

Description

GANC In The Netherlands: Implementation Results

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Summary

To improve pregnancy outcomes, group antenatal care (gANC) was introduced in the Netherlands and is now offered by a third of midwifery practices. So far it has shown improved outcomes and better care satisfaction. However, uptake varies, particularly among populations in vulnerable conditions. If upscaling of the gANC model is to be undertaken, more knowledge is needed on implementation challenges. The aim of this study was to investigate implementation of gANC amongst midwifery practices. Results show that gANC is available to women, but not all. Scaleup of the model is needed to allow all pregnant women and people to access gANC.



Introduction

The Dutch maternity care system is characterised by midwife-led care whereby community midwives play a crucial role in the care provision for women and pregnant people with uncomplicated pregnancies, including the birth and postnatal period. Community midwives operate in one of the almost 600 independent (group) practices, where individual provider-to-user care is standard practice. Typically, women will have 12 antenatal appointments of 15 minutes each, which increase in frequency towards the end of pregnancy. When complications arise, women are referred to a hospital for secondary care. Midwives have reimbursement contracts with nationwide health insurance companies based on a nationally defined tariff.

Although numbers have improved over recent years, the Netherlands still occupies a relatively less favourable position in Europe in terms of perinatal mortality rates.[1] Lifestyle factors and social circumstances of women in vulnerable circumstances affect outcomes.[2] To improve quality of care and pregnancy outcomes, Centering-based group antenatal care (gANC) was introduced in the Netherlands in 2011. Group care replaces individual care whereby eight to 12 women meet up during pregnancy for all medical and psycho-social care, sharing experiences and learning from each other (see Essentials article for model description). What started as a small project in three midwifery practices has now grown into an accepted care model offered by a third of all midwifery practices and some hospitals.[3]

Several Dutch studies on gANC have shown that the model is effective in improving lifestyles, pregnancy, birth outcomes and satisfaction with care. Participants feel more supported to voice opinions about care received and are better able to actively participate in care decisions.[3,4,5,6] gANC is more costly to provide but recent findings indicate that costs are off-set by long-term healthcare cost-savings.[7] However the uptake of gANC differs widely, so disparities remain. Wagijo, et al., investigated gANC adherence and participation rates and showed that these differed considerably amongst midwifery practices and that young, nulliparous women and individuals with high stress levels were more likely to participate. After initial uptake, attendance rates remained good, irrespective of demographic differences.[4] However results may have been biased as few respondents in vulnerable circumstances answered the questionnaire. Commonly reported challenges to participant recruitment are clients' logistical concerns, and a lack of interest and program advocacy by health care providers.8 While few data exists about recruitment of clients in vulnerable circumstances, anecdotal evidence indicates that midwives find it hard to recruit clients belonging to populations which have disproportionate risks of negative perinatal outcomes. If further upscaling of the gANC model is to be undertaken, more knowledge is needed on gANC implementation, on the challenges facing its uptake and on how to increase its utilisation

and efficacy particularly in vulnerable groups. We therefore deployed a monitor to investigate the implementation of gANC, providing an overview of the status quo of gANC the Netherlands, including information on the participation of populations in vulnerable circumstances and barriers as well as facilitators regarding gANC implementation.

Method

Data collection

Study data were obtained from three sources and combined into one database organised by maternity care institution, i.e. primary care midwifery practice or hospital, providing insight in the use and implementation of gANC in the Netherlands.

Included were data from three nationwide group care monitors, (2016, 2018 and 2023), whereby a self-reported online questionnaire was distributed to all gANC trained professionals in the Netherlands. The second source was the Dutch Centering Foundation registration, containing data on the number of gANC trained midwives, year of training and the number of peer learning sessions attended. The third source was the Dutch National Healthcare Institute (ZIN) which executes an annual national quality of care monitor since 2020. The provision of gANC is one of its indicators. Data for this monitor are provided by all maternity care institutions, including primary care midwifery practices. Offering gANC is reported by institutions as yes or no.

Respondents to the nationwide group care monitors in 2016, 2018 and 2023 were recruited via the Dutch Centering Foundation by email containing a link to the online questionnaire. Several reminders were sent and the monitor was promoted on social media. Explanation about the purpose and written consent was included at the questionnaire's start.

All group care monitors included questions to determine if midwifery practices offer or aim to offer gANC, as well as reasons for stopping. In the 2023 monitor, additional information was collected on the estimated number of clients and estimated percentage of clients in vulnerable circumstances that received antenatal care (ANC) as well as in gANC in the institution and the number of groups in 2022. The 2023 monitor utilised multiple-choice, open- response and Likert scale questions to collect mostly quantitative information about varied topics concerning the implementation and experiences of gANC providers, such as self-perceived ease of recruitment measured on a VAS-scale from 0 (impossible to recruit) to 10 (extremely easy to recruit), number of barriers faced in recruiting clients in vulnerable circumstances and actions taken or interventions used to recruit such clients as well as ease of recruitment. Multiple choice options were based on a recent unpublished study by van Bemmel, et al,.[9] Vulnerability was based on the definition by Feijen, et al,.[10]

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Analysis

Analyses were limited to midwifery practices only.

Pearsons correlation coefficients were calculated to assess the linear relationship between study variables using an alpha value of 0.01 to determine a significant linear correlation. Correlations between the dependent variable percentage gANC participants and the independent variables (practice caseload, ratio of gANC staff trained per caseload, years of gANC experience, percentage of clients in vulnerable circumstances and number of actions undertaken to increase participation) were calculated using linear regression analyses using SPSS (Version 28.0.1.1). Frequencies were calculated for the number of gANC participation actions.

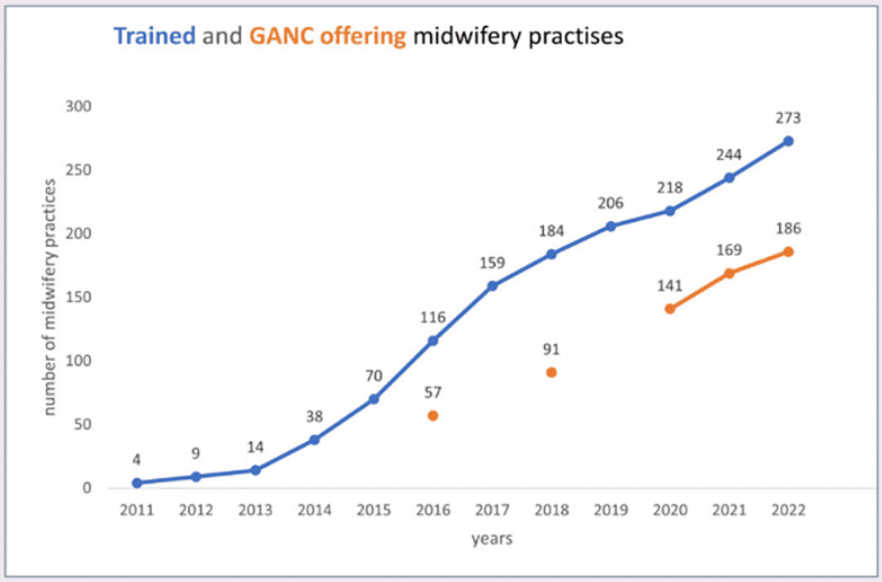
The study was approved by Leiden University Medical Center's Ethics Faculty. Review Board number N20.157, as part of the European GC_1000 project, grant agreement number 848147.

Results

Since the start of implementation of gANC the number of gANC trained midwives and practices which offer gANC show a steady increase over the years (See Figure 1). In 2022, almost 46% (n=273) of all 598 midwifery practices employed at least one gANC trained midwife of which 68.1% (n=186) actually offered gANC. This equates to 31.1% of all

midwifery practices in the Netherlands. A gANC practice had on average 4.8 (SD 3.4) trained midwives available.

Figure 1: **Trained and gANC offering midwifery practices between 2011 and 2022**



Of the 186 midwifery practices offering gANC in 2022, 109 midwifery practices answered the monitor questionnaire (response rate 58.6%) (See Table 1).

Table 1: **gANC in midwifery practices in 2022**

Per gANC offering practice	N 109 (58.9%)	[SD]
Average number of clients entering ANC	374.73	[171.4]
Estimated % clients in vulnerable circumstances in ANC	(20.8)	[15.9]
Estimated average number of Women entering gANC	83 (22.15)	[48.1]
Estimated % Clients in vulnerable circumstances in gANC	(13.1)	[14.3]
Average number of clients per group	9.62	[2.1]
Average years of gANC experience	4.61	[3.3]
Average ratio of gANC trained staff* per number of clients in ANC	0.61	[0.44]
Self-perceived ease of recruitment of clients in vulnerable circumstances for gANC	4.7	[3.2]
Number of actions undertaken to increase participation	2.4	[1.7]

*gANC staff includes co-facilitators, which are not necessarily midwives

Midwifery practices differed considerably in percentage of women attending gANC. On average 21% of the women attended gANC but with a range of 1% to 100%. Midwifery practices with larger caseloads correlated negatively with the percentage of women in gANC (Pearson correlation –0.42 95% CI – 0.58 to – 0.23, p <0.001).

The number of years of experience with gANC did not correlate with higher participation rates (Pearson correlation – 0.09 95% CI – 0.29 to 0.12, p 0.4 but a higher ratio of gANC trained staff and number of clients correlated with higher participation rates (Pearson correlation 0.26 95% CI 0.05 to 0.44, p0.01).

Midwifery practices with a higher percentage of clients in vulnerable circumstances attending ANC also correlated with the overall participation rate in gANC (Pearson correlation – 0.095 95% CI – 0.30 to 0.12, p<0.38 Midwifery practices which offer gANC scored 4.7 (SD 3.2) on the VAS-scale on self-perceived ease of recruitment of clients in vulnerable circumstances. When looking at actions undertaken to increase the participation rate of this group, we found that on

average midwifery practices undertook 2.4 (SD 1.7) actions to increase participation, mainly offering one or more trial sessions (See Table 2). The number of actions undertaken did not correlate with the overall percentage of clients participating in gANC (Pearson correlation 0.05 95% CI -0.16 to 0.26 p 0.65) but did correlate with the percentage of women in vulnerable conditions participating in gANC (Pearson correlation 0.28 95% CI 0.07 to 0.46, p0.009). After logistic regression analyses the only predictors for overall higher attendance rates that remained negatively significantly correlated, was a larger caseload per practice beta – 0.035 95% CI – 0.05 to – 0.02, p< 0.001.

Table 2: **Interventions used in midwifery practices (n=109) to increase gANC participation of clients in vulnerable circumstances**

Intervention	N	%
None	30	26.8
Dissemination of gANC information in different languages via social media	5	4.5
Informing key community figures about gANC	7	6.3
Using an opt-out system (gANC is implemented as the regular care model)	9	8.0
Small incentives for clients	10	8.9
Provision of information and recruitment materials in clients' language	10	8.9
Use of translator/cultural mediator in group sessions	10	8.9
Referral to multilingual information on website midwifery practice	11	9.8
Use of materials during sessions in clients' own language	12	10.7
Offering groups for specific cohorts of clients	13	11.6
Sessions planned at preferred time frames	33	29.5
Offering clients more than one trial session	67	59.8
Offering clients one trial session	69	61.6

Discussion

This study shows that the number of practices employing gANC midwives and offering gANC to clients in the Netherlands has increased substantially over the years, with a third of all midwifery practices currently offering gANC, indicating that the model has firmly taken root within the Dutch maternity care system. Participation rates correlate with practice size and the number of gANC trained midwives in the practice. Providing gANC requires a different attitude from health care professionals, one in which the traditional didactical role is transformed into a facilitating role, empowering

participants. It is possible that when fewer staff in the practice are familiar with the model and its strengths, it is harder for the others to explain to clients why they should participate. However, this needs further investigation.

Despite considerable number of practices offering gANC, the model reaches far from all pregnant women in the Netherlands. As this study has shown, clients in vulnerable circumstances appear to participate less often, whereas it is this group that mostly benefits from the model.[11] Implementation efforts largely depend on midwifery practices with some receiving municipal support in some regions. Although regional maternity care collaborations are in place, little attention is given to the implementation of gANC and availability of gANC is mostly limited to primary care midwifery practices.

However the lack of reach could also be due to issues such as prior expectations of midwives about whether a woman wants to participate, and organisational challenges such as time constraints, transport and childcare facilities.[9]

Lessons learned from the European GC_1000 project (see Article of the Month) show that collaboration between different stakeholders is important from the start, together with a financially stable climate and willingness to invest in organisation and collaboration. It is easier to implement gANC in small vertical organisations with midwives in an autonomous and strong position. The Netherlands is fortunate to be in such a position.

To improve access to gANC for all pregnant women and people, horizontal (more health care facilities) and vertical (more groups per practice or facility) scaling-up needs to be achieved whereby regional collaboration with all stakeholders is essential. All maternity care professionals should be trained in skillful recruitment of women in all layers of society.

Strengths and limitations

The results need to be interpreted with some caution as we assume that most midwives used estimated answers to the questions about numbers and percentages. It is also possible that the monitor is positively biased as those who are more enthusiastic about the gANC model may have been more inclined to answer. However the monitor does expose the areas which need attention when efforts are made to scale-up the model.

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Conclusion

Implementation of gANC has enabled access to gANC to a substantial part of the pregnant population in the Netherlands. However, scale-up of the model is still needed to allow all pregnant women and people to access gANC. Based on currently available results, efforts should be geared towards regional collaboration and recruitment strategies.
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