

## VU Research Portal

### **Client-centred maternity care from women's perspectives: Need for responsiveness**

Petit, V.; Lips, S.R.; Schuitmaker-Warnaar, T.J.; Broerse, J.E.W.

***published in***

Midwifery

2019

***DOI (link to publisher)***

[10.1016/j.midw.2019.03.016](https://doi.org/10.1016/j.midw.2019.03.016)

***document version***

Publisher's PDF, also known as Version of record

***document license***

Article 25fa Dutch Copyright Act

[Link to publication in VU Research Portal](#)

***citation for published version (APA)***

Petit, V., Lips, S. R., Schuitmaker-Warnaar, T. J., & Broerse, J. E. W. (2019). Client-centred maternity care from women's perspectives: Need for responsiveness. *Midwifery*, 74, 76. <https://doi.org/10.1016/j.midw.2019.03.016>

**General rights**

Copyright and moral rights for the publications made accessible in the public portal are retained by the authors and/or other copyright owners and it is a condition of accessing publications that users recognise and abide by the legal requirements associated with these rights.

- Users may download and print one copy of any publication from the public portal for the purpose of private study or research.
- You may not further distribute the material or use it for any profit-making activity or commercial gain
- You may freely distribute the URL identifying the publication in the public portal ?

**Take down policy**

If you believe that this document breaches copyright please contact us providing details, and we will remove access to the work immediately and investigate your claim.

**E-mail address:**

[vuresearchportal.ub@vu.nl](mailto:vuresearchportal.ub@vu.nl)



## Client-centred maternity care from women's perspectives: Need for responsiveness

Violet Petit-Steeghs\*, Sarah R. Lips, Tjerk Jan Schuitmaker-Warnaar, Jacqueline E.W. Broerse

Athena Institute, Faculty of Science, De Boelelaan 1085, 1081 HV, Amsterdam, the Netherlands

### ARTICLE INFO

#### Article history:

Received 29 November 2018

Revised 11 March 2019

Accepted 25 March 2019

#### Keywords:

Maternity care  
Maternal health services  
Woman-centred care  
Client-centred care  
Patient perspectives  
Responsiveness to needs

### ABSTRACT

**Background:** Client- or woman-centred care has become a major focus in improving Western maternity care systems. In measures to increase client-centredness, the perspectives of maternity care professionals and policymakers often predominate. However, to put women at the centre of maternity care, insights into their perspectives are important. Therefore, the aim of this study is to analyze the perspectives of women on maternity care and to provide recommendations on how to achieve client-centred care.

**Methods:** A qualitative study was conducted comprising six focus groups ( $N=43$ ) and 20 semi-structured interviews with women who had given birth less than one year ago in the North-West Netherlands region. For data analysis, a framework based on existing woman-centred care models and the patient-centred care model of Maassen et al. (2017) was applied.

**Findings:** The issues women addressed, underlined the importance of all four dimensions of the framework (client, interaction, professional and organization). Although women were in general positive about the maternity care services, there were differences regarding client-centredness between community-based primary care and secondary/tertiary hospital care. The latter was evaluated more negatively than primary care with regard to taking women's background into account, communicating openly, showing a caring attitude and providing continuous care by a cohesive team. Although primary care appeared to be better able than secondary/tertiary care to adapt to clients' preferences, the women described various cases throughout the care process where they did not feel heard. Besides a lack of flexibility to override existing protocols, activities and roles and tokenism regarding the use of satisfaction questionnaires and the birthplan were mentioned.

**Conclusions and implications for practice:** This study demonstrated that from women's perspective, client-centred maternity care means being responsive to their wishes and needs across all four (client, interaction, professional and organization) dimensions. Current measures often focus on the organizational dimension, integrating different divisions of care. To achieve client-centred care, future measures should foster responsiveness on all four dimensions. This entails empowering maternity care professionals to have a reflective interaction with (especially less educated) women, by acquiring conversational and reflexive skills, within a flexible care system adjusting to specific wishes and needs.

© 2019 Elsevier Ltd. All rights reserved.

### Introduction

In many countries worldwide, the concept of client- or woman-centred care has been suggested as a means to improve the quality of maternity care services (Health Committee of the British House of Commons, 1992; Devane et al., 2007; Health Quality and Safety Commission New Zealand, 2012; WHO, 2018). This development results from the growing recognition that the care system should shift from a physician-based focus to one in which clients' perspectives are increasingly integrated (Laine and Davidof, 1996). To

place women closer to the centre of maternity care services in the Netherlands, a National Committee on Perinatal Care<sup>1</sup> advised to better integrate the different divisions of care (CPZ, 2018). The integration of services has also been suggested as a means to improve maternity care in other Western countries (Information Centre Ministry of Health Wellington, 1993; Shallow, 2001), but is especially relevant in the Netherlands because of the specific way the system is organized.

The Dutch maternity care system is divided between (1) community-based primary care, (2) hospital-based secondary care and (3) specialized academic tertiary care (KNOV, 2016). In princi-

\* Corresponding author.

E-mail address: [v.petit@vu.nl](mailto:v.petit@vu.nl) (V. Petit-Steeghs).

<sup>1</sup> College Perinatale Zorg (CPZ).

ple, midwife-led primary care is provided to women who are at low risk of complications during pregnancy or delivery. Women who are considered to have a medium or high risk of complications receive obstetrician-led secondary and tertiary care. In the course of their care, women can—and often do—shift between the different levels, depending on their risk status (Wieggers, 2009). In 2014, 35% of the pregnant women who started in primary care (86% of all pregnant women) were transferred to secondary or tertiary care during their pregnancy or delivery (Perined, 2015). In 2016, 70% of the deliveries were managed in secondary or tertiary care (Perined, 2018). Between and within the divisions, women are in contact with different organizations that work relatively autonomously, each with their own responsibilities, methodologies and processes (Scheerhagen et al., 2015). Various studies show that in case of referral between different maternity care organizations or professionals, this division-based system negatively affects women's experiences (Jonge et al., 2014; Rijnders et al., 2008; Wieggers, 2009). Women in particular mentioned inaccurate communication and too little attention to their preferences (Jonge et al., 2014; Rijnders et al., 2008).

The concept of integrated care is seen as a means to overcome the negative experiences arising from referrals. To integrate maternity care services in the Netherlands, optimization of the coordination and collaboration between the three divisions is needed (Boesveld et al., 2017; Haggerty et al., 2003; KNOV, 2016; Warmelink et al., 2017). Initiatives like the development of obstetric partnerships were set up to stimulate collaboration and better align the different maternity care practices (de Boer and Zee-man, 2008). Furthermore, health insurance companies have been imposing extended collaboration in their agreements with healthcare providers (NZA, 2015). Different views on the practicalities of these initiatives however exist, especially regarding the distribution of tasks and responsibilities between maternity care professionals and organizations (Perdok et al., 2016).

The integration of services and improved continuity of care will not necessarily result in (experienced) good quality care (Perdok et al., 2018). In addition, client-centredness in the Netherlands is in practice often determined by health professionals. To genuinely place women at the centre of maternity care services, their own preferences should be considered (Wieggers, 2009). A systematic global review of qualitative research on women's perspectives on childbirth conducted by Downe et al. (2018) revealed that most women especially appreciated having a positive experience that fulfilled or exceeded their existing personal and socio-cultural beliefs and expectations. This included giving birth to a healthy baby in a clinically and psychologically safe environment with practical and emotional support from competent, reassuring and kind clinical staff. Other studies, which specifically studied women's perspectives on the maternity care systems in Australia, Iceland, South Africa and Sweden, found that women most valued a collaborative relationship and respectful communication (Berg et al., 2012; Hildingsson and Thomas, 2007; Lewis et al., 2016; Maputle and Donavon, 2013). In-depth knowledge of women's preferences and needs in the Dutch maternity care context still falls short. Dutch studies mostly evaluate women's satisfaction with current maternity care in a quantitative fashion, and focus on only a sub-population or a specific aspect of care (Wieggers, 2009; Janssen and Wieggers, 2006; Rijnders et al., 2008). Moreover, these studies give no insights into how these perspectives can become the central point of maternity care services. Therefore, this study aims to analyze the perspectives of women on maternity care and to provide recommendations on how to achieve client-centred care.

## Client-centred care

To analyze what women consider to be client-centred maternity care, we integrated existing woman-centred care models (Leap, 2009; Pope et al., 2001; Carolan and Hodnett, 2007; Berg et al., 2012; Hunter et al., 2017; Maputle and Donavon, 2010, 2013) and the patient-centred care model of Maassen et al. (2017). The four dimensions (patient, health professional, interaction and healthcare organization) of the patient-centred care model of Maassen et al. (2017) were used as a basis for the framework. These dimensions give an overview of the different actors and their relations in practice and facilitate the formulation of practical recommendations for client-centred interventions. Subsequently, the patient-centred care elements within each dimension were studied for their relevance in the maternity care context. The selected elements were compared to the elements of the woman-centred care models. Although the wording of the elements differ, considerable overlap between them exists, such as 'continuity of service' and 'transition and continuity of care'. Because of the aim to analyze *what* client-centred maternity care means from a women's perspective, only elements that can be seen as direct prerequisites for client-centredness were included.

## Methods

To generate insights into what Dutch women consider to be client-centred maternity care, a qualitative approach using semi-structured interviews and focus groups was used. This study, conducted in the period 2014–2016, was part of a larger monitoring and evaluation study (forthcoming (name) et al., <date>) of a regional maternity care network in North-West Netherlands.

### Participant selection

Participants were women who had given birth in the North-West Netherlands region. To limit recall bias, women who had given birth more than a year ago were excluded (Hassan, 2005). Focus group participants were recruited via announcements and flyers disseminated by teachers of pregnancy-related courses, such as birth breathing or the exercise therapy *mensendieck*. Because of an initial overrepresentation of highly educated women in the focus groups, purposive sampling of those with a low or middle-level educational background<sup>2</sup> was applied for the subsequent interviews. These women were recruited via four midwifery practices, a national care organization supporting vulnerable clients, a hospital and three paediatric clinics. Previous research has shown that personalized strategies, like face-to-face consultations, are more appropriate for recruiting less educated respondents (Alvidrez, 1999; Le et al., 2008). For this reason, women were approached via face-to-face contact by, for instance, directly approaching them in the waiting room at the paediatric clinic. Women who expressed interest in the study were contacted via e-mail or phone to plan the interview.

### Data collection

Six focus groups with in total 43 participants were organized. An overview of the characteristics of the participants is presented in Table 1. The focus groups took place at the location of pregnancy-related courses. Women who were attending the same course participated together in a group. The interaction motivated

<sup>2</sup> This classification is based on the educational system in the Netherlands. Primary education: basic education, HAVO and VWO-middle school, MBO1; Secondary education: HAVO, VWO and MBO2-4; Tertiary education: HBO, WO and PhD (CBS, 2016).

**Table 1**  
Characteristics of focus group participants (n=43).

Aspect	Category	Group 1	Group 2	Group 3	Group 4	Group 5	Group 6	Total
# participants		6	5	8	8	8	3	
Age	<25	0	1	1	0	0	0	2
	25–29	1	4	1	3	2	4	15
	30–35	5	1	3	4	6	4	23
	>35	2	0	0	1	0	0	3
Education	Primary	0	0	0	1	0	0	1
	Secondary	0	0	2	2	3	0	7
	Tertiary	8	6	3	5	5	8	35
Parity	Primi	8	6	3	7	4	8	36
	Multi	0	0	2	1	4	0	7
Delivery location	Home	1	1	1	2	2	1	8
	Birth centre	0	0	0	0	0	0	0
	Hospital	7	5	4	6	6	7	35

**Table 2**  
Characteristics of respondents in interviews (n=20).

Aspect	Category	Amount
Age	<25	3
	25–29	5
	30–35	8
	>35	5
Education	Primary	8
	Secondary	12
	Tertiary	0
Parity	Primi	7
	Multi	13
Delivery location	Home	3
	Birth centre	0
	Hospital	17

women to share their views, helped in recalling experiences and making differences and similarities in their views explicit. The focus groups lasted for 90 min and comprised two parts. In the first part, clients discussed their positive and negative experiences and possible points for improvement. During the second part, experiences with regard to referrals in care were specifically discussed.

In addition, semi-structured interviews were held to specifically include the perspectives of women with a lower (primary) or middle (secondary) educational background. In total, 20 face-to-face interviews of an hour to 90 min were conducted at the woman's home. Table 2 shows an overview of the characteristics of the interviewees. Within the interviews, respondents' experiences with the delivered maternity care were discussed in a chronological order. No further interviews were planned when data-saturation was attained.

#### Data analysis

The interviews and focus groups were tape-recorded and transcribed verbatim. The transcripts were analyzed using the software programme MAXqda 2007. A combination of open and closed coding was applied. Codes were derived from the client-centred care framework in Fig. 1. Subsequently, the coded segments were clustered into sub-themes and structured based upon the main concepts of the framework. The coded transcripts and the analyses were discussed by the researchers to increase the internal validity of the study.

#### Ethics

At the time of data collection, ethical approval was not required by Dutch legislation as the study does not include medical interventions. Researchers adhered to the national Code of Ethics for

Research in the Social and Behavioral Sciences involving Human Participants (VCWE, 2016). All respondents received verbal information about the aim of the study and the possibility of withdrawing at any time without giving reason. The participants gave their verbal informed consent for their participation and all data were analyzed anonymously. Participants of the focus groups received a summary of the discussion as a member check.

#### Results

Participants were generally positive about the maternity care they received, but services were not always responsive towards their wishes and needs. The issues the women identified covered all four dimensions (client, interaction, professional and organization) of the client-centredness framework (Fig. 1). The quotes of the focus groups are identified with (FG (number), RD <number>), where RD stands for respondent. The quotes from the interviews are indicated by (I<number>).

##### Client dimension

Participants' experiences adhere to five elements of the client dimension of the framework: being treated as a person, able to participate, autonomous, respected and well informed.

##### Being treated as a person

Various women addressed the need for care services to focus on the client as a 'whole' person. Non-pregnancy-related aspects, like their mental health or family situation, were crucial for taking care of themselves and their (future) baby. Most of the women said that maternity care professionals showed an interest in their personal background. In practice, the extent to which their background was taken into account, differed. Following participants' stories, primary care midwives more often considered clients' personal situation when scheduling appointments than did hospital staff. A lack of flexibility in taking personal factors into account led many women to feel frustrated about not being heard.

##### Able to participate

Regarding their participation, women generally described the need for being involved by taking their needs and wishes into account. Although they were in general positive about their involvement, women felt left aside in case of urgent or exceptional situations.

*The gynaecologist said he was going to touch me, because he wanted to know how far I was dilated. I did not have anything to say. He just did it. And without any hesitation he broke my water as well. (I13)*

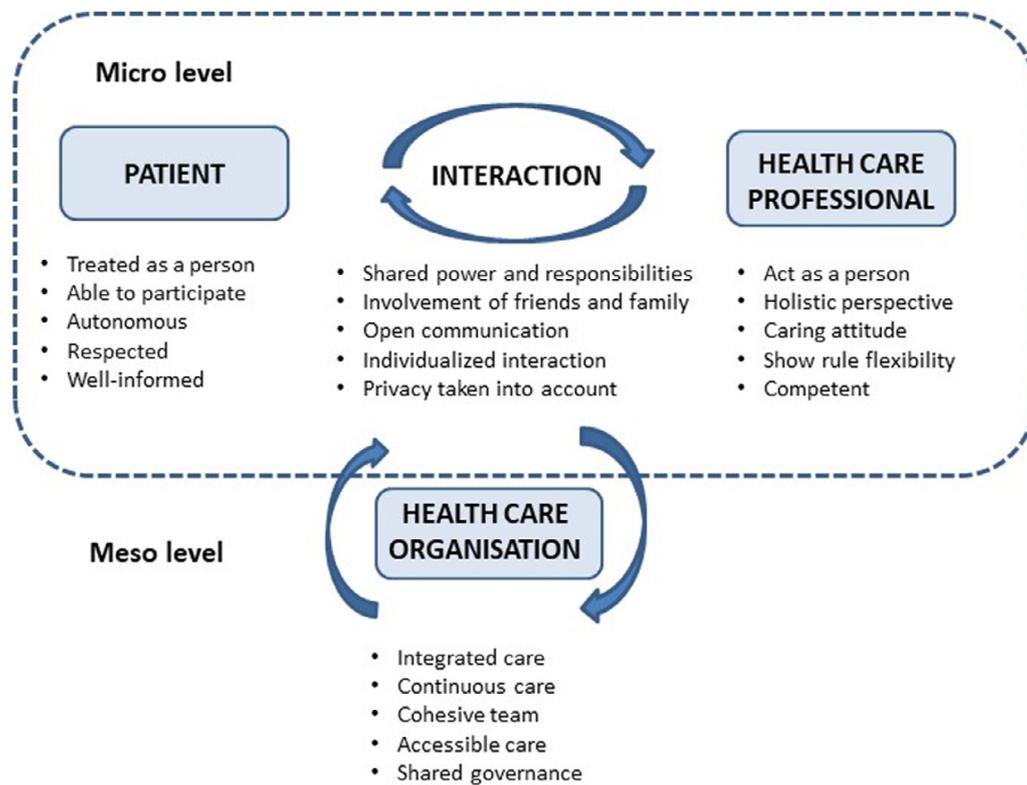


Fig. 1. Client-centred care framework based on existing woman-centred care models and the patient-centred care model of Maassen et al. (2017).

According to most participants, possibilities to evaluate care were limited. Clients who went through traumatic experiences were therefore unable to offload their emotional baggage. In some cases, women received an evaluation form. Verbal feedback was only given on their own initiative. Professionals' response to this feedback differed from being understanding to defensive and patronizing. All of the women who gave feedback had the sense that nothing was actually done with it. As a result, they felt limited partnership.

*I wrote it down in an evaluation form ... But the situation did not change. You still have to ask a hundred times whether someone can visit. And still they reply they are busy; so nothing changed. (118)*

#### Autonomous

Clients were generally positive about the possibilities to become more self-reliant through shared decision-making and information on self-management. However, various cases were mentioned in which parents had difficulties in becoming autonomous after the baby had been born at the hospital. Hospital nurses were found to focus mainly on the medical aspects of care. Support in caring for the newborn was experienced as inadequate or even lacking. As a result, clients felt helpless and dependent.

*An hour passed. Then we asked someone for help. They laid him on my breast, but that was it. It is recommended to try breastfeeding within the first hour, but I did not know what to do. I would have liked to receive some support. (111)*

#### Respected

Clients, and especially women with a lower educational background, mentioned the need to feel respected. Although generally the case, their concerns were not taken seriously when they did not fit the protocol or general situation:

*I frequently suffered from a rigid abdomen. When I expressed my thought that my son was too big for my abdomen, I was laughed at. They said: 'you are small yourself, so you will get a small baby'. Some time later they said that he was too big and therefore did not descend. Then I directly needed a caesarean section. (FG6, RD5)*

#### Well informed

Almost all participants were positive about the verbal and written information provided throughout the whole care process. Less educated women more explicitly mentioned that communication should be easily understood. In one of the focus groups, eight women had participated together in a Centring Pregnancy programme – a model of group antenatal care (Rotundo, 2011). These women felt especially knowledgeable as they experienced double learning through other women's questions and experiences. Special courses that prepared pregnant women for the delivery, such as pregnancy yoga, were also very positively valued. Topics on which information was missing mostly related to issues that arose after childbirth, such as postpartum cramps and the shift from breastfeeding to formula milk. Clients who had a caesarian section specifically mentioned that they lacked information on their recovery process.

#### Interaction dimension

In their stories, participants addressed the following 'interaction' elements: involvement of family and friends, open communication and individualized interaction. The elements 'shared power and responsibilities' and 'privacy taken into account' were only indirectly discussed in the context of other elements, respectively 'being able to participate' and 'individual wishes and preferences taken into account'. Not sharing a room with other women was seen as an individual wish for a good night's sleep and privacy.

### *Involvement of family and friends*

According to a great number of women, their partner, and their other children, were little involved throughout the maternity care process. Communication was almost solely directed towards the mother:

*I said to my husband: 'Could you pick up the phone? I rather receive the news from you than from that woman'. So he picked up the phone. 'Can I talk to your wife?' 'Well', he said, 'She is rather stressed and prefers to receive the news from me.' 'I won't tell you, I would like to talk to your wife.' 'But I am the father so you can just tell me. 'Well then, but I find it ridiculous.' (14)*

A few clients, who needed extra aftercare in the hospital, specifically indicated that the father was not updated about her situation. Only regarding maternity care assistants, some women mentioned they involved their partner and their other children in caring for the baby. The involvement of other relatives was not mentioned by clients, probably because childbirth in the Netherlands is more an intimate family matter.

### *Open communication*

Clients mentioned that primary care midwives were generally transparent about the process. Communication by the hospital staff was experienced by most women to be less transparent. These women were, for instance, not well informed about the progress and possible choices during the delivery and the timing and procedure of the discharge. Moreover, various women mentioned situations in which they received different information from different care professionals at the hospital. According to these women, ambiguous communication arose from differences in hierarchy (overruling of decisions of trainee gynaecologists) or responsibilities (midwives not being permitted to give a ruling). This lack of transparency resulted in badly managed expectations for the woman and feelings of insecurity.

*The midwife said everything went well. Then the gynaecologist comes in and within one minute it is not going to work out and there will be a caesarean. How is that possible? (FG2, RD6)*

### *Individualized interaction*

Generally, the women were positive about the way their individual preferences were taken into account. They appreciated that primary care midwives showed interest and were informed about the content of their birthplan (the woman's written specifications for the management of labour, delivery and recovery). Hospital staff was, on the other hand, often not informed. The lack of awareness concerning their birthplan was disappointing for clients. Freedom of choice was mentioned in relation to pain relief or the place of delivery. Various cases were mentioned where women's freedom of choice was undermined when it did not correspond to the protocol, such as the need for inducing labour. In relation to postpartum maternity care, maternity care assistants performed other activities than expected or needed, or in a different way. Several women mentioned that the maternity care assistants did not clean their house well. Others said they would have preferred other support, like receiving more extensive information.

### *Health professional dimension*

Within their stories, women offered insights into the following elements of the 'health professional' dimension: a holistic perspective, caring attitude, flexibility and competence. Women did not mention the element 'act as a person' as preferable and even expressed dissatisfaction with professionals who shared personal anecdotes.

### *Holistic perspective*

In relation to postpartum care, a few women mentioned that the attention was mainly focused on the newborn and little attention was paid to their own well-being. For some women, a lack of support regarding their physical or psychological problems resulted in feelings of helplessness.

### *Caring attitude*

Almost all women, but especially those who were less educated, valued warm-hearted contact with the maternity care professional. Regarding this caring attitude, a difference between primary and secondary/tertiary care was highlighted. According to most women, primary care midwives showed an interest in them, including after the delivery, and were attentive when providing care. In the hospital, many clients experienced a focus on the medical aspects of birthcare, and less attention to personal contact and emotional support. More personal involvement was experienced when the midwife was present during the transfer to secondary/tertiary care. The midwife could check whether the woman's preferences were being taken into account and gave her personal support.

*And she said clearly: 'this madam is fine with everything but not an epidural!' When I heard her saying that, I thought 'I am so happy you are here'. (FG3, RD2)*

### *Show rule flexibility*

A majority of the women expressed their appreciation when maternity care professionals showed flexibility regarding standard procedures. A frequently mentioned example is that of primary care midwives remaining during delivery after the transfer from primary to secondary/tertiary care (an uncommon situation in the Netherlands). Cases in which professionals stick to the protocols, losing sight of the woman's personal situation, resulted in feelings of frustration for the mother. For instance, paediatric clinics are felt to compare the development of individual babies with statistics on 'average' child development.

*They stick to the fact that he is a certain age and therefore should do this or that. While I am thinking, look at the child. Some children will walk when they are one year old, others do not crawl before nine months... and it will all be fine. (FG4, RD6)*

### *Competent*

Throughout women's stories, maternity care professionals were generally described as knowledgeable and skilled. The main critical comment mentioned by various women was that hospital staff lacked specialized knowledge regarding breastfeeding. As a result, breastfeeding was delayed until support was obtained via maternity care assistants or breastfeeding experts.

*It did not work out in the hospital. But the next day, when the maternity nurse took her time and in a lying position instead of sitting it went much better. (FG2, RD1)*

The support of breastfeeding experts was very much valued in terms of their extensive knowledge and taking the time to apply it. Yet, these experts were often contacted at a very late stage and by the mothers themselves. Women with a lower educational level more often indicated the wish to have contact with an older maternity care professional with personal experience of having children. That gave them more trust in the professional.

### *Healthcare organization dimension*

The organization of healthcare played a major role in the women's stories and addressed the client-centredness elements of continuous care, cohesive team and accessible care. The elements

'integrated care' and 'shared governance' were only indirectly addressed in the context of the elements 'continuous care' and 'cohesive team'.

#### *Continuous care*

Women regularly mentioned a lack of continuity with (unplanned and often acute) transfers to and within the hospital. Several women said that hospital personnel were not aware of the information in the transfer documents. Moreover, problems were highlighted in relation to transferring test results and medical and discharge information from the hospital to other maternity care professionals. Due to a lack of transferral information or erroneous information in transfer documents, clients had to tell their story over and over again.

#### *Cohesive team*

A majority of the clients experienced a lack of cohesiveness regarding hospital personnel: the women did not know who was who and what was each person's function or responsibility. Moreover, they regularly mentioned that hospital staff had only limited awareness of their situation after a shift change and that they received different information from different hospital staff. As a result, these women were undecided about what to do.

*You think everyone is on one track regarding breastfeeding. But the different creams that were advised alone. One person says Lano-line; following the other another cream will help. (I20)*

Almost all clients were positive about the cohesiveness of the team of primary midwives. They appreciated the fact that they had met all midwives beforehand and were therefore familiar with the midwife who attended the delivery. Although often several midwives were involved, all were aware of their birthplans and medical files. Eight participants in one of the focus groups, who experienced a multidisciplinary intake with primary and secondary/tertiary maternity care professionals, spoke about it in very positive terms. Professionals were better informed and more easily accessible, creating the woman's trust.

#### *Accessible care*

Clients were mostly positive about the accessibility of the primary care midwives, especially their 24/7 availability. Regarding the hospital, clients frequently described periods when maternity care professionals were hardly available. Especially during transfers and shift changes, clients experienced feelings of being alone and forgotten. In addition, after the delivery, when no direct care was needed, various cases were mentioned in which few personnel were available to support the new family with caring activities or the discharge procedure.

*I was ready, everything was packed. So I thought let's go; but we had to wait. Finally I approached someone on the hallway and asked: 'Can we go now?!' (FG4, RD5)*

A few clients missed services, because they did not know whom to contact. This was, for instance, the case in relation to extraordinary situations, transfers or when different care professionals were involved at the same time. Women who received hospitalized maternity care mentioned that the services were very limited and could not be considered as replacing home-based maternity care.

### **Discussion (words: 920)**

This study showed that although women are generally positive about their maternity care, services were not always in line with their preferences. The need for responsiveness towards clients' wishes and needs, also formulated as a criterion for good quality care by the [World Health Organization \(2000\)](#), does not necessarily

mean that experiences have to fulfil or exceed clients' expectations, as concluded by [Downe et al. \(2018\)](#). As long as a transparent and individualized interaction takes place, services can deviate from clients' expectations. Responsiveness does, however, call for a respectful collaborative relationship, also identified in previous studies ([Berg et al., 2012](#); [Berg and Dahlberg, 1998](#); [Hildingsson and Thomas, 2007](#); [Lewis et al., 2016](#); [Maputle and Donavon, 2013](#)). Although addressing the importance of mutual understanding within this relationship, clients did not describe the relationship like the partnership of [Guilliland and Pairman \(1995\)](#), in which power and responsibilities are shared ([Guilliland and Pairman, 1995](#)). Clients attribute a leading role to maternity care professionals in which they consider clients' preferences.

Primary care appeared to be better able to respond to clients' preferences than secondary/tertiary care on all four client-centredness dimensions. Hospital care was more negatively evaluated with regard to taking the woman's personal background into account, communicating openly, having an individualized interaction, showing a caring attitude and providing continuous care by a cohesive team. These findings could explain the differences in satisfaction between primary and secondary/tertiary care found by [Wieggers \(2009\)](#). Although primary care was better able to adapt to clients' preferences, clients mentioned various situations throughout the care process where they did not feel heard. This mostly related to a disability to adapt to unexpected or unusual situations or needs due to rigid protocols and procedures. Moreover, clients described cases of tokenism regarding the use of the birthplan and satisfaction questionnaires. In practice, these forms of participation were often a box-ticking exercise rather than genuinely involving clients and acting on their wishes or feedback ([Ooclo and Matthews, 2016](#); [Roberts, 2002](#); [Trujols et al., 2014](#)).

These results describe a task- and clinical outcome-oriented culture in which the medical model of maternity care prevails. This was especially the case for secondary/tertiary care. The medicalization of maternity care is however regularly at odds with clients' wish for a woman-centred approach, in line with the social model. A balancing act is needed between reducing maternal and infant mortality on the one hand and improving clients' satisfaction in a holistic and family-oriented manner on the other hand ([MacKenzie Bryers and van Teijlingen, 2010](#); [Van Teijlingen, 2005](#); [Walsh and Newburn, 2002](#); [Porter, 2000](#)).

Current initiatives in Dutch maternity care, focusing on integrating its different divisions, support specifically two client-centredness elements: that services should be continuous and provided by a cohesive team. A more holistic approach – in line with the social model – is needed in which responsiveness is reached in all four dimensions. Regarding the client dimension, attention should focus on empowering women to become respected and autonomous partners who are aware of and can articulate their implicit knowledge. Special attention should be paid to less educated women, who show a more explicit need for an empowering interaction. The interaction dimension calls for continuously evaluating and adjusting to the specific needs of the woman and her nearest and dearest. By asking reflective questions and listening to their feedback, professionals could stimulate the articulation and integration of clients' implicit knowledge ([Poskiparta et al., 1998](#); [Kettunen et al., 2003](#)). On the professional dimension, sensitive maternity care professionals are needed who are responsive towards clients' needs. To have a reflective interaction with clients, professionals should have reflexive and conversational skills. Professionals' training mainly addresses reflexive skills in relation to self- and peer-reflection and medical decision-making processes ([Oostveen, 2008](#); [Taylor and White, 2000](#); [Wollersheim, 2008](#)). The ability to reflect on and consider intersubjective dynamics, in this case between themselves and the woman, could help to articulate and integrate clients' knowledge and therefore stimulate ex-

periential learning (Kettunen et al., 2003). To stimulate reflexivity among professionals, education to develop reflexive skills and formally evaluating these skills could be helpful. Within the organizational dimension, responsiveness could be fostered by organizing a flexible and integrated care process that can adapt to clients' changing preferences, while including their implicit knowledge.

A strength of this study is that it included a diverse group of women. Participants differed with respect to age, educational status, parity and place of delivery. The only women excluded from the study were those who spoke neither Dutch nor English. Future research on this group would be of interest due to the potential influence of cultural background on the evaluation of maternity care services. A limitation is that participants delivered between three and 11 months at the time of the study. The time difference between data collection and their experiences may have biased what and how participants recall their experiences.

## Conclusion

This study showed that to become client-centred, maternity care services should be responsive to women's needs on all four dimensions (client, interaction, professional and organization). Current measures for integrating different divisions of care mainly focus on two elements of the organizational dimension and are therefore not enough to be responsive towards women's needs. Future measures should adopt a more holistic approach, increasing the emphasis on the social model in maternity care. This entails empowering maternity care professionals to have a reflective interaction with (especially less educated) women by acquiring conversational and reflexive skills within a flexible care system, adjusting to specific wishes and needs.

## Conflict of interest

None declared.

## Ethical approval

Not applicable

## Funding

This work was supported by ZonMw, The Netherlands Organization for Health Research and Development [project number: 209010002].

## Clinical trial registry and registration number

Not applicable.

## Acknowledgements

We would especially like to thank the clients who shared their experiences and views with us in their spare time. We also thank Hilde Schwantje for her help in collecting and analyzing the data, the collaborating baby consultation clinics, midwifery organizations and the instructors of the pregnancy-related courses for helping to recruit participants for this study, and ZonMw – the Netherlands organization for Health Research and Development – for financial support for this research.

## References

Alvirez, J., 1999. Ethnic variations in mental health attitudes and service use among low-income African American, Latina, and European American young women. *Community Ment. Health J.* 35, 515–530.

- Berg, M., Olafsdottir, O.A., Lundgren, I., 2012. A midwifery model of woman-centred childbirth care in Swedish and Icelandic settings. *Sexual Reprod. Healthcare* 3, 79–87.
- Berg, M., Dahlberg, K., 1998. A phenomenological study of women's experience of complicated birth. *Midwifery* 14 (1), 23–29.
- Boesveld, I.C., Bruijnzeels, M.A., Hitzert, M., Hermus, M.A.A., van der Pal-de Bruin, K.M., van Den Akker-van Marle, M.E., Steegers, E.A.P., Franx, A., de Vries, R.G., Wiegers, T.A., 2017. Typology of birth centres in the Netherlands using the Rainbow model of integrated care: results of the Dutch Birth Centre Study. *BMC Health Serv. Res.* 17 (1), 1–13.
- Carolan, M., Hodnett, E., 2007. 'With woman' philosophy: examining the evidence, answering the questions. *Nurs. Inq.* 14 (2), 140–152.
- Centraal Bureau voor de Statistiek (CBS), 2016. Standaard onderwijsindeling 2016. Retrieved from: ([https://www.cbs.nl/-/media/\\_pdf/2017/13/pubsoi2016ed1617.pdf](https://www.cbs.nl/-/media/_pdf/2017/13/pubsoi2016ed1617.pdf)).
- College Perinatale Zorg (CPZ), 2018. Retrieved from: ([www.kennisnetgeboortezorg.nl/over-cpz/88-wat-we-doen.nl](http://www.kennisnetgeboortezorg.nl/over-cpz/88-wat-we-doen.nl)).
- de Boer, J., Zeeman, K., 2008. KNOV-standaard Prenatale Verloskundige Begeleiding, first ed. Koninklijke Nederlandse Organisatie van Verloskunde.
- Devane, D., Murphy-Lawless, J., Begley, C., 2007. Childbirth policies and practices in Ireland and the journey towards midwifery-led care. *Midwifery* 23 (1), 92–101.
- Downe, S., Finlayson, K., Oladapo, O., Bonet, M., Gülmezoglu, A.M., 2018. What matters to women during childbirth: a systematic qualitative review. *PLoS One* 13 (4), e0194906.
- Guilliland, K., Paiman, S., 1995. The Midwifery Partnership: a Model for Practice. Department of Nursing and Midwifery Monograph Series, 95/1.
- Haggerty, J.L., Reid, R.J., Freeman, G.K., Starfield, B.H., Adair, C.E., McKendry, R., 2003. Continuity of care: a multidisciplinary review. *Br. Med. J.* 327, 1219–1221.
- Hassan, E., 2005. Recall bias can be a threat to retrospective and prospective research designs. *Int. J. Epidemiol.* 3 (2), 1–7.
- Health Committee of the British House of Commons, 1992. Report on Maternity Services The Winterton Report. HMSO, London.
- Health Quality and Safety Commission New Zealand, 2012. Excellence through patient and family centred care. Lit. Rev. Retrieved from <http://www.bopdnhb.govt.nz/media/35057/1.1%20Literature%20Review.pdf>.
- Hildingsson, I., Thomas, J.E., 2007. Women's perspectives on maternity services in Sweden: processes, problems and solutions. *J. Midwifery Women's Health* 52 (2), 126–133.
- Hunter, A., Devane, D., Houghton, C., Grealish, A., Tully, A., Smith, Y., 2017. Woman-centred care during pregnancy and birth in Ireland: thematic analysis of women's and clinician's experiences. *BMC Pregnancy Childbirth* 17 (1).
- Information Centre Ministry of Health Wellington, 1993. First Steps Towards an Integrated Maternity Care Services Framework. Coopers & Lybrand.
- Janssen, B.M., Wiegers, T.A., 2006. Strengths and Weaknesses of midwifery care from the perspective of women. *Evid. Based Midwifery* 4 (2), 53–59.
- Jonge, A., de, Stuijt, R., Eijke, I., Westerman, M.J., 2014. Continuity of care: what matters to women when they are referred from primary to secondary care during labour? *BMC Pregnancy Childbirth* 14, 103–114.
- Kettunen, T., Poskiparta, M., Karhila, P., 2003. Speech practices that facilitate patient participation in health counselling – a way to empowerment? *Health Educ. J.* 62 (4), 326–340.
- KNOV, 2016. Het verloskundig systeem. Retrieved from (<https://www.knov.nl/werk-en-organisatie/tekstpagina/273-2/het-verloskundig-systeem/hoofdstuk/265/het-verloskundig-systeem/>).
- Laine, C., Davidof, F., 1996. Patient-centred medicine. A professional evolution. *JAMA* 275 (2), 152–156.
- Le, H., Lara, M.A., Perry, D.F., 2008. Recruiting Latino women in the U.S. and women in Mexico in postpartum depression prevention research. *Arch. Womens Ment. Health* 11, 159–169.
- Leap, N., 2009. Woman-centred or women-centred care: does it matter. *Br J Midwifery* 17 (1), 12–16.
- Lewis, L., Hauck, Y.L., Ronchi, F., Crichton, C., Waller, L., 2016. Gaining insight into how women conceptualize satisfaction: western Australian women's perception of their maternity care experiences. *BMC Pregnancy Childbirth* 16 (29), 1–9.
- Maassen, E.F., Schrevel, S.J.C., Dedding, C.W.M., Broerse, J.E.W., Regeer, B.J., 2017. Comparing patients' perspectives of "good care" in Dutch outpatient psychiatric services with academic perspectives of patient-centred care psychiatric services with academic perspectives of patient-centred care. *J. Ment. Health* 26, 84–94.
- MacKenzie Bryers, H., van Teijlingen, E., 2010. Risk, theory, social and medical models: a critical analysis of the concept of risk in maternity care. *Midwifery* 26, 488–496.
- Maputle, M.S., Donavon, H., 2010. A woman-centred childbirth model. *J. Interdisc. Health Sci.* 15 (1), 1–8.
- Maputle, M.S., Donavon, H., 2013. Woman-centred care in childbirth: a concept analysis (Part 1). *Curatiosis* 36 (1), E1–E8.
- Nederlandse Zorg Autoriteit (NZA), 2015. Quickscan en Beleidsbrief: integrale geboortezorg, samenwerking tussen de eerstelijns en tweedelijns zorgaanbieders. Retrieved from: ([www.rijksoverheid.nl/binaries/rijksoverheid/documenten/rapporten/2015/10/01/integrale-geboortezorg/integrale-geboortezorg.pdf](http://www.rijksoverheid.nl/binaries/rijksoverheid/documenten/rapporten/2015/10/01/integrale-geboortezorg/integrale-geboortezorg.pdf)).
- Ooclo, J., Matthews, R., 2016. From tokenism to empowerment: progressing patient and public involvement in healthcare improvement. *BMJ Qual. Saf.* 25 (8), 626–632.
- Oostveen, S., 2008. Kritisch naar jezelf kijken. *Arts Spe VVE* 28–30.
- Perdok, H., Jans, S., Verhoeven, C., van Dillen, J., Batenburg, R., Mol, B.W., et al., 2016. Opinions of professionals about integrating midwife- and obstetrician-led care in The Netherlands. *Midwifery* 37, 9–18.

- Perdok, H., Verhoeven, C.J., van Dillen, J., Schuitmaker, T.J., Hoogendoorn, K., Colli, J., de Jonge, A., 2018. Continuity of care is an important and distinct aspect of childbirth experience: findings of a survey evaluating experienced continuity of care, experienced quality of care and women's perception of labor. *BMC Pregnancy Childbirth* 18 (1), 13.
- Perined, 2018 retrieved from [www.perined.nl/producten/publicaties/jaarboeken](http://www.perined.nl/producten/publicaties/jaarboeken).
- Perined, 2015 retrieved from [www.perined.nl/producten/publicaties/jaarboeken](http://www.perined.nl/producten/publicaties/jaarboeken).
- Pope, R., Graham, L., Patel, S., 2001. Woman-centred care. *Int. J. Nurs. Stud.* 38, 227–238.
- Porter, M., 2000. The midwife in contemporary industrialised society. In: van Teijlingen, E., Lewis, G., McCaffery, P., Porter, M. (Eds.), *Midwifery and the Medicalisation of Childbirth: Comparative Perspectives*. Nova Science Publishers Ltd, New York, pp. 145–154.
- Poskiparta, M., Ketunen, T., Liimatainen, L., 1998. Reflective questions in health counseling. *Qual. Health Res.* 8 (5), 682–693.
- Rijnders, M., Baston, H., Schönbeck, Y., van der Pal, K., Prins, M., Green, J., et al., 2008. Perinatal factors related to negative or positive recall of birth experience in women 3 years postpartum in the Netherlands. *Birth* 35 (2), 107–116.
- Roberts, K., 2002. Exploring participation: older people on discharge from hospital. *J. Adv. Nurs.* 40 (4), 413–420.
- Rotundo, G., 2011. Centering pregnancy. *Nurs. Women's Health* 15 (6), 508–518.
- Shallow, H., 2001. Connection and disconnection: experiences of integration. *Br. J. Midwifery* 9 (2).
- Scheerhagen, M., van Stel, H.F., Birnie, E., Franx, A., Bonsel, G.J., 2015. Measuring client experiences in maternity care under change: development of a questionnaire based on the WHO responsiveness model. *PLoS One* 10 (2), 1–19.
- Taylor, C., White, S., 2000. *Practising Reflexivity in Health and Welfare: Making Knowledge*, first ed. Buckingham: Open University Press, Philadelphia.
- Trujols, J., Iraurgi, I., Oviedo-Joekes, E., Guàrdia-Olmos, J., 2014. A critical analysis of user satisfaction surveys in addiction services: opioid maintenance treatment as a representative case study. *Patient Prefer. Adherence* 8, 107–117.
- van Teijlingen, E.R., 2005. A critical analysis of the medical model as used in the study of pregnancy and childbirth. *Sociol. Res. Online* 10 (2), 1–15.
- V.C.W.E., 2016. Code of Ethics for Research in the Social and Behavioural Sciences Involving Human Participants. As accepted by the Deans of Social Sciences in the Netherlands.
- Walsh, D., Newburn, M., 2002. Towards a social model of childbirth: part one. *Br. J. Midwifery* 10, 476–481.
- Warmelink, J.C., Wiegers, T.A., de Cock, P., Klomp, T., 2017. Collaboration of midwives in primary care midwifery practices with other maternity care providers. *Midwifery* 55, 45–52.
- Wollersheim, H., 2008. Professioneel gedrag van artsen: de rol van reflectie en verantwoording afleggen. *Kwaliteit van zorg* 4, 4–8.
- World Health Organization, 2000. World Health Report Retrieved from <http://www.who.int/whr/2000/en/>.
- World Health Organization, 2018. WHO recommendations: intrapartum care for a positive childbirth experience. Retrieved from (<http://apps.who.int/iris/bitstream/handle/10665/260178/9789241550215-eng.pdf;jsessionid=F91EE991C2F3ED3E08CEA4D03201285C?sequence=1>).
- Wiegers, T.A., 2009. The quality of maternity care services as experienced by women in the Netherlands. *BMC Pregnancy Childbirth* 9 (1), 18.