UNIVERSITY OF TWENTE.

Master Health Sciences

Managing childbirth expectations

What to expect when you are expecting?

An explorative study on how midwifes manage childbirth expectations of pregnant women in the Dutch obstetric care system.

K.J. Veltjen s1477552

Supervisors:
Dr. M.M. Boere-Boonekamp
Prof. dr. A. Need

Date: 11-07-2017
University of Twente
P.O. Box 217
7500 AE Enschede
The Netherlands

Acknowledgements

This report is the result of my master thesis project for the master Health Sciences. The subject of obstetric care always triggered me and after the first meeting with my supervisor I got enthusiastic for this project. I really enjoyed taking all the interviews and hear all the stories of different midwifes.

This would not have been possible without the effort and support of several people. First, I would like to thank my supervisors M.M. Boere-Boonekamp and A. Need for providing me with good comments and guidance throughout the process of writing this thesis and C. van Stenus for the answers to all my small and quick questions. I would like to thank all the respondents that were willing to fill out the questionnaire, and the twelve interview participants. Without their response, participation and input, this study could not have been successfully conducted.

Special thanks go to E. Kerkhof and H. Baerveldt, for the orientation days and the opportunity to join the '*Pregnancy and Childbirth Symposium'*. Finally, I would like to thank my fellow students from 'kantoor', my family and my friends.

I hope you will enjoy reading this thesis.

Best regards,
Karlijn Veltjen

Enschede, July 2017

Abstract

Background

Pregnancy and childbirth is a life changing experience. Childbirth experiences have an immediate and long-lasting effect on the woman's well-being and her relationship with the baby. A negative childbirth experience is associated with serious problems. Negative and positive childbirth experiences are inherently linked to childbirth expectations, which are usually formed many months before the actual childbirth. Well-executed expectations management during pregnancy could help prepare pregnant women and their partners better for the impeding childbirth. The aim of this study is to discover how Dutch midwifes deal with expectations management in the existing Dutch obstetric care.

Method

This descriptive exploratory study used a sequential two-method design including a questionnaire at the *"Pregnancy and Childbirth Symposium"*, followed by twelve semi-structured interviews with Dutch midwifes. The interview participants were recruited through a request for interview participation integrated in the questionnaire. The interview data-analysis consist of open coding in the software program Atlas ti 8.0.

Results

The twelve Dutch midwifes worked in six different practices in the region of Overijssel in the Netherlands: 1) a big city practice with a high SES population, 2) a big city practice with a low SES population, 3) a small practice with a religious population, 4) a small practice with a population that lives in the countryside and 5) and 6) are quite similar, two middle size practices in villages. Several improvement points were given by the midwifes to improve expectations management within the Dutch obstetric care.

Conclusion

The obstetric care in the Netherlands handles a women centered approach, where midwifes provide tailored care. Dutch midwifes find out what the expectations of pregnant woman for the impeding childbirth are by asking them. The form and how they give substance to expectations management depends on the size of the midwife practice and on the population the practice cares for. Dutch midwifes use different methods to manage childbirth expectations but the most common way is conversation.

Key words: Expectations management, midwifes' experiences, obstetric care

Glossary

Birth	The time when a baby comes out of his or her mother's body.
Birth-plan	An overview of the path a pregnant woman is going to follow for her pregnancy, complemented with her beliefs, wishes and preferences about the childbirth.
Case manager	The care provider (most often the appointed midwife) who is responsible for the coordination of all the needed care for a pregnant woman.
Childbirth	The whole act of giving birth to a baby. It includes both labour and delivery. It refers to the entire process as an infant makes its way from the womb down the birth canal to the outside world.
Expectation	The feeling and thoughts that it is presumed that something is going to happen in the future, based on current facts or circumstances.
Expectations management	Managing expectations means communicating in such a way that all involved have a clear understanding of what to expect-and when to expect it. It also requires keeping communications open. Key points for success include initiating an open dialogue, making the process collaborative, promising only what can realistically be delivered, and documenting plans in clear ways.
Experiences	Something that happens to you that affects the way you feel and how your thoughts will be in the future.
Gynaecologist	A doctor specialized in the wide range of disorders of the reproductive organs and the breasts of women. Gynaecologists are also usually experts in the management of pregnancy and childbirth (obstetrics).
Labour	The last stage of pregnancy from the time when the muscles of the womb start to push the baby out of the body until the baby appears.
Maternity care assistant	In Dutch called "kraamverzorger". Maternity care assistants assist midwives in caring for women and their babies through the vital stages of pregnancy, childbirth and the first few days after birth.
Midwife	A person, usually a woman, who is trained to help, support and coach pregnant women throughout the whole pregnancy and the childbirth.
Multiparous	Being pregnant and having experienced one or more previous childbirths.
Obstetric care	The area of medicine that deals with pregnancy and the birth of babies.
Obstetrician	A doctor with special training in how to care for pregnant women and help in the birth of babies.
Parity	The condition or fact of having borne offspring.
Perinatal	Relating to the period before and soon after childbirth.
Primiparous	Giving or having birth for the first time.
Satisfaction	A pleasant feeling that you get when you receive something you wanted, or when you have done something you wanted to do.

Abbreviations

KNOV	Koninklijke Nederlandse Organisatie van Verloskundigen (Royal Dutch Organisation of Midwifes)
LOI	List of Obstetric Indications
SES	Social Economic Status
CP	Centering Pregnancy

List of figures

List of tables

Table of contents

1. Introduction

In this chapter, the study will be introduced. Paragraph 1.1 will present background information and will point out the importance of this study. Paragraph 1.2 consists of the objective of the study. The chapter concludes with the out-line of this study.

1.1 Background

Women have the honour to be able to carry a child. The whole pregnancy and childbirth is a life changing experience [1]. In Western developed countries childbirth is considered to be a safe event for both mother and child [2]. Giving birth could be the most beautiful experience of a woman's life. Unfortunately, the experience is not always positive even in Western countries. A large Swedish study showed that 6.8% (173/2541) of the women were unhappy with their overall experience of childbirth one year after the event [3]. In the Netherlands, a substantial proportion of 16.5% (197/1213) of the Dutch women looked back quite unhappy till very unhappy on their birth experience three years postpartum when they could choose between: very happy, quite happy, no particular feelings, quite unhappy and very unhappy [4]. Childbirth experiences have an immediate and long-lasting effect on the woman's well-being and her relationship with the baby [5]. A negative childbirth experience is associated with serious problems such as a (postpartum) depression, posttraumatic stress, avoidance behaviour and flashbacks, postponing a successive pregnancy or even not wanting to be pregnant again [3, 6].

Negative and positive childbirth experiences are inherently linked to childbirth expectations. Expectations are usually formed many months before the actual childbirth and have an impact on the eventual childbirth experience [7]. Women are more likely to have higher client satisfaction and positive experiences when their expectations are met and realized [8]. Therefore expectations management in the care sector of pregnant woman, also called 'obstetric care', is important [9]. Expectations management is defined as follows in the PubMed dictionary: '*Managing expectations means communicating in such way all involved have a clear understanding of what to expect- and when to expect it. It also requires keeping communications open. Key points for success include initiating an open dialogue, making the process collaborative, promising only what can realistically be delivered, and documenting plans in clear ways.*' [10]. A woman's expectation towards childbirth is associated with several factors like education, prior experiences, influences from friends and family, health care providers and - increasingly becoming more important – social media. These influences can contribute to what a woman expects to happen when she is in labour and gives birth [4]. Next to these factors women differ in their attitudes towards childbirth. Different researchers have described various types of woman and the expectations that are linked with these types [11-13].

To give pregnant women advice and to ensure women will form a realistic picture, it is suggested that obstetric health care professionals provide care with the pregnant woman as central focus point [14, 15]. A 'woman centered care approach' moves beyond the medical and physical care and seeks to better understand women's particular life situation and attitudes towards pregnancy and childbirth [11]. This approach can be described by using the terms 'patient or woman centered care' or 'tailored care'. In this research, the term 'tailored care' will be used. The Dutch obstetric care system is unique compared to most other countries, because of the specific structure [16]. Within the Dutch obstetric care system there are many different stakeholders involved. Midwifes are in most cases the central person during the pregnancy and, therefore play a significant role in the pregnancy process of Dutch women. Midwifes need to understand and respond to women's beliefs and attitudes during the pregnancy and childbirth to

achieve and optimise positive childbirth experiences [11]. Therefore midwifes have been recognized worldwide as 'women centered care givers' [17].

As mentioned before, it is important that women have a positive childbirth experience, because it will have a long-lasting effect on the baby, the mother and their relationship. Childbirth expectations play an important role to reach this end goal. At the moment, it is not clear how childbirth expectations are taken into account in the obstetric care in the Netherlands. Two recently performed Dutch studies complement each other in the urge to better manage childbirth expectations of pregnant women. The first study showed that discrepancy of expectations with the reality is a significant attribute of traumatic birth experiences. The women in this study believe that caregivers could have prevented their trauma's by discussing their expectations better on forehand [18]. The second study illustrated that well-executed expectations management during pregnancy could help prepare pregnant women and their partners better for the impeding childbirth [19]. Both studies have not addressed the specific role of Dutch midwifes.

1.2 Objective

The aim of this study is to discover how Dutch midwifes consider expectations management in the existing Dutch perinatal healthcare. Important steps in this process are: 1) identification of the current obstetric care in the Netherlands, 2) identification of factors important to pregnant women regarding their expectations for the impeding childbirth, and 3) exploring which methods midwifes use considering childbirth expectations in tailored care and find out which method is preferred. This study will thus explore how Dutch midwifes cope with childbirth expectations of pregnant women in their professional practice. Being embedded in this background, the central question that motivates this paper is**:**

"How do midwifes in the Netherlands manage childbirth expectations of pregnant women while providing tailored care?"

This research question is divided in five **sub-questions:**

1. *How is the current obstetric care in the Netherlands organised?*
2. *How do midwifes in the Netherlands find out what the childbirth expectations of pregnant women are?*
3. *Which methods do Dutch midwifes currently use to manage the childbirth expectations of pregnant women while providing tailored care and what are their experiences with these methods?*
4. *How do Dutch midwifes keep the childbirth expectations of pregnant women realistic?*
5. *Which improvement points do Dutch midwifes see when they look at expectations management in their own obstetric practice?*

This thesis is divided in five chapters in order to provide answers on the formulated questions. In chapter two the theoretical framework of the study will be presented. The existing literature and theories that are related to this research will be discussed. Chapter three consists of the methodology of the research. This includes step by step answers to how the study is performed and why. In chapter four the results of the study will be presented. The last chapter, number five, includes the discussion of the study combined with the conclusion which gives an answer to the stated research question.

2. Theoretical framework

The previous chapter has provided the identification of the problem and the research question with corresponding sub-questions. In this chapter, the theoretical framework will be discussed. It will highlight and discuss the existing literature and theories that are related to this research. For this theoretical framework, a flowchart is developed which shows the process from childbirth expectations till childbirth experience, see Figure 1. The flowchart illustrates where expectations management takes place in this process. This flowchart can be used as a guide for the different topics in this study. The red arrow illustrates the main question and the focus point of this study. How is that part of the process organised? Based on this flowchart all the different components will be discussed starting with the childbirth expectations. A clarification will be given on what childbirth expectations are and which factors influence these expectations. The second part focusses on expectations management. What is it exactly and what role does it play in delivering tailored care for pregnant women? In this part, the currently used methods for childbirth expectations management in the Dutch obstetric care system will be discussed. The third and last part consists of the childbirth experiences. Just like the expectations, the childbirth experiences are also influenced by different factors.

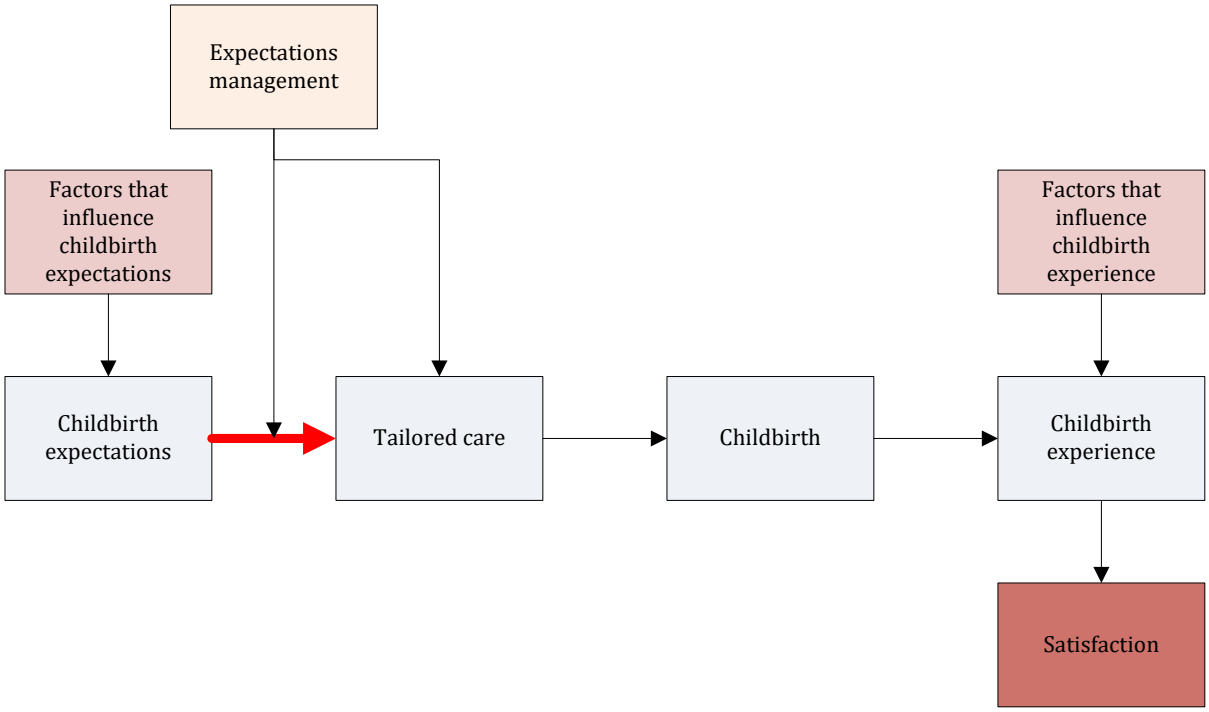

Figure 1. Flowchart of the process from expectations till experience

2.1 Childbirth expectations

Childbirth expectations are formed before the actual childbirth, they consists of feelings and beliefs of what will happen in a prospective view [2]. Childbirth expectations are most likely formed many months before the actual childbirth [20]. Childbirth expectations and women's beliefs differ significantly from one another [10]. There are several factors that can influence these varying childbirth expectations. In this study's theoretical framework, different literature about childbirth expectations is bundled together in Table 1. This table shows six determinants that influence the childbirth expectations of pregnant women. The table is based on the grouping Fenwick et. al made, together with additional literature [1, 2, 7, 8, 11]. The grouping of Fenwick et al. consisted of five determinants; public discourses, private discourses, professional discourses,

self and life experience. Based upon five different articles the names of the determinants are changed except for the public discourses and one extra determinant is added [1, 2, 7, 8, 11]. The different determinants will be discussed separately from each other.

Table 1. Six determinants that influence women's childbirth expectations [7]

GROUP	EXAMPLE
ATTITUDE	Own attitude, different types of women.
SOCIAL ENVIRONMENT	Mothers, family and friends with children, family history of birth, social media, social economic status and other acquaintances.
MEDICAL ENVIRONMENT	Midwifes and visits with midwifes, antenatal classes, general practitioners, private hospital, obstetricians, specialists and parity.
CHARACTERISTICS OF THE PREGNANT WOMAN	Age, life style, religion, civil status, medical status and home situation.
EARLIER EXPERIENCE	Earlier experiences with pregnancy, childbirth and or miscarriage.
PUBLIC DISCOURSES	Folders, television, videos and internet.

Attitude

The first determinant is called attitude. This refers to the attitude of the pregnant woman towards the childbirth. Different childbirth expectations are related to what kind of type the pregnant woman is. Individual women's beliefs and expectations regarding childbirth differ significantly from one another [2, 7]. Women thus differ in their attitudes towards childbirth and, based on earlier studies that have been published on this topic, different types of women can be recognized. Fenwick for example stated that pregnant women can be divided in two groups based on their expectations towards childbirth. The childbirth is either perceived as a medical condition with multiple risks involved, or childbirth is viewed as being a normal and natural process [7].

Raphael-Leff distinguished four types of women to help clinicians understand women's subjective attitudes and approaches towards childbirth [12, 13]. These four types are: 1) facilitators, 2) reciprocators 3) regulators and 4) conflicted. These diverse types are implemented in a model called 'the model of maternal orientations'. Table 2 gives an overview of the typical characteristics of the four types. Women are almost never considered to be a 'pure' type. Most women tend to lean towards one of the three first types, or oscillate between two types like the 'conflicted type'. Studies found that women who belong to the 'regulators' have a higher change of developing a postnatal depression [13].

Table 2. Four types of women with different attitudes towards childbirth [13]

Type of woman	Attitude towards childbirth
The Facilitator	Approach childbirth as a 'natural' and intimate process. These exhilarated women are aware of their own strength and want to manage the birth themselves. As little technology and interventions as possible.
The Regulator	These women see childbirth as the most painful, dangerous and exhausting moment of their lives. Interventions and medication are provided as soon as needed.
The Reciprocator	'Wait and see' approach. These women experience childbirth as a both stressful and exciting event. They do not have a specific birth plan.
Conflicted	These women shift between Facilitator and Regulator. They seem to lack the ability to tolerate both the uncertainty of the outcome as well as the contradicting feelings.

Haines et al. performed a prospective longitudinal cohort study to investigate numerous aspects of pregnancy, birth and early parenting in 2012. They studied a group of pregnant women from regional areas in Sweden (n=386) and Australia (n=123) prospectively and added a questionnaire two months post birth (retrospective). They distinguished three clusters of women called either 1) fearful, 2) take it as it comes or 3) self-determiners [11]. The division of the groups is similar to the model of maternal orientations, except from the fact that conflicted women are spread over the three clear clusters. The cluster 'take it as it comes' is not afraid of childbirth. In contrast, the cluster 'fearful' is afraid and has some concerns about safety during childbirth. The last cluster 'Self determiners' were characterised by the positive attitude towards a natural process of birth and freedom of choice during childbirth [11].

The different types of women could be linked to specific childbirth experiences. Health care professionals could therefore anticipate to these different types of women. Especially the group who sees childbirth as a fearful situation with medical risks involved should be offered tailored care. Literature has shown that this group has a bigger chance of experiencing a less than positive childbirth, which also increases the risks of developing a (postnatal) depression or posttraumatic stress [18]. Midwifes could anticipate on this knowledge and be extra alert to this group of pregnant women. When managing childbirth expectations, it is therefore worthwhile to discover the type of the woman and adjust the given care accordingly.

Social environment

The second determinant of childbirth expectations is the social environment of pregnant women. This includes friends, family, work colleagues, stories of others with kids and increasingly more important, social media. Indeed, stories told by others in the own environment will influence and form their expectations [7, 8]. This can be both negative or positive, which depends on the stories the pregnant women will hear. Next to these 'real life' stories, social media gets increased attention in forming expectations towards childbirth. Pregnant women can talk to each other and exchange stories, thoughts and experiences on for example special forums on the internet.

Medical environment

The medical environment is the third determinant that affects the expectations towards the childbirth. This determinant includes the medical status of the pregnant woman, the relationship with her care givers and parity.

The medical status of the pregnant woman can influence her expectations. When a woman has a high-risk pregnancy due to a chronic illness for example diabetes, her expectations will be different compared to a healthy woman [21]. In the Netherlands, this is linked to the way the obstetric care system is organised. High risks pregnancies follow a different care-path compared to perfectly healthy women. The Dutch obstetric care system will be discussed in Chapter 4.

The relationship with the caregivers is also an important factor, since pregnant women use professional caregivers as an information source about pregnancy and childbirth. Especially the trust in and reliability of a caregiver can create more positive expectations. When this relationship is good and the caregiver and the pregnant woman understand and trust each other, the expectations will be more positive and calm. When this relationship is not good and based on fear and misunderstandings, the expectations will be more negative and stressful [20, 22].

The last and most important factor in this medical environment determinant is parity. Parity has strong influences on childbirth expectations. When a woman gives birth to her first child (primiparous), the expectations are different compared to a mother who is pregnant and gave birth before (multiparous). The multiparous pregnant woman is prepared for the childbirth and the pain that comes with it, as she knows has experienced it before and thus knows what to expect, whereas the primiparous woman should trust on her own preparation for the childbirth [2]. The expectations of the multiparous pregnant woman are also related to the experiences of her past childbirth(s), which can also be either positive or negative.

Characteristics of pregnant women

Characteristics of a pregnant woman are found to be of a significant influence on the expectations towards childbirth. These characteristics include age, lifestyle, level of education, ethnicity, marital status, character and religion. All these characteristics differ significantly for each woman and may influence the expectations towards the childbirth [22]. This regards the fourth determinant.

Earlier experiences

Earlier experiences with pregnancy, childbirth and or miscarriage are the fifth determinant and will influence expectations towards childbirth strongly. Like mentioned before, parity is an important factor which is related to earlier experiences. Most of the time, pregnant women who have prior experiences have a better understanding of what they want and do not want. [7].

Public discourses

The last determinant is the public discourses. This consist of everything a pregnant woman reads watches or hears on the television, internet, newspapers, radio, videos etc. When you are pregnant, you can prepare yourself for the impeding childbirth. Pregnant women can do this themselves by reading brochures and folders and watch different kind of videos. All these things will influence the expectations of the mother [20, 22].

Next to these information sources, the Netherlands has a big supporting system for pregnant women with a lot of different ways to prepare yourself for labour. A few examples to clarify this are pregnancy yoga, gym exercises and group sessions to talk with other women. This supporting system is voluntary for pregnant women to join [21].

2.2 Expectations management and currently used methods

Expectations management has been defined before as "*Managing expectations means communicating in such way all involved have a clear understanding of what to expect-and when to expect it. It also requires keeping communications open. Key points for success include initiating an open dialogue, making the process collaborative, promising only what can realistically be delivered, and documenting plans in clear ways.*" [10]. Figure 1 shows where expectations management takes place in the pregnancy process with expectations and experiences towards childbirth included. First the expectations are being formed and then the expectations can be managed, before and during the delivery of tailored care. Tailored care is care where the pregnant woman is the central focus point. The care given should be tailored to the needs of the individual pregnant woman. The actor in expectations management, are in this study the midwifes.

To be able to manage childbirth expectations, certain methods could and should be used. To guarantee and achieve a safe and healthy pregnancy, for both mother and child, the Dutch steering committee strongly advised three instruments to the government in 2009; 1) a case manager, 2) a birth-plan and 3) a mandatory house visiting. These three instruments should be mandatory implemented in the obstetric care, and used by the midwifes according to the Dutch steering committee [15]. The three instruments and their added values will be described in this paragraph.

The first instrument to manage childbirth expectations is the case manager. He or she is responsible for the coordination of all the needed care for the pregnant woman. The case manager's function is mostly fulfilled by the (clinical) midwife that is appointed to the pregnant woman. Answering questions and taking away uncertainties and fear are some of the important tasks of the case manager. The case-manager is responsible for creating a situation that the right actions can be taken in case of emergency and risk increasing situations. Next to this, the case manager needs to provide continuity care, to ensure the woman and her unborn child cannot become victims of miscommunications or other unclarities. Continuity care consists of a one-to-one support and guidance for the client [15]. This instrument is essential for the continuity of care for pregnant women. Both the Steering committee and the Standard of Care plead for the implementation of a case manager [15, 21].

The second instrument is called a 'birth-plan'. A birth-plan is an overview of the path the pregnant woman is going to follow during her pregnancy. In the Netherlands, this plan should be made before the 13th week of the pregnancy together with the case manager [15]. Creating a birth-plan provides the opportunity to determine personal expectations about the whole pregnancy process and the impeding childbirth, develop a relationship with the care givers and share insight in the decision making. A birth-plan is an important tool to help women achieve the childbirth they want. It is a tool to open communication between the woman and the people caring for her during her childbirth. Communication involves an ongoing dialogue throughout the whole pregnancy and during childbirth to foster trust between the two, or more, parties. The birth-plan has a dynamic character, as it can be adjusted for different kind of changes. When looking at a standard birth-plan it consists of three main questions*: 1) What would I do to stay confident and feel safe? 2) What would I do to find comfort in response to my contractions? 3) Who would support me through labour and what would I need from them?* In addition to these three questions there are other important aspects included in the birth-plan, for example the way of delivery, the preferences for place of delivery and the possibilities of pain medication [23]. This instrument is already implemented in the current Dutch system, but is not mandatory. The Royal Dutch Organisation of Midwifes (Koninklijke Nederlandse Organisatie van Verloskundigen, KNOV)

recommends the use of birth plans and there are a lot of independent obstetric practices that make use of birth plans and [20].

The third and last 'instrument' is the home visit. The Dutch steering committee stated that there should be more insight in pregnant women's lives to exclude possible risks. They propose a standard house visit before the 34th week of the pregnancy [15]. The goal of the visits is 1) to observe if there are problems in the home-situation, 2) if necessary, provide extra prenatal awareness and 3) to judge if the home-situation is safe enough for a new born child and the mother. It is strongly advised to do so, because it can create a better bond between the client and the midwife. The home visit is an excellent possibility to discuss the expectations and wishes the woman has in a more comfortable setting than within a regular consultation at the obstetric practice. However, this home visit takes an additional hour of the client and the care provider. For this reason, the home visits are recommended by the KNOV but not implemented as a standard procedure in the Dutch obstetric care system [20].

With the use of these three instruments, midwifes can find out what the expectations towards childbirth of the pregnant woman are. The independent obstetric practices can decide for themselves whether they want to implement these three instruments or not [9].

2.3 Childbirth experience

Next to the expectations, it is valuable to look at the childbirth experiences of women, according to Hodnett [24]. Experiences are formed during and after the childbirth. It consists of undergoing what is happening and the feelings and thoughts linked to the situation in a retrospective view. What women want before giving birth is mostly different than what women need during childbirth [4]. There are authors who argue that childbirth experiences are depending strongly on the characteristics and demographics of the woman, see Paragraph 2.1 [2, 8].

However, not only the characteristics of the pregnant woman are influencing the childbirth experience. There are other factors that are mentioned frequently in research as being significant. Hodnett performed a systematic review of 137 reports about a woman's attitude towards the experience of childbirth in 2002 [24]. She found out that there are four factors so important, that they override the influences of all the other factors like characteristics and demographics. These four factors are: 1) the amount of support from care givers, 2) personal expectations, 3) involvement in decision making and 4) the quality of the caregiver-patient relationship [24]. A retrospective qualitative study that conducted research on women's suggestions for improving midwifery care in the Netherlands, confirmed these four factors to be most valuable in 2015 [5].

The first factor is support from the professional caregivers during the whole process. Women who are giving birth prefer having the same caregivers around her during the childbirth as during her pregnancy [16, 22]. Familiar faces and a comfortable setting contribute to a positive birth environment. Next to this comfortable environment is it important that the birthing woman has the feeling that there is continuously care available for her [1]. Support from the partner is especially important in Western societies because fathers are willing to participate and provide support during childbirth in these societies [8, 13].

Second are the personal expectations that are usually based on knowledge that is available to the woman. This knowledge often includes stories of friends and family and for example social media. Women with high expectations and women whose experience were better than expected, had more likely positive childbirth experiences. In contrast, negative childbirth experiences are associated with low expectations towards childbirth [8, 24].

The third factor is the participation of the woman in the decision making during childbirth. A woman finds it important to have an active say in the decisions that are made for her, as she wants to be in control of her own childbirth [22]. This aspect confirms the first one, that the actions and interactions from caregivers during labour are important to the overall perception of the woman [8] [18].

The fourth and last-mentioned factor, is the quality of the caregiver-patient relationship. This aspect strongly influences the overall birth experience. The quality of this relationship depends upon communication, information and reports [1, 4]. Labouring women want to feel involved in their own childbirth and need to feel free to express their feelings. This aspect complements the third one of decision making.

What is striking is the fact that the second factor which is important for a positive childbirth experience, is personal expectations. These two terms are linked to each other and almost merge. The childbirth expectations are an important element of the experiences. When you want to manage childbirth expectations it is important to consider the four experience aspects of women who already gave birth, where expectations are already implicitly included. Next to this, it is important to explicitly manage the expectations. When combining the information of both the expectations as well as the experiences, health care professionals will be able to better manage childbirth expectations and deliver better care.

Dealing with pain during childbirth, the level of pain and pain relief is important with respect to childbirth experience, but difficult because women find it difficult to describe and associate it with their feelings [2, 24]. The relationship between pain and childbirth experience is complex, because research showed that the most satisfied women are those who did not use pain-relieving medication. The most dissatisfied women are the ones who were very anxious about birth pain. On the other hand, women who had not been given the choice to choose for pain relief were three times more likely to have a negative childbirth experience [2]. Hodnett even concluded that the amount of pain a woman experienced during childbirth has no influence on the positive or negative outcome. It is important to consider pain when managing childbirth expectations, because it is considered a 'fear' in most cases, but it should not be the central focus point [25].

Satisfaction

The end goal of pregnant women is satisfaction at the end of the process and a healthy baby. Satisfaction is described as a pleasant feeling that you get when you receive something you wanted, or when you have done something you wanted to do [26]. To be able to reach this point of satisfaction it is important to look at childbirth expectations. Women are more likely to reach positive childbirth experiences when their expectations are met [11]. Midwifes are the central caregivers for pregnant women and should help them to create realistic expectations, because realistic expectations are easier to be met [8].

In conclusion, the previous literature gives us information about factors that women find important during childbirth. Midwifes should not underestimate the influence of expectations towards childbirth on the overall experience. Managing the expectations can really make a difference for pregnant women and their overall experience of their childbirth, as is suggested by previous studies. This information, gained from childbirth experiences, can be used in managing the childbirth expectations. All this information can then be combined by midwifes to manage the expectations, to anticipate on these expectations and to assess better care in doing so.

3. Methodology

In this chapter, the methodology of this research will be explained. The study was executed from February till July 2017. It took place in the region Overijssel of the Netherlands. To find answers to the stated research question with corresponding sub-questions a qualitative explorative approach was chosen. This research design is the most suitable because the study is focused on exploring the experiences and perspectives of health care professionals on delivering tailored care. A qualitative approach is suitable for research that is focused on a how- or why-question, which matches the main research question with corresponding sub-questions. The most commonly used methods for a qualitative study are interviews, observations and focus group discussions [27, 28].

The descriptive, exploratory study included a sequential mixed two-method design. The first sub-question was answered with the use of literature. Pubmed and Scopus are the databases that had been used for this. The first method was a two-page questionnaire that was distributed on the *"Pregnancy and Childbirth Symposium"* on the 20th of April 2017. The second method consisted of qualitative semi-structured interviews with several Dutch midwifes. An overview of the whole methodology in chronological order is given in Figure 2. As mentioned before in the objective the main goal of this study is to explore how midwifes deal with childbirth expectations in the existing Dutch perinatal healthcare. In the following paragraphs the research design, participants and instruments will be further explained for the questionnaire and the interviews separately.

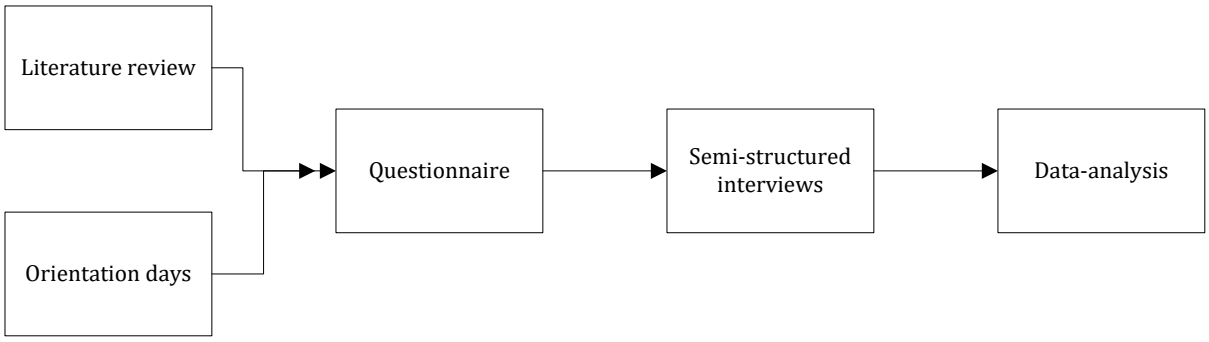

Figure 2. Overview of the methodology in chronologic order

3.1 Questionnaire

In this research, a questionnaire was used. The two intended goals of this questionnaire were; 1) examine how midwifes handle childbirth expectations of pregnant women, and 2) to recruit interview participants.

To be able to create a valuable questionnaire, two orientation days were implemented. During this orientation days, the researcher observed consultation hours in an independently obstetric practice in Overijssel with two different midwifes. The questionnaire is based upon these two orientation days and a literature review. These two components are both part of the preparation and development process of the questionnaire. The questionnaire is written in Dutch and can be found in Appendix I. The researcher received in advance an estimation of the number of midwifes and gynaecologists that would be present at the symposium. Based on this estimation a total of 40 questionnaires were printed for the Symposium.

3.1.1 Participants

The questionnaire was printed and distributed at the *"Pregnancy and Childbirth Symposium"* on the 20th of April 2017 in Zwolle. This printed version was done to increase the respond rate [28, 29]. This symposium was organised for all professionals of obstetric health care in the region of Overijssel in the Netherlands. The questionnaire was brought to the attention by the host of the Symposium and distributed by the researcher during the break.

In total, 26 midwifes and gynaecologists filled out the questionnaire during the *"Pregnancy and Childbirth Symposium"*. This number included all the midwifes and gynaecologists that were present that day. Two midwifes were excluded from filling out the questionnaire because they were students at that moment. Table 3* shows the background variables of the questionnaire participants.

Table 3. Background variables of the questionnaire participants

N (%)		**26 (100)**
Gender	Men	0 (0)
	Women	26 (100)
Function	First line	16 (61.5)
	Second line	7 (26.9)
	Gynaecologists	3 (11.5)
Age	20-29	7 (26.9)
	30-39	9 (34.6)
	40-49	6 (23.1)
	50-59	4 (15.4)
Work experience (years)	1-4	4 (15.4)
	5-9	8 (30.8)
	10-14	7 (26.9)
	15-19	2 (7.7)
	>20	5 (19.2)
Education (place)	Kerkrade	1 (3.8)
	Groningen	6 (23.1)
	Zwolle	4 (15.4)
	Londen	1 (3.8)
	Turnhout	5 (19.2)
	Amsterdam	2 (7.7)
	Nijmegen	3 (11.5)
	Maastricht	3 (11.5)
	Rotterdam	1 (3.8)

* *Currently workplace, question 6, is excluded to ensure the anonymity of the participants.*

3.1.2 Instrument

The questionnaire has a length of two pages. The short length of the questionnaire will increase the respond rate [29]. The first part consists of demographics and includes gender, age, work experience, place of education and current workplace. This was added to get a general picture of the sample. The second part of the questionnaire is focused on eight factors that can influence the childbirth expectations from pregnant women, see Table 1. The answer options in this part are structured as a Likert scale with four agreement points [28]. These questions were added, because

they play an important role in managing childbirth expectations. Being aware of these factors is the first and maybe unconscious step in expectations management. The last part of the questionnaire includes some research specific questions about the three models the Dutch committee recommended to create a global view of Dutch midwifes and expectations management. At the end of the questionnaire a request for interview participation was added. The questionnaire was checked by two researchers and one midwife to determine if the questions were comprehensible.

3.2 Interviews

Next to the questionnaire, interviews were held. The goal of these interviews was to get an in-depth view and more detailed insight in how midwifes take childbirth expectations into account by providing tailored care. With the help of these interviews the researcher can analyse how midwifes find out what the childbirth expectations of pregnant women are and which way is preferred. Next to these two important aspects, the currently used methods were discussed. For this part of the study semi-structured interviews were conducted. This form was chosen because the structure is given, but the researcher can still ask spontaneous questions and can go into more detail when the respondent gives valuable information [29].

3.2.1 Participants

The interview participants were recruited through a request for interview participation integrated in the questionnaire. An important inclusion criterion is that the midwifes are still practicing their profession in the Netherlands in the region of Overijssel. Exclusion criteria in this part are: students, retired midwifes and midwifes that are temporarily not working because of illness or own pregnancy. From the 26 respondents of the questionnaire, 8 respondents gave permission to join the study for an interview.

The midwifes that were willing to participate in the interviews received an invitation by email or telephone the next day to make an appointment for an interview. A reminder was sent one week after the initial mailing, to make sure all the respondents were included in the study. Unfortunately, not all the 8 respondents were accessible. To ensure a reasonable sample size, five more participants were recruited by the researcher. In total twelve female midwifes have been interviewed. The twelve respondents worked in six different practices in the region of Overijssel in the Netherlands; 1) big city practice with a high SES population, 2) big city practice with a low SES population, 3) small practice with a religious population, 4) small practice with a population that lives in the countryside and 5) and 6) are quite similar, two middle size practices in villages. The participants were in the age category of 28 till 51. All midwifes agreed with the informed consent and gave permission to record the interview.

The researcher made it as easy as possible for the respondents to participate in the study and travelled towards them. This means there is no travel distance for the participants, which increased the chance of getting a higher respond rate [29]. All interviews were undertaken by the same researcher.

3.2.2 Instrument

The semi-structured interviews are structured with the use of 1) an interview-protocol 2) an informed consent and 3) an interview-scheme. All these three components are conducted in Dutch and can be found in the Appendix respectively II, III and IV. These three documents were checked by two researchers to determine if the questions and the text are comprehensible.

The interview-protocol consist of an introduction text. This introduction was read out loud by the researcher to the respondent, to make sure the procedure of the interview was clear. It includes the following facts; this interview is totally voluntary, the respondent can stop at any time without any consequences, the respondent can only give good answers, and the question if it is alright to audio record the interview.

To comply with ethical considerations, all the midwifes were asked at the beginning of the interview to give their consent for participation in this study. The researcher brought the document on paper and the informed consent must be signed by both the respondent and the researcher before the interview could take place.

The interview-scheme is based upon the five sub-questions of this study. The scheme consists of six main questions, each accompanied with a few sub-questions. The six themes are 1) discovery of the expectations, 2) differences in expectations patterns, 3) methods or instruments to get insight in the childbirth expectations, 4) experiences with certain methods or instruments, 5) coping with the expectations in the evaluation after the childbirth with the mother, and 6) points for improvement. This interview-scheme was checked by two researchers and as well by an independent midwife, to make sure the scheme was suited for this audience.

The interviews were one-to-one and held face-to-face. The face-to-face approach creates a more open and comfortable conversation. Respondents feel more free to answer the questions compared to for example a telephone interview [28, 29].

Overall this scheme acted like a guide for the researcher, to discuss all the intended subjects, and to make sure nothing was missed. The estimated time for one interview was 30 minutes.

3.3 Data analysis

Table 4 shows which method(s) are used to answer the different research sub-questions.

Table 4. The methods used for each sub-question

Methods	Sub-question(s) number
Literature	1
Questionnaire	2 – 3
Interviews	2 – 3 – 4 – 5

3.3.1 Quantitative analysis

The answers given in the questionnaire were stored in a database. This data was analysed in SPSS to create figures and tables to give a clear overview of the answers given [30]. The questionnaire was split in four categories. Different categories were used to answer parts of sub-question two and three. The results from the questionnaire are presented with the use of tables. These tables with corresponding explanation can be found in Appendix V.

3.3.2 Qualitative analysis

The study generated qualitative data from the interviews, so a structured approach of analysing the data was desired. An overview of the interview analysis can be found in Figure 3. The analysis of the interviews can be divided in five steps.

The first step was to prepare the gathered data for analysis. This was done by transcribing the audio-recorded interviews with the permission of the respondent. These audio fragments were anonymously transcribed in Word, without details like stutter, thinking expressions and pauses. These transcripts are available on request from the first supervisor of this study.

The second step consisted of creating a global overview of the gathered information. The researcher read the interviews to get a first impression of the quality of the materials.

The third step of the analysis of the interviews was the detailed analysis. The transcribed interviews were open coded for the first time and a codebook was created. The main goal of coding the interviews was to get a more detailed insight and at the same time an organised overview divided into different segments (codes). The transcripts were coded and analysed with the use of the program Atlas ti 8.0 [31]. The first round of coding was performed by highlighting certain concepts and categories. These categories were written down in a code book, which is added in the Appendix VI and consists of 16 codes. These 16 codes are based upon the global overview the researcher gained from the data. After the first round a second round of coding was performed. In this round, the researcher searched for more specific labels to redistribute the codes into labels, and searched for labels that could be linked to theories from the theoretical framework. The codes *'expectations patterns'* and *'influence factors'* for example, are based upon Table 2 and 3 from the theoretical framework. The final and last round of coding was performed by an independent master student to ensure validity in this research and to avoid subjective coding of the researcher. The two coding structures were compared and adjusted when necessary.

When all the coding was done a '*quotation-report*' was created in Atlas ti 8.0, this regards the fourth step. This report showed all the different codes and labels, together with the sentences from the interviews that were highlighted with that code or label.

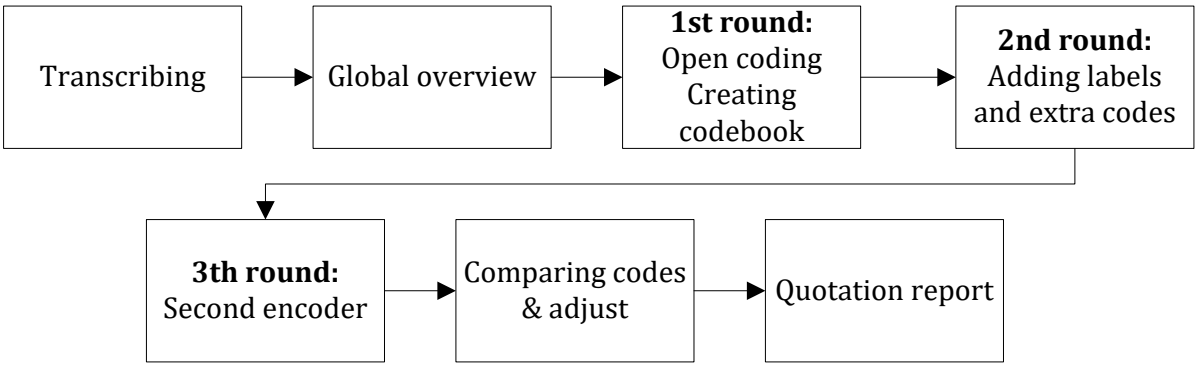

Figure 3. Overview of the interview data-analysis in chronologic order

The fifth and final step in the analysis process was to interpret the final results of the study to the original problem and to present them in a meaningful way. This was done by presenting the results per sub-question in chronologic order. Sorting the results was done with the use of different theories from the theoretical framework, which were built in the code-book as well. An overview of this sorting can be found in Table 5. This means that the results are distinguished and described with the use of literature. Next to this sorting, other sorting can be found, because the first round of the detailed analysis consists of open coding.

To illustrate and clarify certain results, anonymous quotations from the different interviews are used in Chapter 4, all these quotations are italic. The quotations are translated to English by the researcher. The corresponding participant is mentioned after the quote, example given: "*quotation" (P.3, S.234).* The P stands for the participant-number (3) and the S stands for the number of the sentence (234).

Table 5. The research sub-questions with their corresponding theories that are used to sort the results

SUB-QUESTION	THEORIES USED TO SORT THE RESULTS
1	-
2	The six determinants that influence childbirth expectations. (Table 1) The four different types of women. (Table 2)
3	The three methods that are recommended by the Dutch steering committee.
4	-
5	-

4. Results

In this chapter, the results of this study will be presented. The analysis will be done by following the sub-questions in chronological order.

4.1 Overview of the Dutch obstetric care system

To be able to formulate an answer to the first sub-question, it is important to take a closer look on how the Dutch obstetric care system is organised. In what kind of system do Dutch midwifes work, and does the system influence the way tailored care is provided, or the expectations that are being formed by pregnant women in the Netherlands? Sub-question one reads as follows: ***1.*** *How is the current obstetric care in the Netherlands organised?* This question was answered with the use of literature research.

4.1.1 Obstetric care in the Netherlands

The Dutch obstetric care system is viewed by many as a model of care with a high level of physiological approach and with independent midwifes, also called 'community midwifes' [4, 32]. The Dutch system handles pregnancy and childbirth as normal processes that can be treated in the first line. Pregnancy is not an illness and for that reason the system is focused on and the professionals are trained to not get the woman in the medical setting when this is not necessary [33].

The Dutch system has three components which creates a unique combination; 1) it consists of two models, the midwife-led care model and the obstetrician-led care model, 2) within these models there are three lines of obstetric care, and 3) Dutch women have the freedom to choose the place of birth, and the Netherlands have a high homebirth rate [34, 35]. These three components will be discussed separately from each other.

In the midwife-led care model, the midwife is the central professional from the beginning of the pregnancy till the postnatal period and it includes the physiological pregnancies and childbirths. In the obstetrician-led care model, the obstetrician is the central professional and it includes the pathological pregnancies and childbirths.

The three lines of care will be discussed starting with the first one. The first line (primary) of care is easy accessible, as you do not need any referral and can contact the caregivers yourself. The midwifes working in the first line play a key role in providing one-to-one standard obstetric care and are the gatekeepers for the second line [17, 34]. Midwifes in the first line are independent and mostly working in their own practices. They are responsible for the pregnant woman, labour and the postpartum period as long as the process continues to be physiological. When complications occur or the pregnancy is not only physiological anymore, the first line midwife can refer women to the second line. This referral behaviour is controlled by the so called 'List of Obstetric Indications' (LOI). This is a guideline that helps to determine which healthcare professional is best suited and appropriate in the specific situation for that individual pregnant woman [17, 32, 34, 36]. The second line (secondary) care consists of specialized care in general hospitals and is only accessible after referral from the first line. The midwifes working in the second line are working in general hospitals and are called 'clinical midwifes'. They assist pregnant women with an increased risk or initial pathology. They work independently or in cooperation with a gynaecologist. The third and last line (tertiary) of care is for the very specialized care. This care takes place in academic hospitals and is focused on for example babies that have a high chance of being born extremely premature, pathology that occurs during pregnancy, specialized echo's and women with a very high risk pregnancy [17]. The boundaries

between these three lines are very strict and clear [16]. An overview of the obstetric care system can be found in Figure 4 [37]. Perdok et al. published this figure in their article. The percentages were taken out of the figure because they are not relevant in this study.

In the Dutch system, low-risk women have the freedom to choose the place of birth, which can take place at home or in the hospital, but both under the supervision of a midwife [4, 32, 38]. The Netherlands has a high home birth rate, about 22% of all pregnant women give birth at home. Although the number of home births decreased the last decennium (Statistics Netherlands CBS), it is still high compared to the rest of Europe [38].

Rijnders et al. investigated 1309 views of Dutch women's childbirth experiences three years postpartum in 2008. The authors conclude that the current Dutch obstetric model leads to a higher level of satisfaction and more feelings of control by the pregnant women [4]. Perdok et al. stated in a descriptive study using a questionnaire survey in 2013 in the Netherlands that professionals and stakeholders (n=1394) are increasingly questioning the current model [39]. One of the consequences of the current model Perdok et al. mention is the transferral from the first to the second line. The first line midwife is out of sight when she refers a woman to the second line. This may lead to discontinuity of care and loss of important information, which can potentially impact the quality and safety of care [39]. The authors recommend 'integrated care' which is defined as closer relationship and collaboration between the three care lines (primary secondary and tertiary) to enhance continuity of care for pregnant women [37]. Warmelink et al. conducted a qualitative study, using a grounded theory design to measure what the perceptions of midwife students (n=18) are regarding the organisation of the current obstetric care model and alternative models [34]. After graduating, these students will enter the obstetric care system despite of changes that might occur. The students believed in the physiologic and normalcy approach towards childbirth and in tailored care, regardless of any model for this type of care. They had an open attitude towards change because they recognised that a change in the organisation of obstetric care is inevitable.

In summary, the Dutch obstetric care system is unique, since it combines the midwife-led care and the obstetrician-led care model and it consist of three care-lines (primary, secondary and tertiary). The care givers that use the model are not equally satisfied with the current situation. A switch to integrated care has already been put forward. The Dutch system could influence the expectations Dutch women have regarding childbirth. Especially via the way the care providers are performing in this system (referral behaviour) and what kind of effect that will have on pregnant women.

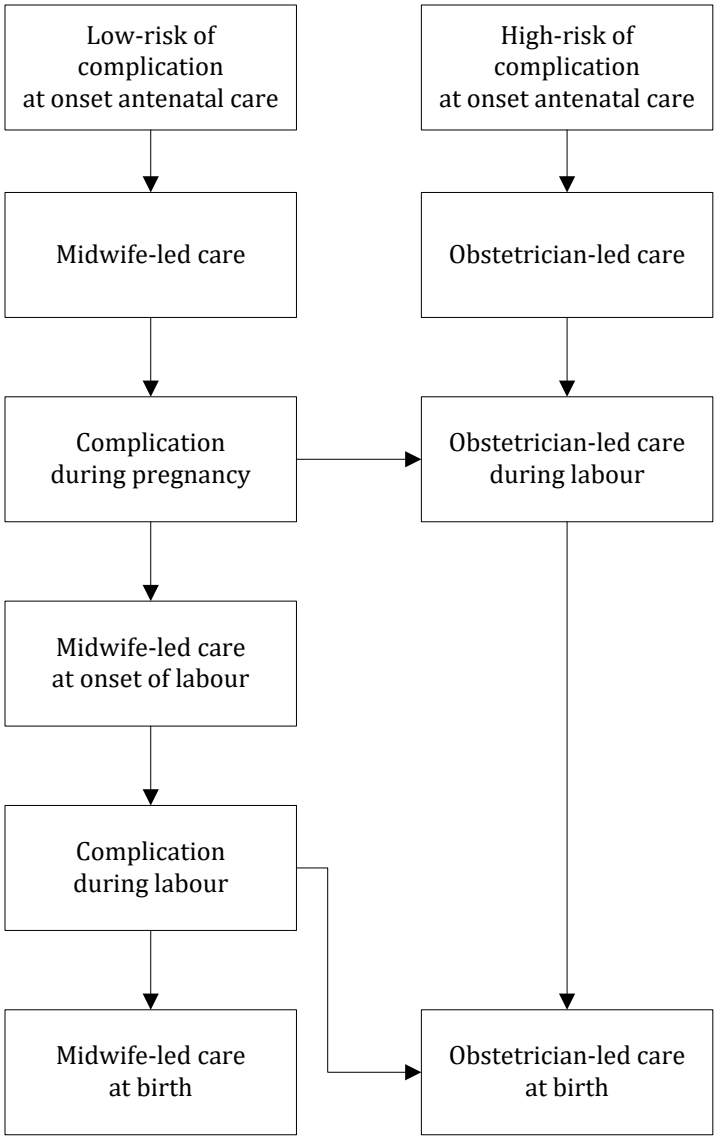

Figure 4. Obstetric care system in the Netherlands, division between midwife-led care- and obstetrician-led care model [37]

4.2 Exploring childbirth expectations

The previous paragraph described how the Dutch obstetric care system is organised. This paragraph will answer the second sub-question, which reads as follows: ***2.*** *How do midwifes in the Netherlands find out what the childbirth expectations of pregnant women are?* When looking at the flowchart of Figure 1, this sub-question can be linked to the very beginning of the flowchart, see the black box in Figure 5. As shown in Figure 5, the block of 'factors that influence childbirth expectations' is part of beginning of the flowchart. This was asked as well next to the stated second research sub-question. The methods that were used to answer this question are the questionnaire and the interviews.

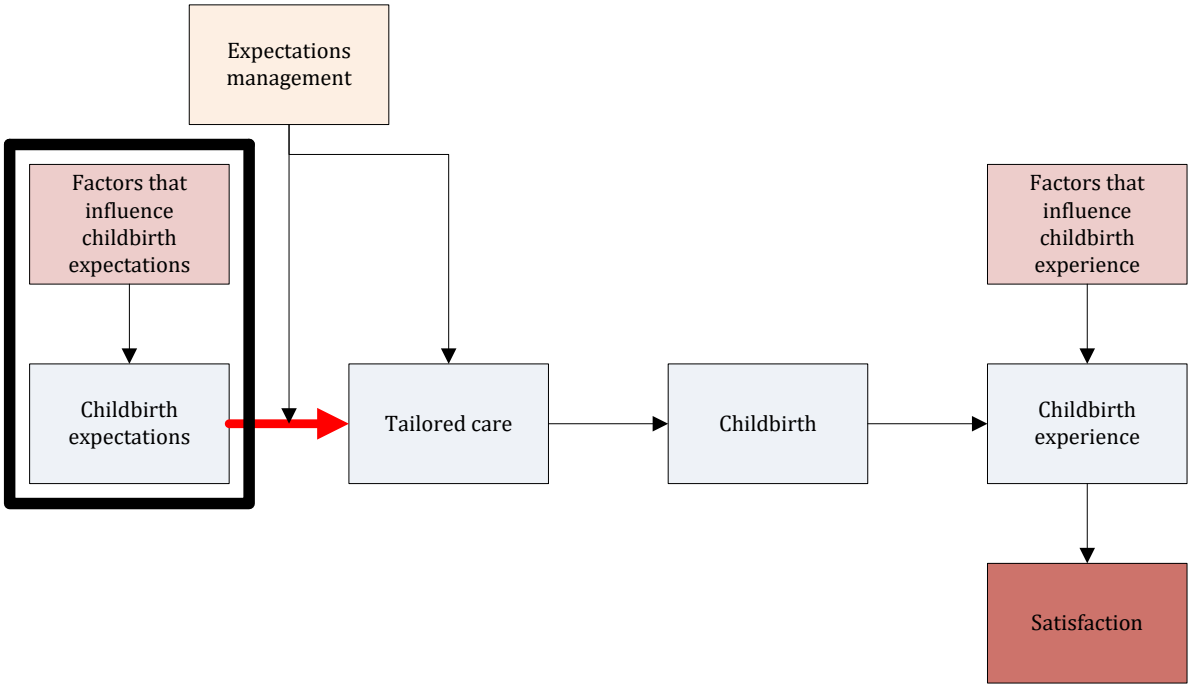

Figure 5. Exploring childbirth expectations

The second section of the questionnaire was focused on eight factors that influence the childbirth expectations. Being aware of those factors is the first and (un)conscious step of expectations management. The results from the questionnaire showed that 25 of the 26 respondents are always aware of the medical situation of their clients. Next to the medical situation, the civil status and earlier experience score high as well, 17 of the 26 respondents are always aware of these two factors. In contrast, the home situation and the religion of the pregnant woman score quite low, 6 of the 26 respondents are always aware of them. The pregnancy courses a pregnant woman might follow scored the lowest with 1 of the 26 respondents that is always aware of this factor. The total overview of all these scores can be found in Appendix V, Table 3.

During the interviews, the participants were asked how they explore childbirth expectations. From the twelve interview participants, everybody was very clear in how they find out what the childbirth expectations of pregnant women are. They 'just' ask the women what their expectations are. *"I just bring it up in the consultation hours and start a conversation." (R.3, S13)* Most of the time this is a natural process that flows through the pregnancy. In the beginning of the pregnancy the childbirth will be mentioned but not discussed in very much detail. *"In the beginning of the pregnancy I will ask for example; did you already think about the place where you want to give birth?" (R.1, S.11)* The conversations about the childbirth will be more frequent and

go into more detail as the pregnancy progresses. The topics that are discussed during the consultation hours are parallel to the phase of the pregnancy. The midwifes look at each woman as an individual and start the process with every single woman from the very beginning. The midwife mostly asks about the expectations the pregnant woman has about her childbirth, since a pregnant woman generally does not bring the topic up herself. There are women who do bring up the topic themselves, but those are mostly women who gave birth before.

Prior experience is one of the six factors that the participants mentioned as being of influence for childbirth expectations. The participants were asked about factors that might influence the childbirth experience.

The first factor the midwifes mentioned is the attitude of the pregnant woman. Table 2 gave us four types of women. In practice, the midwifes recognized the four types of pregnant women as well, but they called them different. The first type that all the twelve participants mentioned is the 'control-freak'. This type of woman wants to be in control of everything in her pregnancy. She reads a lot and wants as much information as possible about all the possible scenario's. The second type of woman was mentioned by ten midwifes and is called 'down to earth'. This type is very calm and aware of the exiting event called childbirth. She is realistic in her expectations, knows it is a day of hard work and will wait and see. One midwife gave this quote of a pregnant lady: *"Yeah, well I can prepare myself for ten different scenarios and you will see I will get scenario number eleven, I will just go with the flow." (R.10, S.50)* The third type is called the 'anxious' woman. This type of woman was mentioned by six midwifes. She finds everything scary and is afraid that things will end up badly. She prefers to give birth in a hospital because that is safer in her opinion, when all the medication and help is within reach. The last and least mentioned type was mentioned by 4 midwifes and called the 'natural' type of woman. She wants to do what her body tells her to do. *"Last week I had a woman whose baby pooped in the amniotic fluid and she did not want to go to the hospital. I feel my baby moving so then it is alright, I do not need extra help she told me." (R.3, S.213)* So, these women want as few medication and hospital time as possible. An overview of the comparison with Table 2 can be found in Table 6. The midwifes pointed out that they all adjust their care for the different types of woman. They pointed out that every type requires a different approach in coaching the woman through her pregnancy and childbirth.

Table 6. Comparison between Table 2 and practice on different types of women

Literature	**Practice**	**Quotes**
Conflicted	Control-freak	*"We call women who wants to know when and how everything is going to happen, from the beginning till the end control-freaks." (R.8, S.52)*
Reciprocator	Down to earth	*"There is the type of woman that knows that it is not going to be easy, but everybody can do it, so I can do it as well." (R.4, S.51)* *"My mom and grandmother could do it, so I can do it too." (R.2, S.83)*
Regulator	Anxiety, fear	*"Sometimes there are women who are really anxious about the impeding childbirth, mostly due to a traumatic childbirth in the past." (R.5, S.17)*
Facilitator	Natural	*"We also experience women who want to do it as natural as possible, and they do not even want an internal examination." (R.3, S.188)*

The second factor is the social environment. This has a very big influence on the expectations according to the participants. *"Everything you will hear from your own mother, grandmother, sister and neighbour will colour your childbirth expectations."* "*When the women in your direct neighbourhood all had a home-birth you will consider that as 'normal'." (R.5, S.73)* All twelve participants mentioned this social environment factor.

Medical environment is the third factor. As mentioned before, all midwifes are aware of the medical situation of their clients. The medical situation itself and the relationship between the caregivers and the pregnant woman were not mentioned by the midwifes as an influence factor on the childbirth expectations of pregnant women. On the other side, the parity was mentioned as the biggest influence factor of all. "*Parity makes all the difference in the world. Women who gave birth before know the feeling and better know what to expect!" (R.1, S.65)* All twelve midwifes stated independently from each other that parity is the most important influence factor for childbirth expectations. This goes hand in glove with the fifth factor (determinant) from Table 1, which includes the earlier experience. Whether the expectations are influenced in a positive or negative way is related to the earlier experience.

The fourth factor are the characteristics of pregnant women. The three main points that were mentioned by the midwifes are the age, SES and the level of education. *"The whole conversation with a young lady is different compared to a conversation with a woman of 40 years old." (R.4, S.55)* Eight midwifes mentioned that they see a relation between the characteristics of a woman and her attitude towards childbirth. For example: *"We have a lot of high educated women, and you see that most of the time those women are the control-freaks. They are really struggling with letting go. Young girls do not care as much, they will wait and see more often." (R.11, S.56)* Four midwifes pointed out that they see a relation between the SES and the expectation patterns. Women with a high SES are more likely to be a control-freak, while women with a low SES are more likely to be a down-to-earth type.

The sixth and last factor is the public discourses. *"Sometimes women who get here for their first appointment are really well prepared on forehand. They already read a lot about pregnancy and childbirth, and you see the difference in expectations with women who are not so well prepared." (R.7, S.39)* This midwife said that the level and the amount of information a pregnant woman has, influences her expectations. There were only two midwifes who also mentioned the pregnancy courses that pregnant women can follow. *"And the different kind of deepening she searches for. For example, Hypnobirthing, that is really specific and will colour your expectations for sure." (R.9, S.84)*

In conclusion, midwifes reported that they find out about childbirth expectations of pregnant women by asking them, talking to them and talking with them during consultation hours. They start a conversation about the impeding childbirth and ask about preferences and wishes. They do not literally ask "what are your expectations?", but they discover the expectations in a natural way during these conversations and sessions with the pregnant woman. There are several factors that influence childbirth expectations. Dutch midwifes are always aware of a few of these factors, and mentioned social environment and parity as the two main factors that influence the childbirth expectations the most.

4.3 Managing childbirth expectations

In the previous paragraph, it was explained how Dutch midwifes in general find out what the expectations of pregnant women are. When looking at the flowchart, we already know what these expectations are, but we do not know how the expectations are being managed. This paragraph will focus on the expectations management part of the flowchart, see the black box in Figure 6. The sub-paragraph 4.3.1 will discuss the different methods Dutch midwifes use in practice. Sub-paragraph 4.3.2 discusses how Dutch midwifes keep the childbirth expectations of pregnant women realistic.

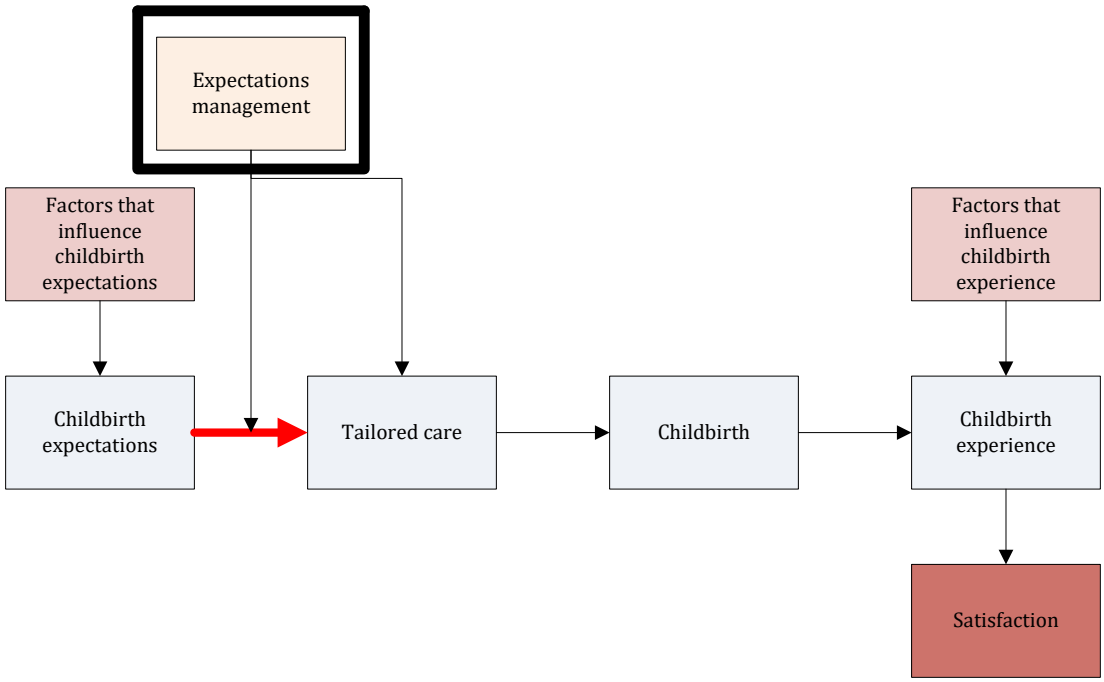

Figure 6. Expectations management

4.3.1 Different methods

This sub-paragraph will answer the third sub-question which reads as follows: ***3.*** *Which methods do Dutch midwifes currently use to manage the childbirth expectations of pregnant women while providing tailored care and what are their experiences with these methods?* Both the questionnaire and the interviews were used to answer this question.

The first method the Dutch steering committee advised to use is the birth-plan. From the questionnaire followed that 21 of the 26 respondents uses the birth plan (Appendix V Table 4). The interviews made clear that although almost every midwife uses this birth plan, the implementation and experiences differ. All the participants know about the birth-plan and in this sample, it is a fully accepted method. A midwife who is working in a small practice with a religious population said: *"Most of the time we do not use birth plans because the women in this population do not have any expectations." (R.2, S.35)* When the researcher asked about negative experiences with the birth plan, eight midwifes pointed out that women do not know what to fill in. Next to this experience, an often-heard experience is that *"Women surf on the internet and fill in stuff that we consider to be 'standard' care." (R.7, S.64)* Examples for this standard care are, the father wants to cut the umbilical cord, the mother wants to breast feed within an hour after birth and other standards things. When these kind of wishes and expectations are written down in a birth plan, it does not exceed its initial aim, according to seven midwifes. Overall, not all practices offer the

birth-plans as a standard for different reasons, but they do have experiences with it. An overview of all the differences methods can be found in Table 7.

The second method the Dutch steering committee advised is the case-manager. The questionnaire showed that 15 of the 26 respondents has implemented a case-manager in their workplace (Appendix V Table 4). During the interviews, the midwifes working in small practices pointed out that they do not need a case-manager. When you are with two or three midwifes in one practice a case-manager is overrated, according to three midwifes. On the other hand, the bigger practices do have a case-manager, but implement it in different ways. A midwife working in a big city practice with a high SES population stated that: *"We as a team divide our clients, everybody is a case manager and is adjusted to a group of clients. The women do not know who their case-manager is, but we as a team do." (R.5, S.106)* In contrast, a midwife working in a big city practice with a low SES population stated that: *"We think it is important that the client knows who her case-manage is. In that way, she always knows who her direct contact person is." (R.11, S.75)*

The third and last method the Dutch steering committee advised is the home-visit. The questionnaire showed that 6 of the 26 respondents has implemented the home-visit (Appendix V Table 4). During the interviews, it was made clear that most midwifes do not value the home-visit. Two main reasons were pointed out by eleven midwifes for not implementing home-visits in their standard care-package: *1) "The maternity care assistant will always perform a home-visit for primiparous women, and with special occasions they will contact us" and, 2) "It is really time consuming to implement home-visits for all the clients."* Especially the midwifes from the small township-practice and the religious population practice find the home-visit unnecessary. *"We know our clients very well, most of the time we even know what the houses look like from the inside because we remember them from a previous child." (R.2, S.183)* Only the midwife working in a big city practice with a low SES population, attaches high values to the home-visits and does perform them. Not as a standard, only in special cases and when women ask for it. *"When performing home-visits, we see the whole picture. Women with a low SES are not very open, in their own house they are more willing to talk about their childbirth expectations." (R.11, S.81)*

During the interviews in the big city practice with a highly educated population the participants mentioned a new method, called Centering Pregnancy (CP). With CP, or group consultation, groups are formed of women who are in the same phase of their pregnancy. There are nine meetings of two hours during their pregnancy and they replace some of the regular check-ups with a midwife (duration 15 minutes). Every meeting has a theme that fits the stage of the pregnancy of that group. In those meetings, pregnant women meet other pregnant women. They can share experiences, ask questions and hear stories from each other [20]. Research has shown that CP has positive influences on the outcomes and childbirth experiences. The midwifes who told about this new method were enthusiastic about it. With every intake, the new clients in this practice get the chance to join the CP. However, a midwife from a small practice mentioned this: *"We consciously decided that we would not introduce CP here, because this town is too small. All women know each other or are family and for that reason they are maybe not able to speak freely and open." (R.1, S.30)* This made clear that the implementation of this new method depends on the context and the population. Practices cannot just implement CP. The midwifes must follow a study and course, which costs money and time.

In conclusion, Dutch midwifes use different kind of methods to manage childbirth expectations. Birth plans are the most commonly used method and a new method called CP is on the move. Case-managers are only used in big practices and home-visits are only used in a big city practice with a low SES population. The methods are used to explore what kind of woman a client

is. When midwifes figured that out, they adjust the care they provide for them, based on the client. The approach towards a control freak, differs from the approach towards a natural woman.

Table 7. Overview implementation of different methods and experiences from Dutch midwifes

Method	Implementations	Positive experiences	Negative experiences
Birth-plan	Most practices do mention the birth-plan during consultation hours, but the decision to use it lies with the pregnant woman.	It is valuable to think about the different options there are for child birthing, and discuss this with your partner.	Women do not know what to fill in, or fill in standard options which are of no use for the midwifes.
Case-manager	Only used by big midwifes practices (>3 midwifes)	Creates clearness in who is responsible for certain things.	Overrated for small practices. (<3 midwifes)
Home-visit	Not implemented	As a midwife, you will get a better view on the home situation.	Costs too much time, and is not necessary because the maternity care assistant already does home-visits.
CP	Only implemented in big practices (>3 midwifes)	Women are better prepared and have more realistic expectations.	Not useful in small villages where everybody knows each other.

4.3.2 Realistic expectations

Next to the different methods that are used to manage childbirth expectations, it is important that the expectations of pregnant women are realistic. This sub-paragraph will discuss the fourth sub-question. The fourth sub-question reads as follows: ***4.*** *How do Dutch midwifes keep the childbirth expectations of pregnant women realistic?* For this question, the interviews were used as method.

During the interviews, the topic realistic expectations has been addressed. The twelve midwifes were consistent in the answers they gave to these questions. Managing the expectations to be realistic is a process of four steps, according to the midwifes. The first step is to discover that a woman has unrealistic expectations of her impeding childbirth. Midwifes find this out when their clients ask doubtful questions, or write down strange and unreal things, such as *"I want you to help me when I am in labour" (R.11, S.117)*, in their birth plan. This is not possible because midwifes work in shifts, the midwife who is on duty will help the clients that are birthing in her shift. The second step is to find out what the reason is behind this expectation or wish. Most of the time, there is a specific reason for certain wishes or expectations. When you can get to the source, the problem is easier to solve. Step number three in this process is giving the pregnant woman extra information about that topic. *"I will provide her with information that I gained from my study, literature and practice and try to explain to her why I would advise something else." (R.4, S.94)* The midwifes pointed out that most of the time they will have a good conversation with these women and try to change the unrealistic expectations into realistic ones. In exceptional cases, the

midwifes must perform step number four, finding another caregiver. *"If all those things do not work in the end, we will try to find her another suitable caregiver." (R.9, S.127)*

All twelve midwifes pointed out that they offer information evenings to prevent these unrealistic expectations from happening. Those evenings are held around the 30th week of the pregnancy and are especially focused on the childbirth. During these evenings, the whole process of childbirth will be highlighted. Subjects like what is going to happen, why, how is the body changing, pain medication, relaxing exercises and different positions for birthing will pass by. *"During these evenings, we use a lot of examples from practice. We emphasize that the information we are providing is based upon a 'standard' childbirth. Every childbirth is unique and it can go much better or sometimes worse compared to these examples." (R.4, S.104)* The partners are empathically asked to join their pregnant partner in this meeting because it is important that they are prepared for the childbirth as well. Preparation is important and yet complicated in this branch. Midwifes studied four years for their profession and learned about all the things that could go wrong. *"I cannot tell them all the horrible things that could happen because that would scare them off, but yet we need to prepare them for a real-life childbirth and not being to rose-coloured." (R.4, S.123)* This illustrates the consideration midwifes must face every time they make a decision and manage the childbirth expectations of pregnant women.

In conclusion, the midwifes keep the expectations realistic by following a four-steps process. To prevent the unrealistic expectations from happening, special childbirth information evenings are offered.

4.4 Points for improvement

Previous paragraphs made clear how midwifes discover what the childbirth expectations of pregnant women are and what kind of methods they use to manage these expectations. During the interviews, the researcher also asked about improvement points. The fifth sub-question will be answered in this paragraph and reads as follows: ***5.*** *Which improvement points do Dutch midwifes see when they look at expectations management in their own expertise?* For this question, the interviews are used as method.

All twelve midwifes could think of some improvement points. An overview of the most mentioned improvement points can be found in Table 8.

Table 8. Improvement points assisted by quotes

Improvement points	Quote example
More time	- *"I would love to spend more time per client to talk about her and her pregnancy and the expectations she has about the impeding childbirth." (R.4, S.102)*
Media	- *"The media has to listen more to the pregnant women in the Netherlands. They want to have continuous care and attach value to personalization." (R.1, S.303)*
More awareness	- *"Creating more awareness and more realistic expectations. Pointing out that every childbirth is different and all the stories and information you will hear are examples, because your childbirth is going to be unique!" (R.5, S.225)*
Pain medication	- *"Women need to trust their own bodies more, instead of rely on pain medication." (R.12, S.159)*
Involving partners	- *"Involving the partners better in the process of managing the expectations. Their role is underestimated but they play a really important role in the childbirth." (R.3, S.153)*
Centering pregnancy (CP)	- "*More and more practices need to implement CP, I see how valuable these sessions are to the women and this should be available for every single pregnant lady." (R.7, S.95)*
Self-directed	- *"Emphasize more that pregnant women always have a choice. We offer a standard package of care but nothing is mandatory. If you do not want an echo at 20 weeks you do not have to. Nothing should go against your mind! More self-directed women would be good." (R.8, S.188)*

More time, media, more awareness and pain medication are the four largest and most pointed out improvement points. Four midwifes would like to have more time per client. They must do a lot of extra and administrative work to the detriment of client-time. *"A mandatory consultation of 60 minutes will be implemented to explain the 20-week echo. Some women are very well prepared and do not need those 60 minutes." (R.2, S.288)*

There were five midwifes who pointed out that the media should change in their notification. Pregnant women benefit from being heard and receiving personalized care. *"When a pregnant woman gets the attention, coaching and support she needs, the childbirth experiences are much better and pain medication is less needed." (R.2, S.318)* The midwifes believe that the media has a high level of influence in how pregnant women look towards their childbirth nowadays. According to these five midwifes, the media should show a different picture of pregnancy and childbirth. *"Television broadcasts that show a childbirth: a few screams, litres of amniotic water and*

there is the baby. These shows are so not realistic!" (R.9, S.141) It is striking that the midwifes did not mention the media as an influence factor for different childbirth expectations, but that they do mention it as an improvement point.

The third improvement point that was mentioned by six different midwifes is 'more awareness'. Six midwifes stated that more awareness needs to be created about realistic childbirths. Every pregnancy and childbirth is different and women need to be aware of that. Every midwife practice performs information evenings nowadays, according to the participants. There is not a standard package in what to tell and how. *"I think the obstetric care can benefit from a high standard package that every practice offers the same 'good' information to their clients, because now there is no overview at all." (R.7, S.104)*

Another improvement point that four midwifes pointed out is pain medication. The midwifes see a change in attitude towards pain medication. *"All those different kinds of pain medication that is available nowadays did not even exist ten years ago." (R.1, S.61)* They believe that they see a decrease in the trust pregnant women have in their own bodies. They call it an 'anxiety culture' among pregnant women in the Netherlands *(R.12, S.154).* More and more pain medication is available, given and preferred, according to the midwifes. "*Even primiparous women ask for an epidural in advance of the childbirth." (R.11, S.48)*

In conclusion, all the twelve midwifes had improvement points for the expectations management in the Dutch obstetric care system. Some improvement points were mentioned by more than one midwife and others were only mentioned once.

5. Discussion

The present study investigated how Dutch midwifes manage childbirth expectations while delivering tailored care. This descriptive exploratory study used a sequential two-method design including a questionnaire at the *"Pregnancy and Childbirth Symposium"*, followed by twelve semi-structured interviews with Dutch midwifes. This chapter will answer the research question and the results will be evaluated. Furthermore, the strengths and limitations of this study will be described and recommendations are given.

5.1 Main findings

The stated research question of this study was: *"How do midwifes in the Netherlands manage childbirth expectations of pregnant women while providing tailored care?"* Five sub-questions were drawn up in order to answer this question.

The obstetric care system in the Netherlands is divided into three lines of care and combines the midwife-led and the obstetrician-led care model. Looking at this structure it is made clear that most of the time, expectations management is the task of the first line midwifes. They are the first contact point for a pregnant woman, and if everything progresses physiological a first line midwife will support the pregnant woman during childbirth.

Midwifes explore childbirth expectations by engaging in dialogue with their clients. They ask about certain wishes and expectations the client has for the impeding childbirth. This is most of the time a fluent conversation in which the expectations will be faced naturally. Social environment and parity are the two factors that influence the childbirth expectations the most.

Different methods are used in the Dutch obstetric care to manage the childbirth expectations. From the three methods the Dutch steering committee advised to be implemented in 2009, the birth-plan is the most popular. Every practice has experiences with this method, but the implementation differs. The case-manager is only used in big practices and the home-visits are only implemented in a practice with a low SES population. A new method called *'Centering Pregnancy'* was brought to light in big practices, which produces good results in terms of positive childbirth experiences.

When childbirth expectations are being managed, it is important that midwifes control that the expectations of pregnant women are realistic. Childbirth experiences are namely more positive when the expectations are being met. This can only be accomplished when the expectations are kept realistic. Midwifes try to accomplish this by offering special information evenings focused on the childbirth.

The twelve midwifes gave several improvement points to improve expectations management within the Dutch obstetric care. Time, media and creating more awareness are the three main topics they pointed out as improvement points.

In the end, the obstetric care in the Netherlands handles a women centered approach, where midwifes provide tailored care. The childbirth expectations are being explored by Dutch midwifes and managed. The form and how they give substance to this expectations management depends on the size of the midwife practice and on the population the practice cares for. Small practices are even more focused on the individual client because they know their clients better compared to the bigger practices. Dutch midwifes use different methods to manage childbirth expectations but the most common way is conversation.

5.2 Relation with the literature

The literature pointed out that it is important to look at the childbirth experiences to be able to create realistic childbirth expectations [2]. Midwifes did put parity forward as the main important determinant that influences the childbirth expectations. However, if they take more of these experiences into account by managing the expectations, outcomes may be better.

The Dutch Steering Committee advised to implement three instruments in the Dutch obstetric care system [21]. Lothian et al. described the positive and negative sides of birth plans complemented with the future of birth plans. This study showed nearly the same results as this article [23]. The midwifes confirmed that the birth plan is a useful tool to encourage pregnant women and their partners to think about choices and what kind of birth they want, and to become acquainted with available options before the childbirth begins. The practice showed a problem that occurs around birth plans, women do not know what to fill in. This creates dissatisfaction with both pregnant women and midwifes. The implementation of the home-visit before the 34th week of pregnancy did not work out in practice. Only the big city practice with a low SES population performed home-visits. The Dutch steering committee could have overlooked the role of the maternity care assistants in the Netherlands and forgot to take this into account by writing the advice rapport [40]. Maternity care assistants already perform home-visits by every primiparous woman and sometimes by multiparous woman, and they alarm the midwifes when something is wrong. When midwifes must perform a home-visit as well, it might fail to achieve the objective of doing it.

The literature stated that pregnant women can be divided into four groups [2, 11-13]. The midwifes confirmed that pregnant women can be divided into groups. Eight of the twelve midwifes came up with two groups, three with three groups and one with four groups. Haines et al. concluded that belonging to the *'Fearful'* group (in this study called anxiety) had a negative effect on women's emotional health during pregnancy and increased the likelihood of a negative birth experience. The midwifes did not confirm this association, but they did saw an association between the level of SES and the attitude of the pregnant woman towards childbirth.

5.3 Strengths and limitations

This study has several strengths and limitations, which will be discussed in this paragraph, starting with the limitations. The limitations should be considered when the results of this study are interpreted. The first limitation is that the sample of the questionnaire includes only the persons who were present at the symposium. This could have influenced the results, because people who join symposia are mostly eager to learn and open towards research. Second, the interviews were performed face-to-face. This approach might have caused that the participants gave socially acceptable answers during the interviews. They could for example have been influenced by the researchers' intonation of the questions. This may have led to information bias. The last limitation is selection bias. This could be caused by the fact that in some practices one midwife was interviewed and in other practices more than one.

Next to these limitations this study consists of strengths. In total, there are five main strengths. The first strength is that information from this study provides a first overview and insight in how childbirth expectations are being managed in the Dutch obstetric care system. In addition, it reveals aspects that might need attention in the future to ensure that all women in the Netherlands have realistic expectations about their impeding childbirth. The second strength of this study is the variation in and the size of the sample for the qualitative part. The six midwife practices differed from each other in their population of clients they take care of. Such sample

variation results in a more complete view about the region of Overijssel in the Netherlands. These two strengths, ensure that the results from this study are generalizable for the region of Overijssel in the Netherland. Third, the high motivation to talk about this topic during the interviews with the participants indicates that this topic is considered to be important by Dutch midwifes. The fourth strength is that the response rate on the questionnaire distributed on the *'Pregnancy and Childbirth Symposium'* was 100%. The last strength is that internal validity was enhanced by a second encoder.

5.4 Recommendations

In this paragraph two types of recommendations will be given, first some practical recommendations and second recommendations for further research.

The results of this study could be strengthened through investigating other regions of the Netherlands on expectations management to create a generalizable overview about the whole Netherlands. This is valuable because literature states that well-executed expectations management can improve the ratio of positive childbirth experiences, but the current situation on expectations management has never been investigated.

When it is clear how expectations management is shaped in the Dutch obstetric care system, adjustments can be made to improve it. The '*Knowlegde network for obstetric care'* is the perfect way to look at expectations management within the Dutch obstetric care and spread the results easily throughout the whole country. ZonMw is the Dutch organisation that finances healthcare research and innovation. It stimulates research and the use of it in practice to improve the healthcare sector. In 2013, ZonMw started a program called 'Pregnancy and childbirth'. This program stimulates a national knowledge network for obstetric care. The mission of this program is to have a healthy mother, pregnancy and child. It consists of 10 consortia spread throughout the Netherlands. Each consortium consists of a large group of professionals/ stakeholders: municipal health services – youth care – child protection – general practitioners – gynaecologists – midwifes – paediatricians – maternity care. They work together as a big multidisciplinary team. The added value of this network of consortia is 1) the cooperation nationwide and 2) development [21]. There is a lot of knowledge available and it is important that this knowledge will be shared and spread throughout the whole country [21, 41].

A practical recommendation would be for the Dutch Steering Committee to write a new advice report with updated information.

A recommendation for further research would be to focus more on the care-givers (midwifes) experiences. How do they support pregnant women during childbirth and what are their opinions about it? The midwifes are namely the persons that can make a difference in this field. There are several studies that aim that positive childbirth experiences can be reached by well-executed expectations management [5, 8, 19, 24, 42]. All these studies took the care-receivers (pregnant woman or the woman who gave birth) as study population. None of these studies focused on the care-givers (Dutch midwifes). Moreover, studies in this field are often focused on negative or even traumatic childbirth experiences [3, 11, 18]. The objective of the study of Hollander, M.H., et al. even included '*what they feel their caregivers could have done differently'.* Which indicates that the problem lies with them.

Further research could dig into the mentioned improvement points, to investigate if these problems with their corresponding improvement points occur more often in the Netherlands. If they do, the feasibility and possibility of these improvement points could be explored.

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Appendix I Questionnaire

Enquête – Verwachtingen van zwangere vrouwen managen

Mijn naam is Karlijn Veltjen en in het kader van mijn master Gezondheidswetenschappen doe ik onderzoek naar verwachtingsmanagement. Het gaat in deze enquête om uw eigen ervaring en mening, waarbij alleen goede antwoorden gegeven kunnen worden. De informatie die u verstrekt zal uitsluitend voor dit onderzoek gebruikt worden. Tevens worden de gegevens anoniem verwerkt in de verslaglegging.

1. Geslacht
O Man
O Vrouw

2. Huidige functie
O eerstelijns verloskundige
O tweedelijns verloskundige
O gynaecoloog
O anders, namelijk .....

3. Leeftijd

.....
4. Hoe lang beoefent u dit beroep al?

.....
5. Waar heeft u uw opleiding gevolgd?

..... (Land) ..... (Stad)
6. Waar werkt u momenteel?

..... (Plaats)

---

7. Wanneer u een zwangere vrouw begeleid in haar zwangerschap en de voorbereiding op de bevalling, bent u dan op de hoogte van de volgende zaken:

Medische situatie	O Altijd	O Meestal wel	O Meestal niet	O Nooit
Burgerlijke staat	O Altijd	O Meestal wel	O Meestal niet	O Nooit
Thuissituatie	O Altijd	O Meestal wel	O Meestal niet	O Nooit
Geloof (religie)	O Altijd	O Meestal wel	O Meestal niet	O Nooit
Eerdere ervaringen met zwangerschap	O Altijd	O Meestal wel	O Meestal niet	O Nooit
Houding t.o.v. bevalling	O Altijd	O Meestal wel	O Meestal niet	O Nooit
Wensen m.b.t. de bevalling	O Altijd	O Meestal wel	O Meestal niet	O Nooit
De cursussen die ze eventueel volgt (zwangerschap gerelateerd)	O Altijd	O Meestal wel	O Meestal niet	O Nooit

8. Laat u uw zwangeren een geboorteplan maken?
O Ja O Nee
Waarom wel of waarom niet?

……

……

9. Wordt er binnen uw huidige werk gebruik gemaakt van een huisbezoek voordat de bevalling heeft plaatsgevonden?
O Ja O Nee
Waarom wel of waarom niet?

……

……

10. Wordt er binnen uw huidige werk 1 vaste zorgverlener (case-manager) gekoppeld aan een zwangere vrouw?
O Ja O Nee
Waarom wel of waarom niet?

……

……

11. Hoe belangrijk acht u de verwachtingen die een zwangere vrouw heeft ten opzichte van de bevalling op een schaal van 1 tot 5? (Omcirkel het cijfer dat van toepassing is)

Niet belangrijk 1 2 3 4 5 Erg belangrijk

12. In hoeverre neemt u deze verwachtingen ook mee in het leveren van zorg aan de zwangere vrouw? (Omcirkel het cijfer dat van toepassing is)

Nooit 1 2 3 4 5 Altijd

Respondenten gezocht! Bent u beschikbaar om mee te werken aan een kort interview (+ - 30min) over dit onderwerp en uw antwoorden kort toe te lichten? Het interview kan telefonisch gevoerd worden, maar kan ook op uw werklocatie gehouden worden op een voor u geschikt tijdstip. Laat dan hier uw emailadres en/ of telefoonnummer achter.

……

Dit is het einde van de vragenlijst. Hartelijk dank voor uw medewerking! Benieuwd naar de resultaten of heeft u andere vragen betreffende dit onderzoek? Dan kunt u mailen naar k.j.veltjen@student.utwente.nl

Nogmaals dank,
Karlijn Veltjen
MSc Student Health Sciences, University of Twente

Appendix II Interview protocol

Interview protocol

Mijn naam is Karlijn Veltjen en ik studeer aan de Universiteit Twente. In het kader van het afstuderen van mijn master Gezondheidswetenschappen zou ik u een paar vragen willen stellen. Mijn onderzoek richt zich op de verwachtingen die zwangere vrouwen hebben over de bevalling en hoe verloskundigen hiermee omgaan. Het gaat hier vooral om de manier waarop u als verloskundige met deze verwachtingen omgaat in het zorgpad dat de zwangere vrouw doorloopt tot aan de bevalling.

Wanneer ik u vraag naar uw mening, gaat het uitdrukkelijk om uw persoonlijke mening. Er kunnen dan ook alleen maar goede antwoorden gegeven worden.

Ik wil graag benadrukken dat de informatie die u verstrekt hoogst vertrouwelijk behandeld zal worden. Dit betekent dat alleen ik weet welke antwoorden u gegeven heeft. De gegevens uit dit interview zullen volledig anoniem worden gebruikt in de verslaglegging.

De duur van het interview zal ongeveer 30 minuten bedragen.

Voor de volledigheid en om er zeker van te zijn dat ik alle benodigde informatie uit dit interview haal, zou ik het graag op willen nemen. Na het transcriberen van de opname zal deze worden vernietigd. Gaat u hiermee akkoord?

Heeft u verder nog vragen voor we gaan starten met het interview?

Appendix III Informed consent

Toestemmingsverklaring formulier

Titel onderzoek: Managing childbirth expectations
Verantwoordelijke onderzoeker: Karlijn Veltjen

In te vullen door de deelnemer

Ik verklaar hierbij dat ik op een duidelijke manier informatie heb gekregen over het doel van het onderzoek en hoe het onderzoek wordt uitgevoerd. Ik stem helemaal vrijwillig in met deelname aan dit onderzoek. Ik weet dat ik op elk moment mag stoppen met het onderzoek. Daarvoor hoef ik geen reden op te geven. Als mijn antwoorden worden gebruikt in publicaties, zal dit volledig geanonimiseerd gebeuren. Mijn persoonsgegevens worden behalve door de onderzoeker niet door anderen bekeken zonder mijn toestemming.

Naam deelnemer: ……..

Datum: …… Handtekening deelnemer: ……..

In te vullen door de uitvoerende onderzoeker
Ik heb een mondelinge en schriftelijke toelichting gegeven op het onderzoek. Ik zal resterende vragen over het onderzoek naar vermogen beantwoorden. De deelnemer zal van een eventuele voortijdige beëindiging van deelname aan dit onderzoek geen nadelige gevolgen ondervinden.

Naam onderzoeker: ……..

Datum: …… Handtekening onderzoeker: ……..

Appendix IV Interviewscheme

1.

Hoe komt u erachter welke verwachtingen zwangere vrouwen hebben ten opzichte van de bevalling?

- Vraagt u zelf naar deze verwachtingen?
- Wanneer in de zwangerschap begint u over de verwachtingen?
- Welke rol speelt het tijdstip in het vragen naar de verwachtingen?
- Hoe betrekt u de aanstaande vaders in dit proces?

2. Welke verschillen ziet u in de verwachtingspatronen van zwangere vrouwen?

- Welke verwachtingen hebben zwangere vrouwen zoal?
- Welke factoren zorgen volgens u voor verschillende verwachtingspatronen?
- *1e of 2e kind – SES – opleiding – leeftijd etc.?*

3. Welke methodes of instrumenten gebruikt u om inzicht te krijgen in de verwachtingen van zwangere vrouwen?

Eventueel specifiek vragen naar de drie instrumenten uit de enquête.

- Waarom is er voor deze methode gekozen binnen uw werkplek?
- Zijn er speciale methodes voor de verschillende verwachtingspatronen van zwangere vrouwen?

4. Kunt u vertellen wat uw ervaringen zijn met deze methode(s)?

- Kunt u de voor- en nadelen van deze methode(s) omschrijven?
- Zou u willen veranderen van methode?
- Welke nieuwe ideeën over methoden die u heeft gehoord lijken u wel wat?

5. Omgaan met de verwachtingen en de evaluatie achteraf.

- Hoe gaat u om met de verschillende verwachtingspatronen van vrouwen?
- Hoe zorgt u ervoor dat de verwachtingen van zwangere vrouwen realistisch blijven?
- Wanneer grijpt u echt in?
- Met welke zorgverleners werkt u samen met betrekking tot deze verwachtingen?
- Hoe evalueert u het verwachtingspatroon na de bevalling met de moeder?

6. Waar ziet u verbeterpunten in het begeleiden van een zwangere vrouw met betrekking tot haar verwachtingen van de bevalling?

- Hoe zouden eventuele veranderingen eruitzien in uw visie?

EXTRA

Hoe ziet voor u de ideale situatie eruit met betrekking tot verwachtingsmanagement?

Als u het kort zou moeten samenvatten hoe gaat u dan om met de verwachtingen die zwangere vrouwen hebben ten opzichte van de bevalling?

Wanneer u een onbeperkt budget ter beschikking heeft, zijn er dan wensen die u kunnen ondersteunen bij het uitvoeren van verwachtingsmanagement? Om de vrouw/ cliënt gerichte zorg nog verder te optimaliseren?

Appendix V Results questionnaire

The questionnaire can be split up in four sections, see Table 1. Each section will be discussed separately.

Table 1. Distribution of the questionnaire into 4 sections

Section	Question number
I	1-6
II	7
III	8-10
IV	11-12

Section one consists of the background variables of participants of the questionnaire. An overview of the answers given to the first six questions can be found in Table 2*. The first thing that needs to be addressed is that this sample of the *"Pregnancy and Childbirth Symposium"* only includes female midwifes and gynaecologists. This is not rare because nationwide the percentage of male midwifes is 1.3 % [43]. The ratio of first line versus second line midwifes was 70/30 in 2015 [43]. These numbers and ratio match the numbers of the sample size.

Table 2. Background variables of participants of the questionnaire, section I

N (%)		**26 (100)**
Gender	Men	0 (0)
	Women	26 (100)
Function	First line	16 (61.5)
	Second line	7 (26.9)
	Gynaecologists	3 (11.5)
Age	20-29	7 (26.9)
	30-39	9 (34.6)
	40-49	6 (23.1)
	50-59	4 (15.4)
Work experience (years)	1-4	4 (15.4)
	5-9	8 (30.8)
	10-14	7 (26.9)
	15-19	2 (7.7)
	>20	5 (19.2)
Education (place)	Kerkrade	1 (3.8)
	Groningen	6 (23.1)
	Zwolle	4 (15.4)
	Londen	1 (3.8)
	Turnhout	5 (19.2)
	Amsterdam	2 (7.7)
	Nijmegen	3 (11.5)
	Maastricht	3 (11.5)
	Rotterdam	1 (3.8)

* *Currently workplace, question 6, is excluded to ensure the anonymity of the participants.*

Section two consists of question 7 with eight sub-questions. The answers given to these questions can be found in Table 3. The first column represents the eight subjects that were asked in question 7, see Appendix I. The average Dutch midwife is always aware of the medical situation of her clients. In contrast, they are divided about the awareness of the religion and pregnancy courses a pregnant woman follows

Table 3. Answers given to question 7 section II

N (%)		**26 (100)**
Medical situation	Always	25 (96.2)
	Most of the time	1 (3.8)
	Seldom	0 (0)
	Never	0 (0)
Marital status	Always	17 (65.4)
	Most of the time	7 (26.9)
	Seldom	2 (7.7)
	Never	0 (0)
Home situation	Always	6 (23.1)
	Most of the time	16 (61.5)
	Seldom	4 (15.4)
	Never	0 (0)
Religion	Always	6 (23.1)
	Most of the time	11 (42.3)
	Seldom	9 (34.6)
	Never	0 (0)
Earlier experience with pregnancy	Always	17 (65.4)
	Most of the time	9 (34.6)
	Seldom	0 (0)
	Never	0 (0)
Attitude towards childbirth	Always	8 (30.8)
	Most of the time	17 (65.4)
	Seldom	1 (3.8)
	Never	0 (0)
Wishes for the childbirth	Always	12 (46.2)
	Most of the time	14 (53.8)
	Seldom	0 (0)
	Never	0 (0)
Pregnancy course(s)	Always	1 (3.8)
	Most of the time	13 (50.0)
	Seldom	11 (42.3)
	Never	1 (3.8)

Section three consist of three questions about the instruments which the Dutch steering committee advised to use in practice. The answers given to these questions can be found in Table 4. In this sample, the birth-plan is the most popular instrument and is used by 80.8%. The home visits are not used very often, only in 23.1% of the cases.

Table 4. Answers given to question 8, 9, and 10 section III

N (%)		**26 (100)**
Birth-plan	Yes	21 (80.8)
	No	5 (19.2)
Case manager	Yes	15 (57.7)
	No	11 (42.3)
Home visit	Yes	6 (23.1)
	No	20 (76.9)

Section four focuses on two questions. The first one is: *"How important do you consider the childbirth expectations of a pregnant woman on a scale from 1 till 5?"*. The second one is: "*To what extent do you include these childbirth expectations in providing tailored care for pregnant women?*" The answers on these two questions can be found in Table 5. What is striking is the fact that almost everyone found the childbirth expectations very important, 76.9%, but only 30.8% always takes them into account by delivering tailored care.

Table 5. Answers given to question 11 and 12 section IV

N (%)		**26 (100)**
How important?	1	0 (0)
	2	0 (0)
	3	0 (0)
	4	6 (23.1)
	5	20 (76.9)
Taking into account?	1	0 (0)
	2	0 (0)
	3	2 (7.7)
	4	16 (61.5)
	5	8 (30.8)

Appendix VI Codebook

Name code	Description	Label
Tailored care	All the information the respondent gives about care that is specifically linked to the individual client.	
Exploring childbirth expectations	All the information the respondent gives on how she discovers what the childbirth expectations of pregnant women are.	
Childbirth expectations	All the information the respondent gives about childbirth expectations of pregnant women, combined with examples from practice.	• Examples • Own opinion
Expectations management	*"Managing expectations means communicating in such way all involved have a clear understanding of what to expect-and when to expect it. It also requires keeping communications open. Key points for success include initiating an open dialogue, making the process collaborative, promising only what can realistically be delivered, and documenting plans in clear ways."* All the information the respondent gives on how she gives substance to the concept of expectations management.	
Expectation patterns	The information the respondent gives about the different expectation patterns she sees in practice.	
Influence factors	All the information the respondent gives on the determinants that can influence and or cause the different expectation patterns.	• Attitude • Social environment • Medical environment • Characteristics • Public discourses • Earlier experiences
New method / instrument	All the experiences the respondent has with a method or instrument we do not yet know about.	• Implementation (how) • Positive experience • Negative experience
Birth-plan	All the experiences the respondent has with the use of a birth plan.	• Implementation (how)

		• Positive experience • Negative experience
Case-manager	All the experiences the respondent has with the use of a case-manager.	• Implementation (how) • Positive experience • Negative experience
Home-visit	All the experiences the respondent has with the use of home-visits before the 34th week in the pregnancy.	• Implementation (how) • Positive experience • Negative experience
Collaboration	All the persons, professions and organisations the midwife works together with.	• Gynaecologists • Hospital • Colleague midwife • Maternity care assistant
Realistic expectations	All the information the respondent gives on how she ensures that the expectations of pregnant women stay realistic.	
Unforeseen events	All the information and examples the respondent gives on unforeseen events.	• Spontaneous actions • Complications • Disagreements
Evaluation	All the information the respondent gives on how the process of childbirth evaluation takes place.	
Points for improvement	All the points of improvement the respondent came up with.	• Netherlands • Practice specific • Individual
Noteworthy	All the information the respondent gives that is remarkable and noteworthy, but cannot be placed under one of the other codes.	