more likely to have a spontaneous vaginal birth than those under supervision of an obstetrician ("obstetrician-led care") (Maassen, et al, 2008; Van der Hulst, et al, 2002). Sandall, et al. (2016) suggest that most women should be offered 'midwife-led continuity of care'. Their systematic review provided evidence that women who received midwife-led continuity models of care, compared with other models of care, were less likely to experience interventions, like an epidural, episiotomy or instrumental birth, and more likely to be satisfied with their care, while birth outcomes were comparable with hospital birth.

Student midwives are the future maternity care providers and they may be entering into a changing maternity care system. In chapter 6 we saw that during their educational experiences, students had experienced a range of approaches to maternity care practice in all levels of care and that they were **open to change**. *"We [students] aren't tied to anything, I mean, we can come and go where we want, we don't have any fixed [ideas]... I think we're much more flexible there, that we're less concerned about precisely how things will be done, as compared to someone who has been running their own practice for twenty years and has established themselves in the field like this."* #fg2 [chapter 6]. Reasons for the students to indicate a preference for a specific maternity care model were mainly related to their desire to provide the best possible maternity care.

Methodological considerations

One of the strengths of this thesis has been the combination of different research methods – quantitative and qualitative data analysis. By combining these research methods, it was possible to gain profound insight in several perspectives on the work of primary care midwives.

Twenty of the 519 primary care practices in the Netherlands were approached and invited to participate in the quantitative DELIVER study. If a practice declined participation, a replacement was found taking region, urbanisation and practice type into account. Ultimately, fourteen practices declined participation, mostly because of time constraints (Manniën, et al., 2012). This could have led to an underrepresentation of 'overworked' primary care midwives in the quantitative studies. Respondents and non-respondents may differ in their willingness or ability to participate and might have different views on organisation of and collaboration in maternity care.

The research question of the qualitative study in chapter 6 had a broad scope and there was relatively little prior knowledge. Our interest was in the

subjective experiences and perception of our participants: student midwives. The participants talked about sensitive topics, generated new ideas and evoked new insights, which resulted in posing questions and paying attention to aspects we would otherwise not have considered. So qualitative research was best suited for our open research question.

Implications

In labour market policy and planning it is important to understand the motivations of people to continue in their current job or to seek other employment. Currently, a growing proportion (28% in 2011, compared to 17% in 2002) of the practising midwives are employed as clinical midwives by hospitals, where they work under the supervision of an obstetrician (Hingstman and Kenens, 2002; 2011). Given this recent shift towards clinical midwifery in the Netherlands, and the increasingly medical approach to pregnancy and birth understanding the wishes of primary care midwives regarding their work situation in the near future can help further workforce planning in maternity care. Despite primary care midwives having been under pressure because of negative media, critics, changing systems, etc. in general, most participating primary care midwives in the Netherlands were satisfied with their job (chapter 2 and 3) and the majority of primary care midwives intended to stay in primary care.

Regarding **health care policy**: lowering perinatal mortality was the main driver of changes in maternity care over the past decade. Due to perceived relatively high perinatal mortality figures, integration between primary and secondary maternity care has been advised, and the number of initiatives for integrating care has been rapidly increasing (CPZ, 2015) and has led to various types of organisation of maternity care throughout the Netherlands [chapter 6]. Integration of care can provide new opportunities but also challenges for the midwifery workforce. In this newly developing system midwives feel the challenge to hold on to their own philosophy, which may at times be in conflict with the ideology and authority of obstetricians. Therefore, the process of implementing a new 'integrated' system can make great demands on midwives' balancing skills (Bluff, et al, 2008) and inter-professional communication (Schölmerich, et al. 2014), which may result in conflicting professional values among maternity care professionals, leading to dissatisfaction and even decisions to leave the workplace and/or workforce [chapter 2 and 3]. Furthermore, a change of a health care system may result in insecurity among all professionals and fear of loss of autonomy (Perdok et al, 2014), which also has been shown to contribute to burnout among midwives

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(Yoshida, et al, 2013). Therefore, being aware of their professional values and practice in the context of these changes, will contribute to the quality of integrated care and the (changing) role of the midwife.

Another important consideration is that, with the much better current perinatal mortality figures (Peristat III, 2013), the case for launching a radically altered perinatal care-system does not seem so evident anymore. Also, implementation of a new system can only be successful if there is support for change among all professionals concerned (Perdok, et al., 2014). There have been calls from different stakeholders to reconsider introducing integrated maternity care (e.g. Clara Wichmann, 2016; Hallensleben, 2016). Furthermore, it should not be forgotten that horizontal integration (cross-sectorial collaboration within primary care) is also key to counteracting the fragmentation of services in the health system (Valentijn, et al. 2013, 2015ab). It has been shown that health care systems with a strong focus on primary care provide better population health (Starfield, 2012). Birth models that are ideologically and practically based on the midwifery-led (humanistic/holistic) model of maternity care produce better outcomes for mothers and babies than technocratic practices based on a more medical model of maternity care (de Jonge, 2015; Hatem, et al. 2008; Prins, et al., 2014; Renfrew, et al. 2014; Sandall, et al. 2013; Wiegerinck, et al, 2015), but they are also fragile and in need of more attention and valuation (Davis-Floyd, et al. 2009). The role of the clients should not be underestimated in the growing medicalization. Clients may require care that is different, or extend beyond the evidence-based choice of care provider (Witte, et al., 2016).

The functions of primary midwifery care, such as first contact, comprehensiveness and coordination, and the person and population health-focused view could give primary care a central role in coordinating and integrating care (de Jonge, 2015; Valentijn, et al. 2013). Many countries saw responsibility move from midwives to obstetricians over the 20th century and in later years calls for more natural childbirth and more community based maternity services have contributed to a trend towards reintroducing or strengthening the roles of midwives (Rowland, et al., 2012). Primary care midwives could be more aware of this added value they bring and advocate it more strongly in the collaboration with other care providers (Henneman, 1995).

Regarding **midwifery education**, Dutch midwifery training has been considered to be among the best in the world (de Vries, et al, 2009; Wiegers, et al. 1998), and it kept up with the times. Anticipating the new professional profile of the Royal Dutch Organization of Midwives (KNOV, 2014), the Midwifery Academy Amsterdam-Groningen (AVAG) introduced/implemented a change in the curriculum (Willemsen, 2013), placing more emphasis on teaching evidence-based practice, providing more opportunities for inter-professional training,

including providing care in case of moderate risk indications (see also chapter 6). On the issue of inter-professional education, the opinions are divided. On the one hand, according to King et al. (2012), inter-professional education is the natural precursor to inter-professional practice. Inter-professional education can improve knowledge of each other's professional skills and boundaries, leading to better understanding of each other's role and thereby better cooperation. On the other hand, educational interventions are not the only key to improving the collaboration between midwives and obstetricians. Van der Lee (2014) indicated that collaboration might already significantly improve by practical interventions aimed at improving the coordination of maternity care, the means of communication, the clarity about professional boundaries and the sharing of information and activities.

The results of this thesis give us a better understanding of the perspectives on the organisation of midwifery care in the Netherlands, but more **research** is needed. In addition to these descriptive studies, future exploratory or explanatory/ deductive research can give more insight in the midwifery practice in everyday work setting. Practice oriented research, such as action research or direct observation, has the potential to identify elements of job satisfaction or inter-professional collaboration that are not so obvious to individuals when asked to self-report.

In order to do more explanatory or deductive analysis, like prediction or class analysis, larger quantitative studies are required. One recommendation is to do a quantitative research study in a larger study population, in which all forms of practices (solo, dual and group practices) are adequately represented and in which job satisfaction, workload and collaboration, are important elements in order to find out what the midwives' intentions are to maintain primary care practices and in what form of practice. Furthermore, future studies should comprise all midwives including those who work in education, in research and in a hospital, and those midwives who are not yet graduated or who are temporarily not working and might consider returning to primary care midwifery. Understanding the wishes of all midwives regarding their (future) work situation can help further midwifery education and workforce planning.

Different stakeholders have given their opinion on the matter of integrated care. However, the voices of clients have not been included and are very important in discussions about the reorganisation of maternity care in the Netherlands (CPZ, 2015, NPCF, 2014; www.geboortebeweging.nl).

De Jonge, et al., (2015) and Renfrew, et al., (2014) called for empowering the client and working in partnership with women to strengthen women's own

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capabilities to care for themselves and their families. Research can give insight into the opinions of clients on the integration of midwife-led care and obstetrician-led care and on the facilitating and inhibiting factors for integrating maternity care.

Recommendations

A number of recommendations can be made for midwifery practice, health care policy, midwifery education and research, based on the findings of this thesis.

Recommendations for primary care midwives

- Strengthen aspects positively associated with job satisfaction: direct contact with clients, the supportive cooperation and teamwork with immediate colleagues, the organisation of and innovation within the practice group and the independence, autonomy, freedom, variety and opportunities experienced in the work.
- Improve the balance between non-client related activities, such as administrative tasks, meetings, etc. and direct client care. Think of ways to reduce or redistribute the workload and restore work-life balance.
- Be aware of the added value you bring (such as the person and population health-focused view, physiological approach to pregnancy and birth) and advocate it strongly in the collaboration with other care providers. Place yourself in a position where your professional input is acknowledged both for client benefits and for the effective functioning of the inter-professional team.
- Discuss and give clarity about your professional boundaries.
- Improve the means of communication between maternity care providers such as exchanging name and phone number of care providers and sharing of information
- Address relational problems between disciplines, by creating multiple opportunities for frequent, informal communication in a shared physical work space, or in inter-professional education, where mutual respect and 'professional courtesy' is required.
- Share relevant information during pregnancy and postpartum with other care providers, for example by using common clinical records that can be shared quickly and easily when and where convenient.

Recommendations for educators

- Student midwives are the future maternity care providers and they are

entering into a changing maternity care system. Educate students in the midwifery philosophy and strengthen them to continue to propagate this philosophy.

- Expand opportunities for inter-professional training, within and outside primary care.

Recommendations for policy makers

- Recognize the value that the majority of primary care midwives are satisfied with their job and intend to stay in primary care.
- Re-evaluate the balance between non-client related activities, such as administrative tasks, meetings, etc. and direct client care, and reconsider further reduction of the number of 'care units'.
- Create opportunities for good collaboration, respectful communication and sharing information with other maternity care providers, like a shared maternity note system and shared guidelines.
- Maintain the high level of job satisfaction of midwives, the physiological, normalcy approach to pregnancy and birth and the client centred care.
- Give primary care midwives a central role in coordinating and integrating care, because of the functions of primary midwifery care, such as first contact, comprehensiveness and coordination, and the person and population health-focused view and the physiological, normalcy approach to pregnancy and birth.
- Envision, apart from vertical integration, other possible changes in the current maternity care model, such as horizontal integration, group antenatal care, maternity care professionals active in the community as well as in the hospital, or expansion of primary care midwives' responsibilities and competencies to supervising medium-risk pregnancies and births.
- Recognise that changing the maternity care system can only be successful if there is support for change among all professionals concerned. Gaining buy-in for any proposed change from future midwives is important.
- Evaluate whether a wholesale re-organisation of maternity care is desirable, since recent focus on maternity care has already led to a reduction in perinatal mortality.

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Recommendations for research

- Include in future human resource studies all midwives, including those who work in solo- or duo-practises, in education, in research and in a hospital, and those midwives who are not yet graduated or who are temporarily not working and might consider returning to primary care midwifery.
- Examine potential discrepancies between ideal and actual midwifery practice among midwives.
- Give more insight in the midwifery practice in everyday work setting through practice oriented research, in order to identify elements of job satisfaction or inter-professional collaboration that are not so obvious to individuals when asked to self-report.
- Involve students' views in research on organisation of midwifery care. They have a unique perspective as semi-outsiders in the system and innovative perspectives as newly integrated members of the system. Final year students took part in various situations during their internships in different places in primary, secondary and tertiary care and were in that way in a position to observe what works and what does not work in the field.

Conclusions

This thesis focused on the organisation of midwifery care in the Netherlands and on views regarding changes to the organisation of midwifery care. The high level of job satisfaction indicates that primary care midwives in the Netherlands generally enjoy their work in the current echelon system: midwife-led care by independent, autonomous primary care midwives. Despite the uncertainties about the future of maternity care, the majority of midwives intended to stay in primary care. Job satisfaction is an important predictor of midwives' intention to leave their current job and will be an important focus of ongoing monitoring. On the other hand, midwives perceived high work pressure. The balance between non-client-related activities, such as administrative tasks, meetings, and direct client care can and should be improved.

Essential components, which are likely to be conditional for successful midwifery practice in the future, such as good collaboration, respectful communication, sharing information and activities with other maternity care providers were formulated. Client centred care and safeguarding the physiological, normalcy approach to pregnancy and birth should be maintained in any maternity care model. Midwives can play a central role here, because of the functions of primary midwifery care, such as first contact, comprehensiveness

and coordination, and the person and population health-focused view as well as the physiological, normalcy approach to pregnancy and birth. In addition to the current echelon system and the proposed shared care between primary and secondary care -vertical integration-, one can envision other possible changes in the current maternity care models, such shared care within primary care -horizontal integration-, group antenatal care, maternity care professionals active in the community as well as in the hospital, or expansion of primary care midwives' responsibilities and competencies to supervising medium-risk pregnancies and births. The perspectives and preferences of all relevant stakeholders, including midwives, student midwives and clients, should be taken into consideration regarding any changes to the maternity care model.

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